MDH Minnesota Department of Health

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name: Ramsey County Care Center	**Report Number:** H5352046	**Date of Visit:** December 19, 2016
Facility Address: 2000 White Bear Avenue	**Time of Visit:** 10:00 a.m. to 4:30 p.m.	**Date Concluded:** June 28, 2017
Facility City: Maplewood	**Investigator's Name and Title:** Jessica Sellner, RN, Special Investigator	
State: Minnesota	**ZIP:** 55109	**County:** Ramsey

☒ **Nursing Home**

Allegation(s):
It is alleged that a resident was neglected when the alleged perpetrator failed to follow the resident's care plan. As a result, the resident had a fall and sustained a left femur fracture.

☒ 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 a preponderance of evidence, neglect occurred when the alleged perpetrator (AP) failed to follow the resident's plan of care. The AP failed to unplug the power to the electric reclining chair as instructed in the resident's care plan. The resident raised the chair using the remote control and fell out of the chair. The resident was sent to the hospital and diagnosed with a left femur fracture.

The resident had moderate cognitive impairment, required extensive assistance from staff with transfers, and had a history of falls. The resident's care plan indicated the resident had poor safety judgment, and staff were directed to unplug the power to the reclining chair before giving the resident the remote control. The residents nursing assistant care sheet also directed staff to hand the resident the reclining chair remote control after unplugging the power, so the resident could not utilize the remote to adjust the chair.

Review of the resident's medical record indicated approximately 10 months prior to the residents fall, the facility met with the resident's family members to discuss the safety of the electric reclining chair. The resident had a fall out of the reclining chair after using the remote control and lifting the chair in an upright position and sliding out onto the floor. The resident had no injury. The family and facility determined the resident was able to safely sit in the reclining chair after the power was unplugged.

Staff transferred the resident using a mechanical lift into the reclining lift chair. Approximately an hour later, staff heard the resident yelling for help from his/her room. The resident was found laying on the floor in front of the recliner and complained of left leg and left hip pain. The power cord was still plugged into the

wall and the remote control was in the resident's reach on the arm of the recliner. The chair had been lifted up to a standing position by the resident using the remote and the resident fell out of the recliner. The resident was sent to the hospital by ambulance and was diagnosed with a left femur fracture. The resident was sent back to the facility four days later on pain medication and comfort care as s/he was not a surgical candidate to repair the left femur fracture.

When interviewed, the resident was unable to recall the fall.

When interviewed, the AP who cared for the resident the day of the fall stated s/he was aware the resident's electric recliner needed to be unplugged prior to giving the resident the remote control. The AP stated the resident's care plan and nursing assistant care sheet included the intervention to unplug the reclining chair. The AP stated s/he cared for the resident in the past, and on the day the resident fell out of the recliner, the AP forgot to unplug the power to the electric reclining chair.

After the residents fall, the electric reclining chair was removed from the facility.

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 resident's care plan and nursing assistant care sheet directed staff to ensure the resident's electric reclining lift chair was unplugged to ensure resident safety. The nursing assistant was aware the resident's recliner was to be unplugged as s/he had provided care for the resident in the past.

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:

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 Licensing Rules for Nursing Homes (MN Rules Chapter 4658) - Compliance Not Met
The requirements under State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) 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):

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.

(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or 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:

- [x] Medical Records
- [x] Care Guide
- [x] Medication Administration Records
- [x] Nurses Notes
- [x] Assessments
- [x] Physician Orders
- [x] Treatment Sheets
- [x] Physician Progress Notes
- [x] Care Plan Records
- [x] Social Service Notes
- [x] Skin Assessments
- [x] Facility Incident Reports
- [x] Activities Reports
- [x] Therapy and/or Ancillary Services Records
- [x] ADL (Activities of Daily Living) Flow Sheets

Other pertinent medical records:

- [x] Hospital Records
- [x] Ambulance/Paramedics

Additional facility records:

- [x] Resident/Family Council Minutes
- [x] Staff Time Sheets, Schedules, etc.
- [x] Facility Internal Investigation Reports
- [x] Call Light Audits
- [x] Personnel Records/Background Check, etc.
- [x] Facility In-service Records

☒ 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: _____

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: Resident was unable to recall incident

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: Seven

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:

- [x] Personal Care
- [x] Nursing Services
- [x] Call Light
- [x] Infection Control
- [x] Use of Equipment
- [x] Dignity/Privacy Issues
- [x] Safety Issues
- [x] Transfers
- [x] Facility Tour
- [x] Injury

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: Chair was removed prior to on-site investigation

cc:

Health Regulation Division - Licensing & Certification

Minnesota Board of Examiners for Nursing Home Administrators

The Office of Ombudsman for Long-Term Care

Maplewood Police Department

Ramsey County Attorney

Maplewood City Attorney

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
August 8, 2017

Mr. Frank Robinson, Administrator
Ramsey County Care Center
2000 White Bear Avenue
Maplewood, MN 55109

RE: Project Number H5352046

Dear Mr. Robinson:

On May 17, 2017, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective May 22, 2017. (42 CFR 488.422)

Furthermore on May 17, 2017, this Department informed you and the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedies were being recommended:

- Civil money penalty for the deficiency cited at F323. (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for an abbreviated standard survey completed on May 9, 2017. The most serious deficiency was found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On June 30, 2017, 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 May 9, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 9, 2017. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our abbreviated standard survey, completed on May 9, 2017, as of June 9, 2017.

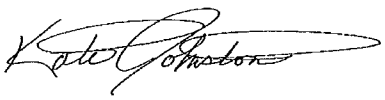
As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective June 9, 2017.

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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,



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Licensing and Certification Program
Health Regulation Division
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DEPARTMENT OF HEALTH

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
	245352	A. BUILDING _____ B. WING _____	C 05/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAMSEY COUNTY CARE CENTER	**2000 WHITE BEAR AVENUE MAPLEWOOD, MN 55109**

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F 000	INITIAL COMMENTS An abbreviated standard survey was conducted to investigate case #H5352046. 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 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement fall interventions according to the plan of care for 1 of 5 residents, R1, reviewed for falls. Findings Include: R1's Annual Minimum Data Set (MDS) dated 10/5/16, indicated the resident had moderate cognitive impairment, required extensive assistance with activities of daily living, and experienced two or more falls in the prior three months. R1's care plan dated 12/19/16, indicated the resident was at risk for falls related to limited mobility, severe cognitive impairment, and poor	F 282		

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

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.

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F 282	Continued From page 1 safety judgement. The care plan intervention for falls included assisting the resident into the reclining lift chair and handing the resident the lift chair remote and unplugging the power supply to the chair so the resident could not utilize the remote. R1's Nursing assistant care sheet (a sheet containing specific resident care information the nursing assistants carried while providing resident care) dated 10/21/16, directed staff after assisting the resident into the reclining chair to unplug the power to the reclining chair and give R1 the remote. A nursing progress note dated 10/21/16, indicated nursing staff heard R1 yelling from her room. R1 was found on her left side on the floor in front of the electric recliner. The electric recliner was not unplugged and R1 used the remote to lift the chair up and fell to the floor. The call light was on the resident's bed which the resident was not able to reach. R1 was noted by nursing as, "Screaming of left leg and left hip pain," and was sent to the hospital by ambulance. R1's hospital notes indicated the resident was admitted to the hospital on 10/21/16, for a left femur fracture. The resident was not a candidate for surgical repair and remained in the hospital for pain control until being discharged back to the facility on 10/24/16. R1 returned to the facility with a brace, pain medications, and on end of life care. A Documentation of Coaching session dated 10/21/16, at 3:25 p.m. indicated NA-E met with registered nurse (RN)-C to discuss R1's fall. NA-E failed to follow the plan of care related to	F 282		

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F 282	Continued From page 2	F 282		

not ensuring R1's call light was within the residents reach, and failing to unplug the power source for the electric recliner. R1 was found on the floor in her room with the lift chair in the high position, the chair was plugged in, and the remote control for the lift chair was on the arm of the chair. NA-E indicated she assisted R1 into the recliner and "forgot" to unplug the power supply to the lift chair remote. NA-E also indicated she, "Forgot to move the call light."

During interview on 12/19/16, at 1:40 p.m. NA-E stated she was the assigned NA for R1 on 10/21/16, during the day shift. NA-E stated on 10/21/16, at approximately 1:30 p.m. NA-D assisted with transferring R1 into the electric recliner using the mechanical lift, and then NA-D left the room. NA-E stated before leaving the room she gave R1 the call light and hid the remote control for the recliner on the side of the recliner so the remote was, "Under [R1's] butt." NA-E stated she had cared for R1 in the past and was aware the recliner should be unplugged, but she forgot on 10/21/16. NA-E stated R1's care sheet directed staff to unplug the power source to the recliner.

During interview on 12/19/16, at 2:15 p.m. RN-C stated she assessed R1 on 10/21/16, immediately following the fall from the recliner. RN-C stated when she entered R1's room the resident was laying on the floor in front of the recliner and the recliner was in the raised position. RN-C stated the power had not been unplugged to the recliner as directed by R1's plan of care, and the remote control was on the arm of the recliner in R1's reach.

A policy regarding following the plan of care was

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F 282	Continued From page 3 requested but not provided.	F 282		
F 323 SS=G	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (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 by: Based on observation, interview, and document review, the facility failed to ensure fall interventions were implemented as assessed for 1 of 5 residents, R1, reviewed for falls. R1 was assessed as safe to sit in a electric reclining chair after staff unplugged the power so the resident could not use the remote control to raise the	F 323		

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F 323	Continued From page 4	F 323		

chair. The facility staff failed to unplug the power to the reclining chair and R1 used the remote control to raise the chair and fell to the floor. This resulted in actual harm for R1 who was sent to the hospital and diagnosed with a left femur fracture.

Findings Include:

R1's Annual Minimum Data Set (MDS) dated 10/5/16, indicated the resident had moderate cognitive impairment, required extensive assistance with activities of daily living, and experienced two or more falls in the prior three months.

R1's care plan dated 12/19/16, indicated the resident was at risk for falls related to limited mobility, severe cognitive impairment, and poor safety judgement. The care plan intervention for falls included after assisting the resident into the electric reclining chair staff were to unplug the power so the resident could not utilize the remote control to adjust the electric chair. Staff were directed to hand the remote to R1 after the power was unplugged.

R1's Nursing assistant care sheet (a sheet containing specific resident care information the nursing assistants carried while providing resident care) dated 10/21/16, directed staff to unplug the power to the reclining chair and give R1 the remote.

R1's nursing progress note dated 12/29/15, indicated nursing and R1's family member discussed the safety of the resident electric recliner. The resident had a fall the prior day from the electric recliner due to using the remote

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F 323	Continued From page 5 control and putting the chair in the elevated position, which caused the resident to tip out of the chair. After discussion, it was determined the resident would be provided the remote for the recliner, however, staff would unplug the power source. A nursing progress note dated 10/21/16, indicated nursing staff heard R1 yelling from her room. R1 was found on her left side on the floor in front of the electric recliner. The electric recliner was not unplugged and R1 used the remote to lift the chair up and fell to the floor. The call light was on the resident's bed which the resident was not able to reach. R1 was noted by nursing as, "Screaming of left leg and left hip pain," and was sent to the hospital by ambulance. R1's hospital notes indicated the resident was admitted to the hospital on 10/21/16, for a left femur fracture. The resident was not a candidate for surgical repair and remained in the hospital for pain control until being discharged back to the facility on 10/24/16. R1 returned to the facility with a brace, pain medications, and on end of life care. A Documentation of Coaching session dated 10/21/16, at 3:25 p.m. indicated NA-E met with registered nurse (RN)-C to discuss R1's fall. NA-E failed to follow the plan of care related to not ensuring R1's call light was within the residents reach, and failing to unplug the power source for the electric recliner. R1 was found on the floor in her room with the lift chair in the high position, the chair was plugged in, and the remote control for the lift chair was on the arm of the chair. NA-E indicated she assisted R1 into the recliner and "forgot" to unplug the power supply to	F 323		

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F 323	Continued From page 6	F 323		

the lift chair remote. NA-E also indicated she, "Forgot to move the call light."

The facility follow up interview with NA-E dated 10/25/16, indicated on 10/21/16, she assisted NA-D transfer R1 into the electric recliner using the mechanical lift. NA-E indicated when caring for R1 she always tucked the remote behind the chair or in the side pocket of the chair. NA-E stated she had not unplugged the power to the electric lift chair but stated she gave R1 the call light.

The facility investigation dated 10/28/16, indicated on 10/21/16, R1 was assisted into the lift recliner by two nursing assistants (NA), NA-D and NA-E, using the mechanical lift. After R1 was transferred to the recliner, NA-D left the room and NA-E stayed with R1 to adjust her recliner. NA-E tucked the remote control for the chair into the side of the recliner as R1 agreed she didn't need the remote control. NA-E did not unplug the power for the electric recliner and R1 lifted the chair up and slid out to the floor.

During interview on 12/19/16, at 1:40 p.m. NA-E stated she was the assigned NA for R1 on 10/21/16, during the day shift. NA-E stated on 10/21/16, at approximately 1:30 p.m. NA-D assisted with transferring R1 into the electric recliner using the mechanical lift, and then NA-D left the room. NA-E stated before leaving the room she gave R1 the call light and hid the remote control for the recliner on the side of the recliner so the remote was, "Under [R1's] butt." NA-E stated she had cared for R1 in the past and was aware the recliner should be unplugged, but she forgot on 10/21/16. NA-E stated R1's care sheet directed staff to unplug the power source to

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F 323	Continued From page 7 the recliner. During interview on 12/19/16, at 2:15 p.m. RN-C stated she assessed R1 on 10/21/16, immediately following the fall from the recliner. RN-C stated when she entered R1's room the resident was laying on the floor in front of the recliner and the recliner was in the raised position. RN-C stated the power had not been unplugged to the recliner as directed by R1's plan of care, and the remote control was on the arm of the recliner in R1's reach. When interviewed on 5/1/17, at 10:20 a.m. family member (FM)-H stated R1 had declined significantly since the fall on 10/21/16, and no longer walks, sits in a regular wheelchair, and is not cognitive. FM-H stated R1 had fallen from the reclining chair in the past, but staff had been unplugging it and there were no further falls until 10/21/17. When interview on 5/1/17, at 10:40 a.m. FM-I stated she met with the facility in December 2015, after the resident fell out of the recliner. FM-I stated R1 enjoyed the recliner but was not safe to utilize the remote control, so it was decided to allow the resident to sit in the recliner but staff should unplug the power so R1 could not use the remote control. FM-I stated there were no further falls from the recliner since December 2015, after staff were instructed to unplug the power. FM-I stated after R1 fell from the recliner on 10/21/16, because staff did not unplug the power, the recliner was removed from the facility.	F 323		

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

August 8, 2017

Mr. Frank Robinson, Administrator
Ramsey County Care Center
2000 White Bear Avenue
Maplewood, MN 55109

Re: Enclosed Reinspection Results - Complaint Number H5352046

Dear Mr. Robinson:

On June 30, 2017 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 May 9, 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,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

DEPARTMENT OF HEALTH

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
	00846	A. BUILDING: _____ B. WING _____	C 05/09/2017

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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 #H5352046. 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		

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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		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement fall interventions according to the plan of care for 1 of 5 residents, R1, reviewed for falls. Findings Include: R1's Annual Minimum Data Set (MDS) dated 10/5/16, indicated the resident had moderate cognitive impairment, required extensive assistance with activities of daily living, and experienced two or more falls in the prior three months.	2 565		

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2 565	Continued From page 2 R1's care plan dated 12/19/16, indicated the resident was at risk for falls related to limited mobility, severe cognitive impairment, and poor safety judgement. The care plan intervention for falls included assisting the resident into the reclining lift chair and handing the resident the lift chair remote and unplugging the power supply to the chair so the resident could not utilize the remote. R1's Nursing assistant care sheet (a sheet containing specific resident care information the nursing assistants carried while providing resident care) dated 10/21/16, directed staff after assisting the resident into the reclining chair to unplug the power to the reclining chair and give R1 the remote. A nursing progress note dated 10/21/16, indicated nursing staff heard R1 yelling from her room. R1 was found on her left side on the floor in front of the electric recliner. The electric recliner was not unplugged and R1 used the remote to lift the chair up and fell to the floor. The call light was on the resident's bed which the resident was not able to reach. R1 was noted by nursing as, "Screaming of left leg and left hip pain," and was sent to the hospital by ambulance. R1's hospital notes indicated the resident was admitted to the hospital on 10/21/16, for a left femur fracture. The resident was not a candidate for surgical repair and remained in the hospital for pain control until being discharged back to the facility on 10/24/16. R1 returned to the facility with a brace, pain medications, and on end of life care. A Documentation of Coaching session dated 10/21/16, at 3:25 p.m. indicated NA-E met with	2 565		

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2 565	Continued From page 3 registered nurse (RN)-C to discuss R1's fall. NA-E failed to follow the plan of care related to not ensuring R1's call light was within the residents reach, and failing to unplug the power source for the electric recliner. R1 was found on the floor in her room with the lift chair in the high position, the chair was plugged in, and the remote control for the lift chair was on the arm of the chair. NA-E indicated she assisted R1 into the recliner and "forgot" to unplug the power supply to the lift chair remote. NA-E also indicated she, "Forgot to move the call light." During interview on 12/19/16, at 1:40 p.m. NA-E stated she was the assigned NA for R1 on 10/21/16, during the day shift. NA-E stated on 10/21/16, at approximately 1:30 p.m. NA-D assisted with transferring R1 into the electric recliner using the mechanical lift, and then NA-D left the room. NA-E stated before leaving the room she gave R1 the call light and hid the remote control for the recliner on the side of the recliner so the remote was, "Under [R1's] butt." NA-E stated she had cared for R1 in the past and was aware the recliner should be unplugged, but she forgot on 10/21/16. NA-E stated R1's care sheet directed staff to unplug the power source to the recliner. During interview on 12/19/16, at 2:15 p.m. RN-C stated she assessed R1 on 10/21/16, immediately following the fall from the recliner. RN-C stated when she entered R1's room the resident was laying on the floor in front of the recliner and the recliner was in the raised position. RN-C stated the power had not been unplugged to the recliner as directed by R1's plan of care, and the remote control was on the arm of the recliner in R1's reach.	2 565		

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2 565	Continued From page 4 A policy regarding following the plan of care was requested but not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review policy and procedures on implementing fall interventions according to the plan of care. The director of nursing or designee could conduct random audits of staff providing resident care to ensure cares are being provided according to the plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
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 observation, interview, and document review, the facility staff failed to ensure residents	21850		

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21850	Continued From page 5 were free from maltreatment for 1 of 5 residents, R1, who did not have fall interventions provided as assessed and sustained a fall. R1 was assessed as safe to sit in a electric reclining chair after staff unplugged the power so the resident could not use the remote control to raise the chair. The facility staff failed to unplug the power to the reclining chair and R1 used the remote control to raise the chair and fell to the floor. This resulted in actual harm for R1 who was sent to the hospital and diagnosed with a left femur fracture. Findings Include: R1's Annual Minimum Data Set (MDS) dated 10/5/16, indicated the resident had moderate cognitive impairment, required extensive assistance with activities of daily living, and experienced two or more falls in the prior three months. R1's care plan dated 12/19/16, indicated the resident was at risk for falls related to limited mobility, severe cognitive impairment, and poor safety judgement. The care plan intervention for falls included after assisting the resident into the electric reclining chair staff were to unplug the power so the resident could not utilize the remote control to adjust the electric chair. Staff were directed to hand the remote to R1 after the power was unplugged. R1's Nursing assistant care sheet (a sheet containing specific resident care information the nursing assistants carried while providing resident care) dated 10/21/16, directed staff to unplug the power to the reclining chair and give R1 the remote.	21850		

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21850	Continued From page 6 R1's nursing progress note dated 12/29/15, indicated nursing and R1's family member discussed the safety of the resident electric recliner. The resident had a fall the prior day from the electric recliner due to using the remote control and putting the chair in the elevated position, which caused the resident to tip out of the chair. After discussion, it was determined the resident would be provided the remote for the recliner, however, staff would unplug the power source. A nursing progress note dated 10/21/16, indicated nursing staff heard R1 yelling from her room. R1 was found on her left side on the floor in front of the electric recliner. The electric recliner was not unplugged and R1 used the remote to lift the chair up and fell to the floor. The call light was on the resident's bed which the resident was not able to reach. R1 was noted by nursing as, "Screaming of left leg and left hip pain," and was sent to the hospital by ambulance. R1's hospital notes indicated the resident was admitted to the hospital on 10/21/16, for a left femur fracture. The resident was not a candidate for surgical repair and remained in the hospital for pain control until being discharged back to the facility on 10/24/16. R1 returned to the facility with a brace, pain medications, and on end of life care. A Documentation of Coaching session dated 10/21/16, at 3:25 p.m. indicated NA-E met with registered nurse (RN)-C to discuss R1's fall. NA-E failed to follow the plan of care related to not ensuring R1's call light was within the residents reach, and failing to unplug the power source for the electric recliner. R1 was found on the floor in her room with the lift chair in the high	21850		

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21850	Continued From page 7 position, the chair was plugged in, and the remote control for the lift chair was on the arm of the chair. NA-E indicated she assisted R1 into the recliner and "forgot" to unplug the power supply to the lift chair remote. NA-E also indicated she, "Forgot to move the call light." The facility follow up interview with NA-E dated 10/25/16, indicated on 10/21/16, she assisted NA-D transfer R1 into the electric recliner using the mechanical lift. NA-E indicated when caring for R1 she always tucked the remote behind the chair or in the side pocket of the chair. NA-E stated she had not unplugged the power to the electric lift chair but stated she gave R1 the call light. The facility investigation dated 10/28/16, indicated on 10/21/16, R1 was assisted into the lift recliner by two nursing assistants (NA), NA-D and NA-E, using the mechanical lift. After R1 was transferred to the recliner, NA-D left the room and NA-E stayed with R1 to adjust her recliner. NA-E tucked the remote control for the chair into the side of the recliner as R1 agreed she didn't need the remote control. NA-E did not unplug the power for the electric recliner and R1 lifted the chair up and slid out to the floor. During interview on 12/19/16, at 1:40 p.m. NA-E stated she was the assigned NA for R1 on 10/21/16, during the day shift. NA-E stated on 10/21/16, at approximately 1:30 p.m. NA-D assisted with transferring R1 into the electric recliner using the mechanical lift, and then NA-D left the room. NA-E stated before leaving the room she gave R1 the call light and hid the remote control for the recliner on the side of the recliner so the remote was, "Under [R1's] butt." NA-E stated she had cared for R1 in the past and	21850		

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21850	Continued From page 8 was aware the recliner should be unplugged, but she forgot on 10/21/16. NA-E stated R1's care sheet directed staff to unplug the power source to the recliner. During interview on 12/19/16, at 2:15 p.m. RN-C stated she assessed R1 on 10/21/16, immediately following the fall from the recliner. RN-C stated when she entered R1's room the resident was laying on the floor in front of the recliner and the recliner was in the raised position. RN-C stated the power had not been unplugged to the recliner as directed by R1's plan of care, and the remote control was on the arm of the recliner in R1's reach. When interviewed on 5/1/17, at 10:20 a.m. family member (FM)-H stated R1 had declined significantly since the fall on 10/21/16, and no longer walks, sits in a regular wheelchair, and is not cognitive. FM-H stated R1 had fallen from the reclining chair in the past, but staff had been unplugging it and there were no further falls until 10/21/17. When interview on 5/1/17, at 10:40 a.m. FM-I stated she met with the facility in December 2015, after the resident fell out of the recliner. FM-I stated R1 enjoyed the recliner but was not safe to utilize the remote control, so it was decided to allow the resident to sit in the recliner but staff should unplug the power so R1 could not use the remote control. FM-I stated there were no further falls from the recliner since December 2015, after staff were instructed to unplug the power. FM-I stated after R1 fell from the recliner on 10/21/16, because staff did not unplug the power, the recliner was removed from the facility. SUGGESTED METHOD OF CORRECTION: The	21850		

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21850	Continued From page 9 director of nursing or designee, could review policy and procedures on implementing fall interventions as assessed and review with all staff. The director of nursing or designee could conduct random audits of staff providing resident care to ensure cares are being provided and fall interventions are being provided as assessed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21850		