MDH Minnesota Department of Health

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:			Report Number:	Date of Visit:
Castle Ridge Care Center			H5312028	September 1, 2017
Facility Address:			**Time of Visit:**	**Date Concluded:**
625 Prairie Center Drive			9:00 a.m. to 5:00 p.m.	January 18, 2018
Facility City:			**Investigator's Name and Title:**	
Eden Prairie			Arthur Biah, RN, Special Investigator	
State:	**ZIP:**	**County:**		
Minnesota	55344	Hennepin		

☒ **Nursing Home**

Allegation(s):

It is alleged that a resident was neglected when facility staff transferred resident from bed to wheelchair and resident fell. It is alleged that resident passed away due to complications from the fall.

- ☒ Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
- ☒ State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)
- ☒ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
- ☒ State Statutes Chapters 144 and 144A

Conclusion:

Based on preponderance of evidence, neglect occurred when the facility assessed and updated the resident's care plan to require two staff participation to turn and reposition in bed, and failed to provide the updated care plan to staff. The resident fell from the bed during incontinence care and repositioning, suffering laceration, and bruising of the right side of the face, neck, and chest when s/he was turned and repositioned by one staff person.

The resident was admitted to the facility for long-term care with the diagnoses of chronic obstructive pulmonary disease, history of falling, and right shoulder pain. The resident required two-staff assistance with repositioning, bed mobility, personal hygiene, and dressing. The resident was on hospice.

Months prior to the resident's fall, the resident was assessed to require two staff participation to turn and reposition in bed. The facility updated the care plan and failed to provide the updated care plan to staff. The nursing assistant was rounding during a night shift and noted the resident was incontinent of urine. The nursing assistant stated s/he proceeded to provide incontinence care, and turn and repositioning the resident. The nursing assistant stated s/he was providing care using the outdated care plan. The nursing

assistant was not aware the updated care plan required assistance of two staff to turn and reposition the resident. The nursing assistant stated the resident fell when s/he was rolled the resident to thé right side during tuning and reposition. The resident fell from the bed and head his/her head on the nightstand as s/he fell to the floor. After the fall, the nursing assistant immediately called the other staff for help. The facility assessed the resident after fall, provided first aid, and notified the resident's family and hospice provider.

Nursing and physician progress notes indicated the resident was bleeding from the right side of head, hours after the fall, as result of a laceration, measured at 4 centimeters (cm) by 1.5 cm by 1.0 cm. The resident had a hematoma under the right eye, measured at 8 cm by 4 cm. The resident's face was swollen and bruised in addition to laceration. The hospice physician progress note indicated the resident had increased pain with significant facial laceration, large facial hematoma, and bruising as result of the fall. The resident's pain medication was increased from as needed to schedule three times a day for acute facial pain.

The administrative nurse was interviewed and stated the resident's care plan was updated to require two staff participation for repositioning, turning, personal hygiene, and dressing. The nurse stated the resident's care plan used by nursing assistants prior to the resident's fall was not updated required assistance of one staff.

The resident's family member was interviewed and stated she was notified of the resident's fall immediately after the fall. The family member stated, upon arrival at the facility hours later, the resident was still bleeding.

The resident's assigned nursing assistant on the night of the fall was interviewed and stated s/he was not aware of the changes to the resident's care plan, requiring two-staff assistance for turning and repositioning. The nursing assistant stated s/he was re-educated on the revised care plan after the fall.

The facility updated the resident's care plan and re-educated staff after the fall.

The resident died three weeks after fall and the death was due to complication of blunt force facial trauma and fall.

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:

Facility failed to provide an updated resident care plan to the nursing assistants. The facility has no policy or system to ensure direct care staff are made aware of changes to resident care plans.

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 Licensing Rules for Nursing Homes (MN Rules Chapter 4658) – Compliance Met
The facility was found to be in compliance with State Licensing Rules for Nursing Homes (MN Rules Chapter 4658). No state orders were issued.

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) – Compliance Met
The facility was found to be in compliance with State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557. No state licensing orders were issued.

Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B) - Compliance Not Met
The requirements under the Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B), were not met.

Deficiencies are issued on form 2567: ☒ Yes ☐ No

(The 2567 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:

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; and

(2) which is not the result of an accident or therapeutic conduct.

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
- ☒ Care Guide
- ☒ Medication Administration Records
- ☒ Nurses Notes
- ☒ Assessments
- ☒ Physician Orders
- ☒ Physician Progress Notes
- ☒ Care Plan Records
- ☒ Facility Incident Reports

Other pertinent medical records:

- ☒ Death Certificate

Additional facility records:

- ☒ Resident/Family Council Minutes
- ☒ Staff Time Sheets, Schedules, etc.
- ☒ Facility Policies and Procedures

Number of additional resident(s) reviewed: Five

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

Specify: _____

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

○ Yes ◉ No ○ N/A

Specify: Deceased

Interviews: The following interviews were conducted during the investigation:

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

Specify: _____

If unable to contact reporter, 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: Deceased

Did you interview additional residents? ◉ Yes ○ No

Total number of resident interviews: Six

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

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: Nine

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:

☒ Nursing Services

☒ Cleanliness

☒ Facility Tour

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 - Licensing & Certification

Minnesota Board of Examiners for Nursing Home Administrators

The Office of Ombudsman for Long-Term Care

Eden Prairie Police Department

Hennepin County Attorney

Eden Prairie City Attorney

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 9, 2018

Ms. Molly Senske, Administrator
Castle Ridge Care Center
625 Prairie Center Drive
Eden Prairie, MN 55344

RE: Project Number H5312028

Dear Ms. Senske:

On January 11, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for an abbreviated standard survey, completed on December 28, 2017.

On February 16, 2018, the Minnesota Department of Health, Office of Health Facility Complaints completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an abbreviated standard survey, completed on December 28, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 19, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 28, 2017, effective January 19, 2018 and therefore remedies outlined in our letter to you dated January 11, 2018, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245312	A. BUILDING _____ B. WING _____	R-C 02/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLE RIDGE CARE CENTER	625 PRAIRIE CENTER DRIVE EDEN PRAIRIE, MN 55344

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS A Post Certification revisit was conducted on February 16, 2018, to follow up on deficiencies issued relate to complaint H5312028. Castle Ridge Care Center is in compliance with 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 9, 2018

Ms. Molly Senske, Administrator
Castle Ridge Care Center
625 Prairie Center Drive
Eden Prairie, MN 55344

Re: Enclosed Reinspection Results - Complaint Number H5312028

Dear Ms. Senske:

On February 16, 2018 an investigator from the Minnesota Department of Health, Office of Health Facility Complaints, completed a reinspection of your facility, to determine correction of licensing orders found during the investigation completed on December 28, 2017. At this time these correction orders were found corrected.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the president of your facility's governing body.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

Minnesota Department of Health

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	00973	A. BUILDING: _____ B. WING _____	R-C 02/16/2018

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CASTLE RIDGE CARE CENTER	625 PRAIRIE CENTER DRIVE EDEN PRAIRIE, MN 55344

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{2 000}	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: A licensing order follow-up was completed to follow up on correction orders issued related to complaint H5312028. Castle Ridge Care Center was found in compliance with state regulations. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of	{2 000}		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Electronically Signed

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{2 000}	Continued From page 1 correction is required, it is required that the facility acknowledge receipt of the electronic documents.	{2 000}		

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	245312	A. BUILDING _____ B. WING _____	C 12/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLE RIDGE CARE CENTER	**625 PRAIRIE CENTER DRIVE EDEN PRAIRIE, MN 55344**

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F 000	INITIAL COMMENTS An abbreviated standard survey was conducted to investigate case #H5312028. As a result, the following deficiencies are issued. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance.	F 000		
F 323 SS=G	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced	F 323		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 323	Continued From page 1 by: Based on interviews and record review, the facility failed to provide adequate supervision for one of six residents, (R1), reviewed when the facility assessed R1 to need the assistance of two staff persons for turning, repositioning and incontinence care, updated the care plan, however the facility did not provide staff with the updated care plan. R1 was harmed when R1 fell from her bed during care provided by one staff, suffered laceration, contusion and bruising of the right side of the face, neck and chest. Findings include: R1's medical record was reviewed. R1 was admitted to the facility for long term care with the diagnoses of chronic obstructive pulmonary disease, history of falling, and right shoulder pain. R1 was incontinent of bowel and bladder. R1's care plan was last reviewed on February 10, 2017 and indicated R1 required two staff assistance with repositioning, turning, bed mobility, personal hygiene, and dressing. The nursing progress note dated March 24, 2017 at 7:55 a.m. indicated R1 fell from her bed during care at 4:45 a.m. One staff assisted R1 with incontinence care, involving tuning and repositioning. R1 fell from the bed and hit her head against the night stand resulting in bleeding from the right side of the head that resulted in a laceration measured at 4 centimeters (cm) by 1.5 cm by 1.0 cm. and a hematoma measured at 8 cm by 4 cm. The indicated bleeding stopped after staff applied pressure. A hospice nursing progress note dated March 24, 2017 indicated R1 had facial swelling and	F 323		

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F 323	Continued From page 2 bruising in addition to a laceration above the right eye due to a fall. The hospice nursing note indicated R1 continued to bleed at the time of the hospice nurse's visit. The hospice nurse contacted the hospice physician regarding R1's wound and associated pain management. R1's pain medication was increased from as needed to three times daily for acute pain due to a laceration above the right eye and pain with the dressing change. Hospice physician progress note dated March 27, 2017 indicated R1 had pain with significant facial laceration and bruising as result of the March 24, 2017 fall. The note indicated R1 had prominent facial hematoma, with tenderness, under the right eye, measured at 8 cm by 4 cm. The director of nursing (DON) was interviewed on September 1, 2017 at 3:30 p.m. and stated R1 required two staff persons for repositioning, bed mobility, personal hygiene, and dressing. The DON stated the staff did not use the updated care plan, which required of two staff persons when R1 fell from the bed in her room. The administrator was interviewed on September 1, 2017 at 4:13 p.m. and stated the care plan used by NA-F did not match R1's updated care plan, which required assistance of two persons for repositioning, bed mobility, transfer and dressing. The administrator stated the nursing assistant's care plan was not updated with the latest changes to R1's care plan. R1's family member was interviewed on October 4, 2017 at 4:00 p.m. and stated she was notified of R1's fall in the morning. The family member stated R1 was still bleeding hours later when she	F 323		

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F 323	Continued From page 3 visited her at the facility. Photo taken and provided by family member indicated the resident was still bleeding hours after the fall. Nursing assistant (NA)-F was interviewed on October 5, 2017 at 11:09 a.m. and stated he was assigned to R1 during his night shift. NA-F stated he noticed during routine rounds that R1 was incontinent. NA-F stated R1 required assistance of one staff per the care sheet (Kardex) provided by the facility. NA-F stated, during incontinence care, he rolled R1 to the right side and was providing incontinent care when she fell off the bed and hit her head. NA-F stated he was not aware R1 required assistance of two staffs and was following the guidance of the nursing assistant's care plan, which the facility provided, and used by all nursing assistants. NA-F stated he had training abuse and neglect as well as providing care to vulnerable adults. NA-F stated he was later re-educated on the revised care plan. The clinical nurse manager (NM)-M was interviewed on December 1, 2017 at 11:38 a.m. and stated she changed R1's care plan due to increased weakness and inability to assist staff during turning, repositioning and bed mobility. NM-M stated R1's care plan was updated to require assistance of two persons during turning and incontinence, but she forgot to update the care sheet used by the nursing assistants. NM-M stated R1's fall may have been prevented with the updated care plan because one staff was required to be on one side of the bed for R1's turning and repositioning. NM-M stated it was her responsibility to ensure the care plan used by all staff was accurate at all times.	F 323		

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F 323	Continued From page 4 R1's death certificate indicated the R1's died three weeks later and the death was due to inanition, complication of blunt force facial trauma, and fall. The facility's policy and procedure on Care Plan, dated December 2016 indicated the care plan will ensure the resident has the appropriate care to maintain or attain the highest level of practicable function possible for the resident. The policy and procedure indicated the care plan is to be updated based on resident's care needs and current at all times. The facility's policy and procedure on Care Plan, dated December 2016 did not include how changes on care plan would be communicated to staff to ensure adequate education on changes to a resident's care. The facility's policy and procedure on Vulnerable Adult Abuse Prevention Plan dated April 2017 indicated the facility will provide a safe and protective environment for all residents and ensure the risks to residents are minimized.	F 323		

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CASTLE RIDGE CARE CENTER	625 PRAIRIE CENTER DRIVE EDEN PRAIRIE, MN 55344

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: A complaint investigation was conducted to investigate complaint #H5312028. As a result, the following correction orders are issued. The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00973	A. BUILDING: _____ B. WING _____	C 12/28/2017

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2 000	Continued From page 1 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. Then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000		
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. This MN Requirement is not met as evidenced by: Based on interviews and record review, the facility failed to ensure a resident was free from maltreatment for one of six residents, (R1), reviewed when the facility assessed R1 to need	21850		

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21850	Continued From page 2 the assistance of two staff persons for turning, repositioning and incontinence care, updated the care plan, however the facility did not provide staff with the updated care plan. R1 was harmed when R1 fell from her bed during care provided by one staff, suffered laceration, contusion and bruising of the right side of the face, neck and chest. Findings include: R1's medical record was reviewed. R1 was admitted to the facility for long term care with the diagnoses of chronic obstructive pulmonary disease, history of falling, and right shoulder pain. R1 was incontinent of bowel and bladder. R1's care plan was last reviewed on February 10, 2017 and indicated R1 required two staff assistance with repositioning, turning, bed mobility, personal hygiene, and dressing. The nursing progress note dated March 24, 2017 at 7:55 a.m. indicated R1 fell from her bed during care at 4:45 a.m. One staff assisted R1 with incontinence care, involving tuning and repositioning. R1 fell from the bed and hit her head against the night stand resulting in bleeding from the right side of the head that resulted in a laceration measured at 4 centimeters (cm) by 1.5 cm by 1.0 cm. and a hematoma measured at 8 cm by 4 cm. The indicated bleeding stopped after staff applied pressure. A hospice nursing progress note dated March 24, 2017 indicated R1 had facial swelling and bruising in addition to a laceration above the right eye due to a fall. The hospice nursing note indicated R1 continued to bleed at the time of the hospice nurse's visit. The hospice nurse contacted the hospice physician regarding R1's	21850		

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21850	Continued From page 3 wound and associated pain management. R1's pain medication was increased from as needed to three times daily for acute pain due to a laceration above the right eye and pain with the dressing change. Hospice physician progress note dated March 27, 2017 indicated R1 had pain with significant facial laceration and bruising as result of the March 24, 2017 fall. The note indicated R1 had prominent facial hematoma, with tenderness, under the right eye, measured at 8 cm by 4 cm. The director of nursing (DON) was interviewed on September 1, 2017 at 3:30 p.m. and stated R1 required two staff persons for repositioning, bed mobility, personal hygiene, and dressing. The DON stated the staff did not use the updated care plan, which required of two staff persons when R1 fell from the bed in her room. The administrator was interviewed on September 1, 2017 at 4:13 p.m. and stated the care plan used by NA-F did not match R1's updated care plan, which required assistance of two persons for repositioning, bed mobility, transfer and dressing. The administrator stated the nursing assistant's care plan was not updated with the latest changes to R1's care plan. R1's family member was interviewed on October 4, 2017 at 4:00 p.m. and stated she was notified of R1's fall in the morning. The family member stated R1 was still bleeding hours later when she visited her at the facility. Photo taken and provided by family member indicated the resident was still bleeding hours after the fall. Nursing assistant (NA)-F was interviewed on October 5, 2017 at 11:09 a.m. and stated he was	21850		

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21850	Continued From page 4 assigned to R1 during his night shift. NA-F stated he noticed during routine rounds that R1 was incontinent. NA-F stated R1 required assistance of one staff per the care sheet (Kardex) provided by the facility. NA-F stated, during incontinence care, he rolled R1 to the right side and was providing incontinent care when she fell off the bed and hit her head. NA-F stated he was not aware R1 required assistance of two staffs and was following the guidance of the nursing assistant's care plan, which the facility provided, and used by all nursing assistants. NA-F stated he had training abuse and neglect as well as providing care to vulnerable adults. NA-F stated he was later re-educated on the revised care plan. The clinical nurse manager (NM)-M was interviewed on December 1, 2017 at 11:38 a.m. and stated she changed R1's care plan due to increased weakness and inability to assist staff during turning, repositioning and bed mobility. NM-M stated R1's care plan was updated to require assistance of two persons during turning and incontinence, but she forgot to update the care sheet used by the nursing assistants. NM-M stated R1's fall may have been prevented with the updated care plan because one staff was required to be on one side of the bed for R1's turning and repositioning. NM-M stated it was her responsibility to ensure the care plan used by all staff was accurate at all times. R1's death certificate indicated the R1's died three weeks later and the death was due to inanition, complication of blunt force facial trauma, and fall. The facility's policy and procedure on Care Plan, dated December 2016 indicated the care plan will	21850		

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21850	Continued From page 5 ensure the resident has the appropriate care to maintain or attain the highest level of practicable function possible for the resident. The policy and procedure indicated the care plan is to be updated based on resident's care needs and current at all times. The facility's policy and procedure on Care Plan, dated December 2016 did not include how changes on care plan would be communicated to staff to ensure adequate education on changes to a resident's care. The facility's policy and procedure on Vulnerable Adult Abuse Prevention Plan dated April 2017 indicated the facility will provide a safe and protective environment for all residents and ensure the risks to residents are minimized. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21850		