MDH Minnesota Department of Health

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name: Golden Horizons	**Report Number:** HL23660007	**Date of Visit:** September 13, 2016
Facility Address: 518 Seventh Avenue Northeast	**Time of Visit:** 9:30 a.m.- 5:30 p.m.	**Date Concluded:** October 25, 2016
Facility City: Aitkin	**Investigator's Name and Title:** Rhylee Gilb, RN Special Investigator	
State: Minnesota	**ZIP:** 56431	**County:** Aitkin

☒ **Home Care Provider/Assisted Living**

Allegation(s):

It is alleged that a client was neglected when the client fell on multiple occasions and was injured.

- ☒ State Statutes for Home Care Providers (MN Statutes, section 144A.43 - 144A.483)
- ☒ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
- ☒ State Statutes Chapters 144 and 144A

Conclusion:

Based on a preponderance of evidence, neglect is substantiated. A client experienced three falls with injuries in a month, and the home care provider staff failed to provide adequate assessments, interventions, or consult with the client's physician.

The client received services from the home care provider for diagnoses that included Lewy Body dementia and chronic obstructive pulmonary disease. The client's service plan indicated the client required assistance of one person for all activities of daily living, transfers, ambulation, repositioning every two hours, and toileting assistance every two hours.

The client experienced a fall early in the morning, during an overnight shift. The client was found laying on his/her floor with a laceration to his/her forehead. The home care provider staff updated the client's family member, who transported the client to the urgent care. In the clinic, the client received four sutures. A home care provider's post-fall investigation concluded the client was in bed prior to the fall, but it was unknown how the client received the laceration.

Approximately three weeks later, the home care provider staff was ambulating with the client, while the client used a walker. The client lost his/her balance, fell onto his/her wheelchair, and received a skin tear to his/her right arm. The staff member did not have a gait belt on the client while ambulating. Staff updated the client's family member, who transported the client to the emergency department (ED). At the ED, the skin tear was closed with dermabond. The registered nurse (RN) educated the staff member to use a gait belt at all times when walking with clients.

A week later, the client experienced a third fall. The client was sitting on the edge of his/her bed, when the staff member began to place a gait belt around the client's waist. The client became frightened and fell off the bed onto his/her left side. The client received a hematoma to the back of the head, and staff suspected the client had hit his/her head on the bed. The home care provider staff updated the client's family member. The following day, the client expressed having pelvic pain and the client's family member brought the client to the ED. At the ED, an x-ray was completed, but could not exclude a pelvic fracture. The client was too confused to comply with further imaging. A troponin level (lab test to indicate a heart attack) was also elevated. The client was hospitalized for two days and discharged on comfort cares.

After each of the three falls, the client's vitals signs were not taken and the client's physician was not updated. There were no post-fall RN assessments completed after the first and second fall, therefore no new interventions were implemented or changes made to the service plan. A RN assessment was completed after the client returned from the hospital following the third fall, but the only change in status documented was the client was no longer able to ambulate. No other changes were made to the service plan. Approximately two weeks later, the client passed away. The death certificate indicated the client died from natural causes.

Interviews were completed with the home care provider staff. The RN stated the client was toileted and repositioned on alternating times, therefore the client had staff interaction at least hourly. In addition, the RN stated s/he updated the client's nurse practitioner verbally regarding the client's first fall, in which the client required sutures, but did not update the physician on any of the other falls. The staff stated the client had a slight decline in health status before the falls, but had gotten worse after the first fall. In addition, staff stated no new interventions were implemented after each fall except that staff were reminded to keep a closer eye on the client. Another RN conducted an investigation related to the client's falls and concluded that staff needed improvement in documenting, updating the physician, and providing assessments.

During an interview with the client's family member, the family member stated s/he felt the client's injuries were not consistent with the report of how the client had fallen with the first and third fall. The family member also stated s/he had seen staff not using gait belts with other clients and felt staff were not properly trained nor supervised. In addition, the family member stated s/he brought concerns to the RN and management, but did not receive communication on any follow up into the client's falls.

Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557)

Under the Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557):

☐ Abuse ☒ Neglect ☐ Financial Exploitation

☒ Substantiated ☐ Not Substantiated ☐ Inconclusive based on the following information:

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ☐ Individual(s) and/or ☒ Facility is responsible for the

☐ Abuse ☒ Neglect ☐ Financial Exploitation. This determination was based on the following:
The facility failed to ensure staff followed an established policy. The facility fall policy indicated a RN assessment will be completed after any fall, and determine if any service plan changes need to be made. The policy also indicated interventions will be incorporated to reduce the risk of falls and the client's physician will be updated if treatment is considered (client was sent to the ED). It is reasonable to expect vital signs to be taken after the client experienced a head injury, but the facility did not consistently require this.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

Compliance:

State Statutes for Home Care Providers (MN Statutes section 144A.43 - 144A.483) - Compliance Not Met
The requirements under State Statutes for Home Care Providers (MN Statutes, section 144A.43 - 144A.483) were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) - Compliance Not Met
The requirements under State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

State Statutes Chapters 144 & 144A – Compliance Not Met - Compliance Not Met
The requirements under State Statues for Chapters 144 &144A were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

Compliance Notes:

Facility Corrective Action:

The facility took the following corrective action(s):

A second RN was hired in September 2016, to reduce the caseload, which the home care provider determined was too high caseload for one RN.

Definitions:

Minnesota Statutes, section 626.5572, subdivision 17 - Neglect

"Neglect" means:

(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult.

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

The Investigation included the following:

Document Review: The following records were reviewed during the investigation:

- ☒ Medical Records
- ☒ Medication Administration Records
- ☒ Nurses Notes
- ☒ Assessments
- ☒ Physician Orders
- ☒ Treatment Sheets
- ☒ Physician Progress Notes
- ☒ Care Plan Records

☒ Facility Incident Reports
☒ ADL (Activities of Daily Living) Flow Sheets
☒ Service Plan

Other pertinent medical records:

☒ Hospital Records ☒ Death Certificate
☒ Police Report

Additional facility records:

☒ Staff Time Sheets, Schedules, etc.
☒ Facility Internal Investigation Reports
☒ Personnel Records/Background Check, etc.
☒ Facility Policies and Procedures

Number of additional resident(s) reviewed: three

Were residents selected based on the allegation(s)? ◉ Yes ○ No ○ N/A

Specify: fall history

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

○ Yes ◉ No ○ N/A

Specify: the client is deceased

Interviews: The following interviews were conducted during the investigation:

Interview with complainant(s) ◉ Yes ○ No ○ N/A

Specify:

If unable to contact complainant, attempts were made on:

Date: Time: Date: Time: Date: Time:

Interview with family: ◉ Yes ○ No ○ N/A Specify:

Did you interview the resident(s) identified in allegation:

○ Yes ○ No ◉ N/A Specify:

Did you interview additional residents? ◉ Yes ○ No

Total number of resident interviews:four

Interview with staff: ◉ Yes ○ No ○ N/A Specify:

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: eight

Physician Interviewed: ○ Yes ◉ No

Nurse Practitioner Interviewed: ○ Yes ◉ No

Physician Assistant Interviewed: ○ Yes ◉ No

Interview with Alleged Perpetrator(s): ○ Yes ○ No ◉ N/A Specify: _____

Attempts to contact:

Date:	Time:	Date:	Time:	Date:	Time:

If unable to contact was subpoena issued: ○ Yes, date subpoena was issued _____ ○ No

Were contacts made with any of the following:

☐ Emergency Personnel ☐ Police Officers ☐ Medical Examiner ☐ Other: Specify _____

Observations were conducted related to:

☒ Call Light

☒ Cleanliness

☒ Transfers

☒ Meals

☒ Facility Tour

☒ Incontinence

☒ Other: use of alarms and transfer belts

Was any involved equipment inspected: ○ Yes ○ No ◉ N/A

Was equipment being operated in safe manner: ○ Yes ○ No ◉ N/A

Were photographs taken: ○ Yes ◉ No Specify: _____

cc:

Health Regulation Division - Home Care & Assisted Living Program

Minnesota Board of Nursing

The Office of Ombudsman for Long-Term Care

Aitkin County Medical Examiners

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H23660	A. BUILDING: _____ B. WING _____	C 10/05/2016

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0 000	Initial Comments *****ATTENTION****** HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: On 9/13/16, a complaint investigation was initiated to investigate complaint #HL23660007 . At the time of the survey, there were 33 clients that were receiving services under the comprehensive license. The following correction orders are issued.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER ' S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144A.474 SUBDIVISION 11 (b)(1)(2)	
0 265 SS=D	144A.44, Subd. 1(2) Up-To-Date Plan/Accepted Standards Practice Subdivision 1. Statement of rights. A person who	0 265		

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0 265	Continued From page 1 receives home care services has these rights: (2) the right to receive care and services according to a suitable and up-to-date plan, and subject to accepted health care, medical or nursing standards, to take an active part in developing, modifying, and evaluating the plan and services; This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to complete vital signs or update the client's physician after a client fell and experienced a head injury for one of four clients (C1) reviewed. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: C1's medical record was reviewed. C1 was admitted with diagnoses that included Lewy Body dementia and chronic obstructive pulmonary disease. C1's registered nurse (RN) assessment dated 4/26/16 indicated C1 required assistance of one staff for all activities of daily living, including transfers, ambulation, repositioning every two hours, and toileting every two hours. The assessment also indicated C1 was a fall risk, and was to wear non-skid footwear when ambulating.	0 265		

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0 265	Continued From page 2 An incident report dated 5/4/16, indicated C1 was found laying on the floor in her apartment at approximately 1:45 p.m. and had a laceration to her forehead. The RN came to the facility, placed steri-strips over the laceration, and updated C1's family in the morning. C1's family took C1 to urgent care. At the clinic, C1 received four sutures. C1's vitals record and nurse notes were reviewed. No vital signs were taken. There is no record of an update being sent to C1's physician. An incident report dated 6/4/16, indicated that at 3:00 p.m., C1 sat on the edge of the bed with an unlicensed staff member. The staff member attempted to put a gait belt around C1, when C1 became frightened, lunged forward, and fell on her left side. C1 received a hematoma to the back of her head. A follow-up dated 6/5/16 indicated the RN assessed C1 after the fall and indicated C1 moved all extremities without issue and pupils reacted to light. In the morning on 6/5/16, C1 expressed increased pain to the pelvic area. C1's family member transferred C1 to the ED for evaluation. No vital signs were taken by the facility and no fall assessments were completed. C1's hospital record dated 6/5/16 to 6/7/16 indicated C1's X-ray report could not exclude a pelvic fracture, however further imaging could not be completed due to increased confusion and non-cooperation. C1 also had an elevated troponin level (lab test to indicate a heart attack). C1 was placed on comfort care and discharged by the licensee. During an interview with unlicensed personnel (ULP)-C on 9/13/16 at 1:40 p.m., ULP-C stated the nurse informs staff if vitals are needed after each fall. On 9/13/16 at 1:55 p.m., ULP-D stated after each	0 265		

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0 265	Continued From page 3 fall an incident report is completed and the RN is updated. ULP-D added vital signs are taken depending on the severity of the fall. During an interview on 9/13/16 at 2:10 p.m., ULP-E stated vitals are done if the nurse so directs. During an interview on 9/13/16 at 2:58 p.m., ULP-F stated vitals are supposed to be done if a client has a true fall, but not if the client slides off the bed onto their bottom. ULP-F stated for client's who can recall events, the need for vitals depends on the situation, but if a client cannot explain an event, then vitals should always be completed on that client. On 9/13/16 at 3:27 p.m., ULP-G stated vital signs are completed if something serious occurs with a client, for instance hitting their head. During an interview with RN-B on 9/13/16 at 4:20 p.m., RN-B stated she did not update C1's physician for either of C1's falls. In addition, RN-B stated if a client experiences a fall, staff are to notify her. RN-B stated if the client hit their head, experienced an injury or is in pain, then she will come to the licensee to perform an assessment on the client. The licensee policy titled "Falls Prevention and Reduction" dated 7/1/14, did not include any standard of when to complete vital signs. The incident report did not include any identification if vital signs were taken, and the form does not include a place to document vital signs. The licensee policy titled "Reporting, Documenting and Reviewing Incidents Involving Clients" dated 7/1/4, indicated the RN will	0 265		

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0 265	Continued From page 4 document in the client's chart details of the incident and any follow up actions that were taken. However, the policy did not include any identification of when vitals signs should be taken. The licensee policy titled "Initial and On-going Nursing Assessment of Clients" dated 7/1/14, indicated an assessment will be completed after a client experiences an incident such as a fall, but did not included details of what needed to be included in that assessment. TIME PERIOD FOR CORRECTION: Twenty One (21) days	0 265		
0 315 SS=G	144A.44, Subd. 1(12) Served by People Who Are Competent Subdivision 1. Statement of rights. A person who receives home care services has these rights: (12) the right to be served by people who are properly trained and competent to perform their duties; This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee staff failed to use a gait belt while ambulating with a client for one of four clients (C1) reviewed. The client fell and experienced a skin tear. This practice resulted in a level three violation (a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a	0 315		

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0 315	Continued From page 5 limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: C1's medical record was reviewed. C1 was admitted with diagnoses that included Lewy Body dementia and chronic obstructive pulmonary disease. C1's registered nurse (RN) assessment dated 4/26/16 indicated C1 required assistance of one staff for all activities of daily living, including transfers and ambulation. The assessment also indicated C1 was a fall risk, and was to wear non-skid footwear when ambulating. C1's resident service plan history dated 3/1/15 to 6/8/16 indicated C1 required a gait belt for all transfers. C1's incident reports were reviewed. On 5/27/16, staff ambulated with C1 and a walker; however, they did not have a gait belt on C1. C1 lost balance, fell into her wheelchair, and received a skin tear to her right arm. C1 was brought into the emergency department and was treated with dermabond (liquid sutures) to close the skin tear. The staff member was educated by RN-B to use a gait belt at all times when ambulating a client. During an interview with unlicensed personnel (ULP)-C on 9/13/16 at 1:40 p.m., ULP-C stated gait belts should be used with everyone. ULP-C stated there were gait belts in the office for staff to use. In addition, ULP-C stated at times staff do not use a gait belt during a transfer with a client because they do not have one on their person. ULP-C stated use of a gait belt is "not pushed" by management. During an interview on 9/13/16 at 1:55 p.m., ULP-D stated gait belts are used with certain	0 315		

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0 315	Continued From page 6 clients, but other clients are not identified to have one used. During an interview on 9/13/16 at 2:10 p.m., ULP-E stated gait belts are used only with specific clients, and it would be in the client's care plan to identify if the client needed one. During an interview on 9/13/16 at 2:58 p.m., ULP-F stated gait belts are supposed to be used on every client. ULP-F stated staff are expected to have a gait belt with them at all times, and some client's have a gait belt in their room. On 9/13/16 at 3:27 p.m., ULP-G stated almost every client is supposed to use a gait belt. ULP-G stated if a client ambulates independently, then that client does not need one. During an interview on 9/13/16 at 3:55 p.m., ULP-H stated the client's care plan identifies whether that client requires a gait belt. Also, ULP-H stated that any client who requires an assist needs to use a gait belt. During an interview on 9/13/16 at 4:20 p.m., RN-B stated gait belts are used with some client's and are identified on their care plans. RN-B stated the care plans are made available for staff to review. On 10/3/16 at 9:50 a.m., C1's family member stated she witnessed a client fall and the staff asked the client, who had dementia, if the client had fallen. The family member stated that staff did not bring a wheel chair to the client; instead, staff pulled the client up by the arms and sat the client on a chair. Also, the family member stated staff did not use a gait belt and she questioned staff if they should be using one. The family	0 315		

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0 315	Continued From page 7 member stated that staff replied "well, yes," but still did not use a gait belt. The family member stated that staff need more training and supervision. The licensee policy titled "Training and Competency Evaluation of Unlicensed Staff" dated 7/1/14, indicated staff are trained on the prevention of falls. TIME PERIOD FOR CORRECTION: Twenty One (21) days	0 315		
0 325 SS=J	144A.44, Subd. 1(14) Free From Maltreatment Subdivision 1. Statement of rights. A person who receives home care services has these rights: (14) the right to be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act; This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure patient was free from maltreatment when a client experienced three falls with injury in a month, for one of four clients (C1) reviewed. This practice resulted in a level four violation (a violation that results in serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	0 325		

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0 325	Continued From page 8 C1's medical record was reviewed. C1 was admitted with diagnoses that included Lewy Body dementia and chronic obstructive pulmonary disease. C1's registered nurse (RN) assessment dated 4/26/16 indicated C1 required assistance of one staff for all activities of daily living, including transfers, ambulation, repositioning every two hours, and toileting every two hours. The assessment also indicated C1 was a fall risk, and was to wear non-skid footwear when ambulating. C1's resident service plan history dated 3/1/15 to 6/8/16 indicated C1 was scheduled to reposition and toilet every two hours on the odd hour and had safety checks every two hours on the even hours from 6:00 a.m. to 10:00 p.m., then hourly through the night shift. An incident report, dated 5/4/16, indicated C1 was found laying on the floor in her apartment at approximately 1: 45 p.m. and had a laceration to her forehead. The RN came to the facility, placed steri-strips over the laceration, and updated C1's family in the morning. C1's family took C1 to urgent care. At the clinic, C1 received four sutures. C1's vitals record, nurse notes, and RN assessments were reviewed. After this fall, no vital signs were taken, there is no record of an update sent to C1's physician, no fall assessment was completed, and no new interventions were implemented. The RN follow-up report dated 5/7/16 indicated C1 was in her bed prior to the fall and it was unknown what C1 had hit her head on to receive a laceration. A RN note dated 5/10/16 indicated C1 was seen by the nurse practitioner on 5/10/16 and determined sutures should be rechecked for healing prior to removal at the end of the week. A RN note dated 5/16/16 indicated the sutures were removed on 5/13/16. An incident report dated 5/27/16, indicated that at	0 325		

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	H23660	A. BUILDING: _____ B. WING _____	C 10/05/2016

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0 325	Continued From page 9 8:51 p.m., C1 ambulated with a walker and an unlicensed staff member, when C1 lost her balance and fell into her wheelchair. C1 received a skin tear to her right arm. The staff member did not use a gait belt while ambulating with C1, and staff were reminded by RN to use a gait belt at all times while ambulating clients. An RN note dated 5/28/16, indicated C1's family was updated and the family member took C1 to the emergency department (ED) the same evening of the incident. At the ED, C1 had dermabond (liquid sutures) applied to the skin tear. Vitals were recorded on 5/27/16 for C1 as all zero, indicating vital signs were not done. There was also no record of an update send to C1's physician, no fall assessments were completed, and no new interventions were implemented. An incident report dated 6/4/16, indicated that at 3:00 p.m., C1 sat on the edge of the bed with an unlicensed staff member. The staff member attempted to put a gait belt around C1, when C1 became frightened, lunged forward, and fell on her left side. C1 received a hematoma to the back of her head. When C1's family was updated, staff became aware C1 had a history of child abuse with a belt. An RN follow up dated 6/5/16 indicated the RN assessed C1 at the time of the fall and indicated C1 moved all extremities without issue and pupils reacted to light. Staff were educated to use reassurance and apply a gait belt not in plain sight or to use a gait belt with handles that did not appear like a belt. In the morning on 6/5/16, C1 expressed increased pain in the pelvic area. C1's family member transferred C1 to the ED for evaluation. The facility had not taken vital signs or completed a fall assessment. C1's hospital record dated 6/5/16 to 6/7/16 indicated C1's X-ray report could not exclude a pelvic fracture, however further imaging could not	0 325		

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0 325	Continued From page 10 be completed due to increased confusion and non-cooperation. C1 also had an elevated troponin level (lab test to indicate a heart attack). C1 was placed on comfort care and discharged by the licensee. During an interview with unlicensed personnel (ULP)-C on 9/13/16 at 1:40 p.m., ULP-C stated there were no interventions implemented after each of C1's falls. ULP-C also stated C1 did not have any signs of decline until after C1 experienced those falls. On 9/13/16 at 1:55 p.m., ULP-D stated she worked the day shift following C1's first fall. ULP-D stated she received report that RN-B did not believe C1 needed to be seen by a physician, however ULP-D stated C1's laceration bled too much and ULP-D chose to send C1 to the ED. ULP-D stated no new interventions to prevent falls were implemented after this incident, except a reminder by RN-B to keep a closer eye on C1. ULP-D stated C1 was already getting checked on every hour. ULP-D stated C1 had some decline in health before she started falling, but declined further after the first fall. During an interview on 9/13/16 at 2:58 p.m., ULP-F stated C1's room was very cluttered and a person could barely move around. ULP-F described items in C1's room as a kitchen table, dresser, rocking chair, another small table, mini fridge, a big cabinet, wheelchair, and a walker. During an interview on 9/13/16 at 3:27 p.m., ULP-G stated C1 displayed signs of decline such as screaming out, unstable gait, difficult to transfer, more incontinent, decline in appetite, and needing pills crushed.	0 325		

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0 325	Continued From page 11 During an interview on 9/13/16 at 3:55 p.m., ULP-H stated prior to C1's falls, C1 was more difficult to complete cares with, more unstable, and had an increased fear of falling. ULP-H stated C1 had a lot of clutter in her room, and had a low wood platform bed that stuck out further than the mattress, which made it difficult for C1 to move in and out of bed. In addition, ULP-H stated no new interventions were implemented after the falls. During an interview on 9/13/16 at 4:20 p.m., RN-B stated nine months prior to the first fall, family had updated staff about C1's history of child abuse with a belt, but RN-B was unsure if that was included in C1's plan of care. RN-B stated she thought the first fall was caused by C1 getting her feet caught on the blanket when attempting to get out of bed, the second fall was caused by loss of balance, and the third fall was caused by fear from history of abuse. RN-B stated she never sent a fax to C1's physician with an update after each of C1's falls and there was not an expectation of the licensee to update the physician on falls unless an injury occurred. In addition, RN-B stated C1 was checked on at least hourly by staff and RN-B had believed that was sufficient. RN-B stated the licensee did not have a call system for clients to use, so staff had to anticipate the client's needs. During an interview with C1's family member on 10/13/16 at 9:50 a.m., the family member stated C1's injuries did not match the description of the first and third fall. In addition, the family member stated the RN never shared the fall investigation results. The licensee policy titled "Falls Prevention and Reduction" dated 7/1/14, indicated the RN would	0 325		

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0 325	Continued From page 12 incorporate any interventions to prevent or reduce the risk of falls into the client's plan of care and will contact the physician if therapy or treatment should be considered. The licensee policy titled "Initial and On-going Nursing Assessments of Clients" dated 7/1/14, indicated if a client experiences an incident such as a fall, the RN will reassess the client, communicate any new problems or concerns to the client's physician, review the service plan, and update if necessary. TIME PERIOD FOR CORRECTION: Twenty One (21) days	0 325		
0 860 SS=J	144A.4791, Subd. 8 Comprehensive Assessment and Monitoring Subd. 8. Comprehensive assessment, monitoring, and reassessment. (a) When the services being provided are comprehensive home care services, an individualized initial assessment must be conducted in person by a registered nurse. When the services are provided by other licensed health professionals, the assessment must be conducted by the appropriate health professional. This initial assessment must be completed within five days after initiation of home care services. (b) Client monitoring and reassessment must be conducted in the client's home no more than 14 days after initiation of services. (c) Ongoing client monitoring and reassessment must be conducted as needed based on changes	0 860		

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0 860	Continued From page 13 in the needs of the client and cannot exceed 90 days from the last date of the assessment. The monitoring and reassessment may be conducted at the client's residence or through the utilization of telecommunication methods based on practice standards that meet the individual client's needs. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to complete a registered nurse (RN) reassessment on a client after the client experienced a change in condition, for one of four clients (C1) reviewed. This practice resulted in a level four violation (a violation that results in serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee policy titled "Initial and On-going Nursing Assessments of Clients" dated 7/1/14, indicated if a client experiences an incident such as a fall, the RN will reassess the client, communicate any new problems or concerns to the client's physician, review the service plan, and update if necessary. C1's medical record was reviewed. C1 was admitted with diagnoses that included Lewy Body dementia and chronic obstructive pulmonary disease. C1's RN assessment dated 4/26/16 indicated C1 required assistance of one staff for all activities of daily living, including transfers, ambulation, repositioning every two hours, and	0 860		

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0 860	Continued From page 14 toileting every two hours. The assessment also indicated C1 was a fall risk, and was to wear non-skid footwear when ambulating. C1's resident service plan history dated 3/1/15 to 6/8/16 indicated C1 was scheduled to reposition and toilet every two hours on the odd hour and had safety checks every two hours on the even hours from 6:00 a.m. to 10:00 p.m., then hourly through the night shift. C1's medication administration record was reviewed for May 2016. C1 required as needed medication for anxiety six days out of the month. In addition, the client began to refuse to take medications on 5/22/16 and staff documented "very unusual". On 5/27/16, C1 also refused evening medications by spitting them out. An incident report, dated 5/4/16, indicated C1 was found laying on the floor in her apartment at approximately 1:45 p.m. and had a laceration to her forehead. The RN came to the facility, placed steri-strips over the laceration, and updated C1's family in the morning. C1's family took C1 to urgent care. At the clinic, C1 received four sutures. C1's vitals record and nurse notes were reviewed. No vital signs were taken by the facility and no new interventions were implemented. The RN follow-up report dated 5/7/16 indicated C1 was in her bed prior to the fall and it was unknown what C1 had hit her head on to receive a laceration . A RN note dated 5/10/16 indicated C1 was seen by the nurse practitioner on 5/10/16 and determined sutures should be rechecked for healing prior to removal at the end of the week. A RN note dated 5/16/16 indicated the sutures were removed on 5/13/16. An incident report dated 5/27/16, indicated that at 8:51 p.m., C1 ambulated with a walker and an	0 860		

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0 860	Continued From page 15 unlicensed staff member when C1 lost her balance and fell into her wheelchair. C1 received a skin tear to her right arm. The staff member had not used a gait belt while ambulating with C1, and staff were reminded by RN to use a gait belt at all times while ambulating clients. An RN note dated 5/28/16, indicated C1's family was updated and the family member took C1 to the emergency department (ED) the same evening of the incident. At the ED, C1 had dermabond (liquid sutures) applied to the skin tear. Vitals were record on 5/27/16 for C1 as all zero, indicating vital signs were not done and no new interventions implemented. An incident report dated 6/4/16, indicated at 3:00 p.m., C1 sat on the edge of the bed with an unlicensed staff member. The staff member attempted to put a gait belt around C1, when C1 became frightened, lunged forward, and fell on her left side. C1 received a hematoma to the back of her head. When C1's family was updated, staff became aware C1 had a history of child abuse with a belt. An RN follow-up dated 6/5/16 indicated the RN assessed C1 at the time of the fall and indicated C1 moved all extremities without issue and pupils reacted to light. Staff were educated to use reassurance and apply a gait belt not in plain sight or to use a gait belt with handles that did not appear like a belt. In the morning on 6/5/16, C1 expressed increased pain to the pelvic area. C1's family member transferred C1 to the ED for evaluation. No vital signs were done by the facility. C1's hospital record, dated 6/5/16 to 6/7/16, indicated C1's X-ray report could not exclude a pelvic fracture, however further imaging could not be completed due to increased confusion and non cooperation. C1 also had an elevated troponin level (lab test to indicate a heart attack). C1 was placed on	0 860		

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0 860	Continued From page 16 comfort care and discharged by the licensee. C1's RN assessments were reviewed. The last RN assessment was completed on 4/26/16, which indicated C1 had no behaviors that required intervention and no falls in the past ninety days. No RN assessments were completed after each fall C1 experienced. The next RN assessment dated 6/7/16, was completed after C1's 6/5/16 hospitalization. During an interview with unlicensed personnel (ULP)-F on 9/13/16 on 2:58 p.m., ULP-F stated C1's room was very cluttered with a kitchen table, dresser, rocking chair, another small table, mini fridge, a big cabinet, wheelchair, and a walker. During an interview on 9/13/16 at 3:27 p.m., ULP-G stated C1did not fall often until May 2016, but had a fear of falling. ULP-G\stated C1 began to decline in health by yelling out more, being unstable during ambulation, and needing to use the wheelchair more. In addition, ULP-G stated C1 also became more incontinent, ate less, and needed pills crushed. On 9/13/16 at 3:55 p.m., ULP-H stated C1 had a history of falls which usually occurred on the evening or night shift. ULP-H stated C1's fear and anxiety increased, and C1 would attempt to ambulate independently. Also, ULP-H stated C1 had a lot of clutter in her room and a low wood platform bed that contributed to falling. ULP-H stated C1 became more difficult to complete cares with, and more unsteady with transfers. During an interview on 9/13/16 at 4:20 p.m., RN-B stated C1 was checked on at least hourly, with safety checks completed on the even hours and toileting/repositiong on the odd hours. RN-B	0 860		

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0 860	Continued From page 17 stated she thought those interventions were sufficient and were in place prior to C1's first fall on 5/4/16. In addition, RN-B stated she did not update C1's physician after each fall, because C1 was seen at the emergency room or urgent care. TIME PERIOD FOR CORRECTION: Twenty One (21) days	0 860		
02015 SS=D	626.557, Subd. 3 Timing of Report Subd. 3. Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above.	02015		

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02015	Continued From page 18 (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to report suspected maltreatment for one of four clients (C1) reviewed. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to	02015		

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02015	Continued From page 19 cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: C1's medical record was reviewed. C1 was admitted with diagnoses that included Lewy Body dementia and chronic obstructive pulmonary disease. C1's registered nurse (RN) assessment dated 4/26/16 indicated C1 required assistance of one staff for all activities of daily living, including transfers, ambulation, repositioning every two hours, and toileting every two hours. The assessment also indicated C1 was a fall risk, and was to wear non-skid footwear when ambulating. C1's resident service plan history dated 3/1/15 to 6/8/16 indicated C1 was scheduled to reposition and toilet every two hours on the odd hour and had safety checks every two hours on the even hours from 6:00 a.m. to 10:00 p.m., then hourly through the night shift. C1's incident reports were reviewed. On 5/4/16, C1 experienced a fall from bed. Staff found C1 on the floor with a head laceration and it was unknown how C1 acquired the wound. C1 was brought into urgent care and received four sutures. On 5/27/16, staff walked with C1 and a walker, but did not have a gait belt on C1. C1 lost balance, fell into her wheelchair, and received a skin tear to her right arm. C1 was brought into the emergency department and treated with dermabond (liquid sutures) to close the skin tear. On 6/4/16, C1 experienced another fall when C1 sat on the edge of the bed, a staff member attempted to place a gait belt on her, and C1 lunged forwarded. C1 fell onto her left side and received a hematoma to the back of her head.	02015		

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02015	Continued From page 20 The following day, C1 expressed pelvic pain and was sent to the hospital for evaluation. An X-ray was completed on C1 and could not exclude a pelvic fracture. C1 was discharged back to the licensee on comfort cares, no longer able to ambulate. No vulnerable adult reports were submitted to the Minnesota Adult Abuse Repotting Center for any of the three falls C1 experienced, each with injury. During an interview with registered nurse (RN)-A on 9/13/16 at 2:25 p.m., RN-A stated she is notified on significant injuries and falls. RN-A stated she had been contacted to follow up on the incidents on C1. RN-A stated she began the investigation on 6/24/16 and concluded good care was given, but staff documentation was weak. RN-A stated staff did not update the physician because C1's family member had taken C1 to the emergency department to be evaluated. RN-A stated she educated staff that the physician still needs to be updated. In addition, RN-A stated she counseled RN-B on importance of documentation of change of status and new orders, and to document after symptoms are clear on her client. RN-A also stated she did not see any new interventions implemented to reduce the risk of falls, and RN-A also educated RN-B on that. RN-A stated she was told a vulnerable adult report was filed on each of these falls. The licensee policy titled "Vulnerable Adult Reporting and Investigation Policy" dated 7/1/14, indicated for any unexplained physical injury, if within twenty-four hours after an RN investigation it is unclear whether maltreatment has occurred, the RN or the home care director will make a report the common entry point.	02015		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H23660	A. BUILDING: _____ B. WING _____	C 10/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN HORIZONS	518 SEVENTH AVE NE AITKIN, MN 56431

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02015	Continued From page 21 TIME PERIOD FOR CORRECTION: Twenty One (21) days	02015		