DEPARTMENT OF HEALTH

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:			**Report Number:**	**Date of Visit:**
Zumbrota Care Center			H5376014 and H5376015	October 23, 2017
Facility Address:			**Time of Visit:**	**Date Concluded:**
433 Mill Street			8:10 a.m. to 5:10 p.m.	January 17, 2018
Facility City:			**Investigator's Name and Title:**	
Zumbrota			Matt Absher, RN, Special Investigator	
State:	**ZIP:**	**County:**		
Minnesota	55992	Goodhue		

☒ **Nursing Home**

Allegation(s):

It is alleged that a resident was neglected when staff/alleged perpetrator did not unplug the resident's lift chair according to the resident's plan of care. The resident fell and sustained head hematomas. The facility transferred the resident to the hospital.

- ☒ 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 unplug the resident's lift chair according to the resident's plan of care. As a result, the resident fell out of her/his lift chair and sustained a large hematoma on the right side of her/his forehead, with bruising around the right eye.

The resident had varying, mild to moderate cognitive impairment, around the date of the incident. The resident's diagnoses included end-stage renal disease, leukemia, and cognitive impairment. The resident required extensive assistance with most activities of daily living and was dependent on staff for transfers and locomotion.

Several days prior to the resident's fall, a family member witnessed the resident use the remote control to raise her/his lift chair to the maximum incline. The family member held the resident against her/his chair and lowered the chair to the sitting position, so the resident would not fall. The family member immediately notified staff of her/his safety concern with the resident's use of the lift chair, and staff transferred the resident back to her/his bed. The next day, there was a sign on the wall in the resident's room that

indicated to unplug the recliner when not in use and that only staff were to operate the chair, but the chair was plugged in. The facility updated the resident's care plan to keep the lift chair unplugged except for use by staff.

One weekend morning, two staff transferred the resident to her/his electric lift chair. One staff left the room and the other staff/alleged perpetrator, who had been assigned to the resident, finished cares including handing the resident a call button before leaving the room. Thirty-minutes later a family member, and a staff person walking by the resident's room, saw the resident lying on the floor between the lift chair and the bed. No one witnessed the fall. The lift chair was fully raised and the electric cord was plugged into the wall outlet. Staff provided immediate cares to the resident, who experienced pain and discomfort, and summoned an ambulance to transport the resident to the emergency room. The resident sustained a large hematoma to her/his right forehead and a black eye but was admitted to the hospital for a different reason.

During an interview, the resident stated he had a bad fall with a bruise on his face and bump on his forehead. The resident stated, "it was bad, you can see it was four weeks ago." At that time the resident still had two small bumps above her/his right eyebrow and some bruising below the right eye.

When interviewed, the AP acknowledged s/he was the last staff person to be with the resident before the fall. The AP stated the resident's care guide indicated not to leave the resident's lift chair plugged in while the s/he was in it, but the AP did not see the information as it did not stick out on the paper. The AP stated s/he also did not see the dark sign that was on the wall. The AP stated s/he did not think anything was said about the safety precaution for the resident in shift-to-shift report that morning. The AP stated the safety precaution to keep the lift chair unplugged when the resident was in it was a new intervention, and new interventions are often reported during the week but not passed on to weekend staff. The AP asked, "If residents are not allowed to be in electric chairs, why are they provided with them." The AP accepted responsibility for the incident, was temporarily suspended, and received corrective action. The AP no longer works at the facility.

A provider stated the resident's injuries did not result in a change in her/his health condition, but the resident had obvious bruising and discomfort from the fall. The provider stated there was no excuse for leaving the lift chair plugged in.

One and a half weeks prior to the fall, the resident had experienced a recent change in health condition but the facility had assessed the resident as safe to continue using her/his lift chair. Most recently, the resident had returned to the facility from a hospital, four days prior to the fall. According to assessments, the resident was at risk for falling. A fall risk assessment completed three days before the incident indicated, "Consider environment risk factors in the resident's interventions. Consider addition or removal of balance mobility devices." The facility did not specifically assess the resident's ability to safely sit in or use an electric lift chair unsupervised after her/his return from the hospital. After the fall and subsequent hospitalization, the resident no longer sat in the lift chair.

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 alleged perpetrator accepted responsibility for not implementing the safety precaution written on the care guide. The facility did not ensure all staff were aware of, and following, the safety precaution on the resident's care guide. The facility did not reassess the resident for safety with his lift chair after a significant change in condition and admission from the hospital.

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 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.

State Statutes Chapters 144 & 144A – Compliance Met
The facility was found to be in compliance with State Statutes for Chapters 144 & 144A. 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 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.)

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.

(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] Nurses Notes
- [x] Assessments
- [x] Care Plan Records
- [x] Social Service Notes
- [x] Facility Incident Reports
- [x] Therapy and/or Ancillary Services Records

Other pertinent medical records:

☒ Hospital Records ☒ Death Certificate

☒ Police Report

Additional facility records:

☒ Resident/Family Council Minutes

☒ Staff Time Sheets, Schedules, etc.

☒ Facility Internal Investigation Reports

☒ Personnel Records/Background Check, etc.

☒ Facility Policies and Procedures

Number of additional resident(s) reviewed: Two

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 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: _____

Did you interview additional residents? ◉ Yes ○ No

Total number of resident interviews: Eight

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:

☒ Nursing Services
☒ Call Light
☒ Infection Control
☒ Use of Equipment
☒ Cleanliness
☒ Dignity/Privacy Issues
☒ Safety Issues
☒ Meals
☒ Facility Tour
☒ 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: _____

cc:

Health Regulation Division - Licensing & Certification

The Office of Ombudsman for Long-Term Care

Zumbrota Police Department

Goodhue County Attorney

Zumbrota City Attorney

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

February 26, 2018

Ms. Krista Siddiqui, Administrator
Zumbrota Care Center
433 Mill Street
Zumbrota, MN 55992

Re: State Nursing Home Licensing Orders - Complaint Numbers H5376014, H5376015

Dear Ms. Siddiqui:

A complaint investigation was completed on December 19, 2017. At the time of the investigation, the investigator assessed compliance with Minnesota Department of Health Nursing Home Rules. The investigator from the Minnesota Department of Health, Office of Health Facility Complaints, noted one or more violations of these rules. These state licensing orders are issued in accordance with Minnesota Statute section 144.653 and/or Minnesota Statute Section 144A.10. If, upon reinspection, it is found that the violations cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the licensing order(s), a "suggested method of correction" was added to the Minnesota Department of Health, State Form.

On January 26, 2018 an investigator from this office completed a reinspection of your facility, to determine correction of licensing orders found during the investigation completed on January 26, 2018. 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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245376	A. BUILDING _____ B. WING _____	R-C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZUMBROTA CARE CENTER	433 MILL STREET ZUMBROTA, MN 55992

(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 January 26, 2018, to follow up on deficiencies issued related to complaints H5376014 and H5376015. Zumbrota 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

February 26, 2018

Ms. Krista Siddiqui, Administrator
Zumbrota Care Center
433 Mill Street
Zumbrota, MN 55992

Re: State Nursing Home Licensing Orders - Complaint Numbers H5376014, H5376015

Dear Ms. Siddiqui:

A complaint investigation was completed on December 19, 2017. At the time of the investigation, the investigator assessed compliance with Minnesota Department of Health Nursing Home Rules. The investigator from the Minnesota Department of Health, Office of Health Facility Complaints, noted one or more violations of these rules. These state licensing orders are issued in accordance with Minnesota Statute section 144.653 and/or Minnesota Statute Section 144A.10. If, upon reinspection, it is found that the violations cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the licensing order(s), a "suggested method of correction" was added to the Minnesota Department of Health, State Form.

On January 26, 2018 an investigator from this office completed a reinspection of your facility, to determine correction of licensing orders found during the investigation completed on January 26, 2018. 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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00917	A. BUILDING: _____ B. WING _____	R-C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZUMBROTA CARE CENTER	433 MILL STREET ZUMBROTA, MN 55992

(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) COMPLETE DATE
{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 complaints H5376014 and H5376015. Zumbrota Care Center was found in compliance with state regulations. The facility is enrolled in ePOC and therefore a	{2 000}		

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

Electronically Signed

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00917	A. BUILDING: _____ B. WING _____	R-C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZUMBROTA CARE CENTER	433 MILL STREET ZUMBROTA, MN 55992

(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) COMPLETE DATE
{2 000}	Continued From page 1 signature is not required at the bottom of the first page of the state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	{2 000}		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 3, 2018

Ms. Krista Siddiqui, Administrator
Zumbrota Care Center
433 Mill Street
Zumbrota, MN 55992

RE: Project Numbers H5376014, H5376015

Dear Ms. Siddiqui:

On December 19, 2017, an abbreviated standard survey was completed at your facility by the Minnesota Department of Health, Office of Health Facility Complaints to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567 and/or Form A, whereby corrections are required.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Potential Consequences - the consequences of not attaining substantial compliance 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Lindsey Krueger, Supervisor
Office of Health Facility Complaints
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Email: lindsey.krueger@state.mn.us
Phone: (651) 201-4135
Fax: (651) 281-9796

NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

For all surveys completed after September 1, 2016, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when one or more of the following circumstances exist:

- Immediate jeopardy (IJ) (scope and severity levels J, K, and L) is identified on the current survey; OR
- Deficiencies of Substandard Quality of Care (SQC) that are not IJ are identified on the current survey; OR
- Any G level deficiency is identified on the current survey in 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15, Quality of Life, or 42 CFR 483.25 Quality of Care; OR
- Deficiencies of actual harm or above (level G or above) on the current survey as well as having deficiencies of actual harm or above on the previous standard health or Life Safety Code (LSC) survey OR deficiencies of actual harm or above on any type of survey between the current survey and the last standard survey. These surveys must be separated by a period of compliance (i.e., from different noncompliance cycles).; OR
- A facility is classified as a Special Focus Facility (SFF) AND has a deficiency citation at level "F" or higher on its current health survey or "G" or higher for the current LSC survey.

Note: the "current" survey is whatever Health and/or LSC survey is currently being performed, i.e., standard, revisit, or complaint.

Your facility meets one or more criterion and remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

- State Monitoring effective January 8, 2018. (42 CFR 488.422)

The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

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

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedy be imposed:

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Office of Health Facility Complaints staff if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by March 19, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 19, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
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
	245376	A. BUILDING _____ B. WING _____	C 12/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZUMBROTA CARE CENTER	433 MILL STREET ZUMBROTA, MN 55992

(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 An abbreviated standard survey was conducted to investigate case #H5376014 and #H5376015. As a result, the following deficiencies are issued related to H5376014 and #H5376015. 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	SERVICES BY QUALIFIED PERSONS/PER CARE PLAN CFR(s): 483.21(b)(3)(ii) (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 interview and document review, the facility failed to implement care plan interventions for safety precautions for the use of a recliner with a lift function, for 1 of 3 residents (R1) reviewed for falls. Findings include: R1's Quarterly Review dated June 1, 2017 indicated the resident was cognitively intact. R1's Significant Change in Status Assessment dated September 13, 2017, indicated the resident required extensive assistance with most activities of daily living (ADL's), was totally dependent on staff for transfers and locomotion, and falls was a	F 282	Zumbrota Health Services ensures that resident□s environment remains as free from accident hazards as is possible and that each resident receives adequate supervision and assistive devices to prevent accidents by ensuring safety risks with regard to falls are comprehensively assessed. Staff caring for R1 was re-educated on 9/23 of the care plan interventions. All staff were re-educated on the need to follow the care plan for all residents as it relates to recliners with life function. This re-education was completed by October 1, 2017. All residents utilizing recliners with lift	1/16/18

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

Electronically Signed | 01/09/2018

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F 282	Continued From page 1 triggered care area. R1's care plan dated March 8, 2016, indicated the resident was at risk for falls due to limited mobility and dependence on staff for transfers. R1's care plan dated December 5, 2016 indicated a safety risk for the resident due to use of a recliner with a lift function. The care plan intervention for recliner use, dated September 20, 2017, indicated the resident was unable to get out of the chair independently or use the lift control, and for staff to keep the lift chair unplugged except for use by staff. R1's Nursing Assistant (NA) undated care guide (a sheet of paper containing specific resident care information that NA's carried while providing resident care), directed staff to unplug the recliner when the resident was sitting in it. A nursing progress note dated September 20, 2017 at 9:30 p.m., indicated R1 refused or was unable to participate with lift transfer from his recliner to his bed. A nursing progress note dated September 23, 2017, indicated R1 was transferred to his recliner and last observed at 10:00 a.m. According to the note, at 10:30 a.m., the resident was found lying prone on the floor in his room with his head under the foot of his bed. The recliner was in the maximum inclined position and the resident stated "no" when asked if he was okay. When asked what he was trying to do, the resident stated, "I don't know." The resident had a large hematoma on the right side of his forehead extending from above the right eyebrow to the resident's hairline and he complained of a severe headache rated 10/10. The remote to the lift chair	F 282	function are at risk for deficient practices in this area. Care guides with recent changes of information were immediately highlighted to bring to greater attention important changes to resident□s plan of care. New signage was put in the room to be more likely to draw the attention of all staff members. Policies and procedures were reviewed and revised to ensure that staff would be aware of the care plan for each resident and the importance of following that plan of care when providing care to residents. A new Care Guide Knowledge and Expectations policy was put into place on 1/5/18. The purpose of this policy is to ensure that at all times, the staff providing cares to the residents at Zumbrota Health Services will have and understand the most up to date information on each resident that they serve throughout their shift. This includes a shift to shift report for a minimum of one week for all new safety measures implemented for a resident as well as any downgrades in status with regard to transfers, ambulation, and diet. The Director of Nursing or designee will do a minimum of 3 random audits of nursing staff per week for one month, then one per week for 3 months, and monthly thereafter to ensure that staff have all necessary information to competently care for their residents available to them, and that they are knowledgeable of changes in a resident□s status. The Director of Nursing or designee will also do weekly random audits of resident safety	

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F 282	Continued From page 2 was near the right arm of the chair and the chair was plugged into the electrical outlet and operational. Staff sent the resident to the hospital via ambulance. NA-G provided a written statement dated September 23, 2017 wherein she indicated she was walking by R1's room at about 10:30 a.m. and noticed the resident face down on the floor with his top half under the bed. NA-G stated, "His chair had been lifted up." NA-I provided a written statement dated September 23, 2017 wherein he indicated at approximately 10:00 a.m. R1's ADL's were completed and R1 was transferred to his lift chair. NA-I indicated, "Unbeknownst to myself the recliner was to be unplugged. There was a sign in room stating this and it was stated on the care guides." NA-I further indicated at 10:30 a.m. R1 was found face down on the floor between his recliner chair and bed, and the recliner was fully raised and plugged in at the time. R1's emergency room notes indicated R1 had an acute, large soft-tissue hematoma overlying the right frontal bone, without underlying fracture. R1 was admitted to the hospital for treatment of pneumonia. R1 returned to the facility four days later. A Performance Improvement Plan (PIP) dated September 23, 2017 indicated NA-I met with Registered Nurse (RN)-C. RN-C documented NA-I had assisted the resident into his lift chair at 10:00 a.m., placed the recliner in the reclined position, and left the room. Thirty minutes later the resident was found on the floor and had used the remote to lift the chair to the standing	F 282	interventions to ensure that all are in place for that resident. This will be ongoing. All audit results will be brought to quarterly QAPI meeting to make recommendations for ongoing monitoring. Date of Completion: January 16th, 2018	

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F 282	Continued From page 3	F 282		

position. The resident sustained a hematoma to his right forehead. The resident care guide stated to unplug the lift chair and it was a new intervention in the past three days. Remarks indicated NA-I stated "I feel absolutely horrible about this." The incident was noted to be due to NA-I's carelessness and not following the care guide. Corrective action indicated NA-I was pulled from the floor following the incident while an investigation was completed. The investigation supported the incident was an accident. NA-I was educated on the importance of reading and following the care guides to prevent injuries. NA-I was suspended without pay for the remainder of his shift.

A nursing progress note dated September 27, 2017, after R1 returned to the facility, indicated R1's right eye socket and forehead above the eye were purple due to bruising, with a light purple hematoma on his right (R) forehead measuring approximately 6 centimeters (cm) by 5.5 cm, due to his fall on September 23rd. The hematoma was tender to the touch. The resident had a number of other bruises on his body and was at risk for bruising due to anticoagulant use and low platelets.

A nursing progress note dated October 1, 2017, indicated "Hematoma to R forehead above eyebrow has decreased in size," and a cold pack was intermittently placed on the hematoma throughout the shift.

During interview on October 23, 2017 at 10:40 a.m., R1 stated he'd had a bad fall with a bruise on his face and bump on his forehead. R1 stated "it was bad, you can see it was four weeks ago." Observation at that time showed R1 still had two

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small bumps above his right eyebrow and some bruising below his right eye.

During interview on December 11, 2017 at 9:30 a.m., NA-I acknowledged he was the assigned NA for R1 on September 23, 2017 during the day shift, and was the last staff person to be with R1 before his fall. NA-I stated he and NA-G used a mechanical lift to move R1 from his bed to his lift chair. NA-I stated the lift chair was put in the flat or sitting position and may have been reclined. NA-I stated he gave R1 the call button and left the room. NA-I stated he did not recall if he had plugged in the lift chair or if it had already been plugged into the electrical outlet that morning. NA-I stated he heard a call on the radio and went to R1's room to assist. NA-I stated he saw R1 lying on the floor with a "goose egg" about "the size of a tennis ball" on his forehead. NA-I stated R1 showed a lot of discomfort at the time, NA-I did not see any bleeding.

NA-I also stated during the interview that he did not think anything was said about safety precautions for R1 and his lift chair in morning report prior to the incident. NA-I acknowledged the care guide indicated not to leave R1's lift chair plugged in while R1 was in it, and stated he had not noticed the information. NA-I stated the information in the care guide may have been in bold print, but it did not stick out on the paper. NA-I stated staff reports any changes to the resident's plans that occur during the week, but once it gets to the weekend, it is not usually reported. NA-I asked, "If residents are not allowed to be in electric chairs, why are they provided with them?" NA-I stated he accepted responsibility for the incident, the information was in the care guide and staff should be reviewing

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F 282	Continued From page 5 the information every morning. An undated policy titled, "Resident Care Plan Implementation Policy", indicates nursing staff will ensure a care plan is completed and made available to all nursing staff. The policy further indicated NA's are to use this information to provide appropriate care to residents, and nurse managers will update care plans and care guides as resident needs/situation changes.	F 282		
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	F 323		1/16/18

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F 323	Continued From page 6 appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement fall interventions for 1 of 3 residents (R1) reviewed for falls. R1 sustained harm, an acute, large soft-tissue hematoma overlying the right frontal bone of the face when staff failed to ensure the power to an electric lift chair was unplugged while the resident was seated in the chair. Findings include: R1's Quarterly Review dated June 1, 2017 indicated the resident was cognitively intact. R1's Significant Change in Status Assessment dated September 13, 2017, indicated the resident required extensive assistance with most activities of daily living (ADL's), was totally dependent on staff for transfers and locomotion, and falls was a triggered care area. R1's care plan dated March 8, 2016, indicated the resident was at risk for falls due to limited mobility and dependence on staff for transfers. R1's care plan dated December 5, 2016 indicated a safety risk for the resident due to use of a recliner with a lift function. The care plan intervention for recliner use, dated September 20, 2017, indicated the resident was unable to get out of the chair independently or use the lift control, and to keep the lift chair unplugged except for use by staff. R1's Nursing Assistant (NA) care guide (undated), a sheet of paper containing specific resident care information that NA's carried while providing resident care, directed staff to unplug the recliner when the resident was sitting in it.	F 323	Fall interventions for R1 were implemented on 9/20/17 instructing staff to unplug the lift chair when in use. Care plan and care guides were updated 9/20/17. NAR caring for R1 was reeducated on care plan interventions on 9/23/17. All staff were reeducated on R1□s care plan interventions regarding lift chair safety by 10/1/17. All residents utilizing lift chairs will be reassessed for safety in utilizing lift chair independently by 1/12/18. Care plans and care guides will be updated based on the results of those assessments. Staff will be made aware of any changes by following the Care guide Knowledge and expectation policy dated 1/5/18. Policies and procedures were reviewed and revised to ensure that staff would be aware of the care plan for each resident and the importance of following that plan of care when providing care to residents. A new Care Guide Knowledge and Expectations policy was put into place on 1/5/18. The purpose of this policy is to ensure that at all times, the staff providing cares to the residents at Zumbrota Health Services will have and understand the most up to date information on each resident that they serve throughout their shift. This includes a shift to shift report for a minimum of one week for all new safety measures implemented for a resident as well as any downgrades in status with regard to transfers, ambulation, and diet.	

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F 323	Continued From page 7 Facility staff completed a comprehensive assessment of R1 on September 14, 2017, as part of a Significant Change in Status Assessment. The assessment indicated, "Resident is assessed to be safe to utilize his lift chair control." A nurse progress note dated September 15, 2017, indicated R1 had fallen out of his wheelchair in a transportation van in front of the facility. The resident complained of right knee and left hip pain and was transported to the emergency room for evaluation. A nurse progress note dated September 20, 2017 at 2:30 a.m., indicated upon return from the hospital R1 was "very confused" and did not recognize staff in the room. The note indicates that later R1 became more oriented to his surroundings and people. A Fall Risk assessment completed on September 20, 2017 at 2:33 a.m. indicated the resident was at high risk for falls. The assessment indicated, "Consider environment risk factors in the resident's interventions. Consider addition or removal of balance mobility devices." A nursing progress note dated September 20, 2017 at 9:30 p.m., indicated R1 refused or was unable to participate with lift transfer from his recliner to his bed. A nursing progress note dated September 23, 2017, indicated R1 was transferred to his recliner and last observed at 10:00 a.m. At 10:30 a.m., the resident was found lying prone on the floor in his room with his head under the foot of his bed.	F 323	The Director of Nursing or designee will do a minimum of 3 random audits of nursing staff per week for one month, then one per week for 3 months, and monthly thereafter to ensure that staff have all necessary information to competently care for their residents available to them, and that they are knowledgeable of changes in a resident□s status. The Director of Nursing or designee will also do weekly random audits of resident safety interventions to ensure that all are in place for that resident. This will be ongoing. All audit results will be brought to quarterly QAPI meeting to make recommendations for ongoing monitoring. Completion Date: January 16, 2018	

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The recliner was in the maximum inclined position and the resident stated "no" when asked if he was okay. When asked what he was trying to do, the resident stated, "I don't know." The resident had a large hematoma on the right side of his forehead extending from above the right eyebrow to the resident's hairline and he complained of a severe headache rated 10/10. The remote to the lift chair was near the right arm of the chair and the chair was plugged into the electrical outlet and operational. Staff sent the resident to the hospital via ambulance.

NA-G provided a written statement dated September 23, 2017 wherein she indicated she was walking by R1's room at about 10:30 a.m. and noticed the resident face down on the floor with his top half under the bed. NA-G stated, "His chair had been lifted up."

NA-I provided a written statement dated September 23, 2017 wherein he indicated at approximately 10:00 a.m. R1's ADL's were completed and R1 was transferred to his lift chair. NA-I indicated, "Unbeknownst to myself the recliner was to be unplugged. There was a sign in room stating this and it was stated on the care guides." NA-I further indicated at 10:30 a.m. R1 was found face down on the floor between his recliner chair and bed, and the recliner was fully raised and plugged in at the time.

R1's emergency room notes indicated R1 had an acute, large soft-tissue hematoma overlying the right frontal bone, without underlying fracture. R1 was admitted to the hospital for treatment of pneumonia. R1 returned to the facility four days later.

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A Performance Improvement Plan (PIP) dated September 23, 2017 indicated NA-I met with Registered Nurse (RN)-C. RN-C documented NA-I had assisted the resident into his lift chair at 10:00 a.m., placed the recliner in the reclined position, and left the room. Thirty minutes later the resident was found on the floor and had used the remote to lift the chair to the standing position. The resident sustained a hematoma to his right forehead. The resident care guide stated to unplug the lift chair and that it was a new intervention in the past three days. Remarks indicated NA-I stated "I feel absolutely horrible about this." The incident was noted to be due to NA-I's carelessness and not following the care guide. Corrective action indicated NA-I was pulled from the floor following the incident while an investigation was completed. The investigation supported the incident was an accident. NA-I was educated on the importance of reading and following the care guides to prevent injuries. NA-I was suspended without pay for the remainder of his shift.

A nursing progress note dated September 27, 2017, after R1 returned to the facility, indicated R1's right (R) eye socket and forehead above the eye were purple due to bruising, with a light purple hematoma on his right forehead measuring approximately 6 centimeters (cm) by 5.5 cm, due to his fall on September 23rd. The hematoma was tender to the touch. The resident had a number of other bruises on his body and was at risk for bruising due to anticoagulant use and low platelets.

A nursing progress note dated October 1, 2017, indicated "Hematoma to R forehead above eyebrow has decreased in size," and a cold pack

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was intermittently placed on the hematoma throughout the shift.

During interview on October 23, 2017 at 10:40 a.m., R1 stated he had a bad fall with a bruise on his face and bump on his forehead. R1 stated "it was bad, you can see it was four weeks ago." Observation at that time showed R1 still had two small bumps above his right eyebrow and some bruising below his right eye.

On October 23, 2017 at 1:00 p.m., it was observed that R1's electric lift chair was plugged into an electrical outlet.

During interview on October 23, 2017 at 1:15 p.m., NA-A stated her understanding of the incident was R1 had his remote, lifted his chair up, and fell to the floor. NA-A stated a couple days prior she was told by the charge nurse to place a dark sign in R1's room that read (approximately), "Unplug at all times, staff to operate only." NA-A stated a brighter, laminated sign was placed in R1's room after the fall. NA-A stated no one witnessed the fall. NA-A stated her understanding is R1's lift chair is to be unplugged at all times, except for while staff are operating it. NA-A stated new information used to be in bold print on the care guide, but after the incident new information is now highlighted dark and more difficult to miss.

During interview on October 23, 2017 at 2:14 p.m., NA-B stated she was aware R1 had used his remote to raise his lift chair as high as it would go and slid out of the chair. NA-B stated that after the fall everyone said R1's chair has to be unplugged. NA-B stated the care guide and shift-to-shift report are ways staff know what

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F 323	Continued From page 11 safety precautions a resident requires. During interview on October 23, 2017 at 3:59 p.m., the Director of Nursing (DON) stated R1's cognition was variable and has steadily declined since his second diagnosis of leukemia in July. The DON stated the facility had implemented the lift chair precautions for R1 after a hospitalization since he was much less alert. The DON stated the signs on the wall for lift chair precautions are generic and staff look at the care guide for specifics. The DON stated some residents are mobile and need to have their lift chair unplugged at all times, whereas R1 was not mobile and only needed his lift chair unplugged while sitting in it. The DON stated NA-I told her the lift chair precaution for R1 was such a new intervention he was not used to doing it, NA-I walked out and simply forgot. The DON stated after the incident a second sign was put up and she reiterated to staff to include reminders in shift-to-shift report to unplug R1's chair when he was in it. During interview on November 27, 2017 at 3:31 p.m., medical doctor (MD)-E stated R1 had mild cognitive impairment with short-term memory problems. MD-E stated R1's fall did not result in a change in R1's health condition, but R1 had obvious bruising and discomfort from the fall, with no other known sequelae. MD-E stated there was no excuse for leaving the lift chair plugged in. During interview on November 29, 2017 at 10:15 a.m., family member (F)-F stated there was a sign put behind the lift chair to unplug it that was not followed. F-F stated another family member, F-H, visited R1 before the fall and saw R1 trying to use his lift chair. F-F stated F-H told staff there was a safety concern with R1 operating his lift	F 323		

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F 323	Continued From page 12 chair. During interview on November 30, 2017 at 3:25 p.m., NA-G stated on the day of the incident she was walking past R1's room and saw him lying on the floor with his lift chair raised up. NA-G stated R1's lift chair was plugged in. When asked if she knew R1 was not to have his chair plugged in when he was in it, NA-G stated, "I don't believe so." NA-G stated she was not working on the hall where R1 was located and did not have his care guide. NA-G stated after the incident the charge nurse informed all staff R1's lift chair needed to be unplugged. NA-G stated at the time of the fall she did not see the dark sign on the wall in R1's room indicating the chair was to be unplugged, but later went to check and saw the sign. NA-G stated for residents that are not to use the remote of their lift chair, staff usually leave the chair plugged in, and only unplug the chair once the resident is sitting in it. NA-G said the chair should have been unplugged to keep R1 from lifting it up, paying attention to the care guide. NA-G identified NA-I as the NA who had been caring for R1 prior to the fall. During interview on December 6, 2017 at 3:48 p.m., F-H stated he visited R1 in the facility for several consecutive days, a few days before the fall. F-H stated R1 was not very cognizant for the entire duration of his visit and they did not make an intellectual connection. F-H stated he watched R1 use the remote control of his lift chair to tip the chair up. F-H stated R1 was moving the chair to go all the way forward and all the way back and seemed to be enjoying it. F-H stated when R1 tipped the chair up, F-H held R1 in the lift chair and lowered it back to a sitting position. F-H stated he went to the hallway and grabbed a staff	F 323		

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member and expressed his concern for R1's safety using the lift chair, and staff transferred the resident back to his bed. F-H stated he came back to visit the next day and there was a paper sign on the wall behind the chair that read something like, "Don't operate without supervision," but the chair was plugged in.

During interview on December 11, 2017 at 9:30 a.m., NA-I acknowledged he was the assigned NA for R1 on September 23, 2017 during the day shift, and was the last staff person to be with R1 before his fall. NA-I stated he and NA-G used a mechanical lift to move R1 from his bed to his lift chair. NA-I stated the lift chair was put in the flat or sitting position and may have been reclined. NA-I stated he gave R1 the call button and left the room. NA-I stated he did not recall if he had plugged in the lift chair or if it had already been plugged into the electrical outlet that morning. NA-I stated he heard a call on the radio and went to R1's room to assist. NA-I stated he saw R1 lying on the floor with a "goose egg" about "the size of a tennis ball" on his forehead. NA-I stated R1 showed a lot of discomfort at the time, NA-I did not see any bleeding.

NA-I also stated during the interview that he did not think anything was said about safety precautions for R1 and his lift chair in morning report prior to the incident. NA-I acknowledged the care guide indicated not to leave R1's lift chair plugged in while R1 was in it, and stated he had not noticed the information. NA-I stated the information in the care guide may have been in bold print, but it did not stick out on the paper. NA-I stated staff reports any changes to the resident's plans that occur during the week, but once it gets to the weekend, it is not usually

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reported. NA-I asked, "If residents are not allowed to be in electric chairs, why are they provided with them?" NA-I stated he accepted responsibility for the incident, the information was in the care guide and staff should be reviewing the information every morning.

During interview on December 13, 2017 at 8:35 a.m., F-J stated he was the first to find R1 on the floor with a big welt on his head. F-J stated R1 was alone and he found a staff person and told them. F-J stated R1 had a black eye and even weeks later he could still see a bruise from R1's hairline to his eyebrow. F-J stated after the fall R1 had a difficult time focusing and the fall seemed to affect R1's ability to think. F-J stated he and R1 are/were both engineers and after the fall, R1 was no longer able to talk with him about technical things. F-J stated R1 told him his head hurt for weeks after the fall.

A policy dated October 3, 2016, titled "Maltreatment Prohibition Policy", includes under the definition of neglect: "failure to prevent exposure to unsafe activities and environments."

An undated policy titled, "Resident Care Plan Implementation Policy", indicates nursing staff will ensure a care plan is completed and made available to all nursing staff. The policy further states NA's are to use this information to provide appropriate care to residents, and nurse managers will update care plans and care guides as resident needs/situation changes.

Minnesota Department of Health

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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 #H5376014 and #H5376015. As a result, the following correction orders are issued related to H5376014 and #H5376015. The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of	2 000		

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2 000	Continued From page 1 Health Informational Bulletin 14-01, available at 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 interview and document review, the facility failed to implement care plan interventions for safety precautions for the use of a recliner with a lift function, for 1 of 3 residents (R1) reviewed for falls. Findings include: R1's Quarterly Review dated June 1, 2017 indicated the resident was cognitively intact. R1's Significant Change in Status Assessment dated September 13, 2017, indicated the resident required extensive assistance with most activities	2 565	Zumbrota Health Services ensures that resident□s environment remains as free from accident hazards as is possible and that each resident receives adequate supervision and assistive devices to prevent accidents by ensuring safety risks with regard to falls are comprehensively assessed. Staff caring for R1 was re-educated on 9/23 of the care plan interventions. All staff were re-educated on the need to follow the care plan for all residents as it relates to recliners with life function. This re-education was	1/16/18

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2 565	Continued From page 2 of daily living (ADL's), was totally dependent on staff for transfers and locomotion, and falls was a triggered care area. R1's care plan dated March 8, 2016, indicated the resident was at risk for falls due to limited mobility and dependence on staff for transfers. R1's care plan dated December 5, 2016 indicated a safety risk for the resident due to use of a recliner with a lift function. The care plan intervention for recliner use, dated September 20, 2017, indicated the resident was unable to get out of the chair independently or use the lift control, and for staff to keep the lift chair unplugged except for use by staff. R1's Nursing Assistant (NA) undated care guide (a sheet of paper containing specific resident care information that NA's carried while providing resident care), directed staff to unplug the recliner when the resident was sitting in it. A nursing progress note dated September 20, 2017 at 9:30 p.m., indicated R1 refused or was unable to participate with lift transfer from his recliner to his bed. A nursing progress note dated September 23, 2017, indicated R1 was transferred to his recliner and last observed at 10:00 a.m. According to the note, at 10:30 a.m., the resident was found lying prone on the floor in his room with his head under the foot of his bed. The recliner was in the maximum inclined position and the resident stated "no" when asked if he was okay. When asked what he was trying to do, the resident stated, "I don't know." The resident had a large hematoma on the right side of his forehead extending from above the right eyebrow to the resident's hairline and he complained of a severe	2 565	completed by October 1, 2017. All residents utilizing recliners with lift function are at risk for deficient practices in this area. Care guides with recent changes of information were immediately highlighted to bring to greater attention important changes to resident□s plan of care. New signage was put in the room to be more likely to draw the attention of all staff members. Policies and procedures were reviewed and revised to ensure that staff would be aware of the care plan for each resident and the importance of following that plan of care when providing care to residents. A new Care Guide Knowledge and Expectations policy was put into place on 1/5/18. The purpose of this policy is to ensure that at all times, the staff providing cares to the residents at Zumbrota Health Services will have and understand the most up to date information on each resident that they serve throughout their shift. This includes a shift to shift report for a minimum of one week for all new safety measures implemented for a resident as well as any downgrades in status with regard to transfers, ambulation, and diet. The Director of Nursing or designee will do a minimum of 3 random audits of nursing staff per week for one month, then one per week for 3 months, and monthly thereafter to ensure that staff have all necessary information to competently care for their residents available to them, and that they are knowledgeable of changes in a resident□s status. The Director of Nursing or designee will also do weekly random audits of resident safety	

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2 565	Continued From page 3 headache rated 10/10. The remote to the lift chair was near the right arm of the chair and the chair was plugged into the electrical outlet and operational. Staff sent the resident to the hospital via ambulance. NA-G provided a written statement dated September 23, 2017 wherein she indicated she was walking by R1's room at about 10:30 a.m. and noticed the resident face down on the floor with his top half under the bed. NA-G stated, "His chair had been lifted up." NA-I provided a written statement dated September 23, 2017 wherein he indicated at approximately 10:00 a.m. R1's ADL's were completed and R1 was transferred to his lift chair. NA-I indicated, "Unbeknownst to myself the recliner was to be unplugged. There was a sign in room stating this and it was stated on the care guides." NA-I further indicated at 10:30 a.m. R1 was found face down on the floor between his recliner chair and bed, and the recliner was fully raised and plugged in at the time. R1's emergency room notes indicated R1 had an acute, large soft-tissue hematoma overlying the right frontal bone, without underlying fracture. R1 was admitted to the hospital for treatment of pneumonia. R1 returned to the facility four days later. A Performance Improvement Plan (PIP) dated September 23, 2017 indicated NA-I met with Registered Nurse (RN)-C. RN-C documented NA-I had assisted the resident into his lift chair at 10:00 a.m., placed the recliner in the reclined position, and left the room. Thirty minutes later the resident was found on the floor and had used the remote to lift the chair to the standing	2 565	interventions to ensure that all are in place for that resident. This will be ongoing. All audit results will be brought to quarterly QAPI meeting to make recommendations for ongoing monitoring. Date of Completion: January 16th, 2018	

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2 565	Continued From page 4	2 565		

position. The resident sustained a hematoma to his right forehead. The resident care guide stated to unplug the lift chair and it was a new intervention in the past three days. Remarks indicated NA-I stated "I feel absolutely horrible about this." The incident was noted to be due to NA-I's carelessness and not following the care guide. Corrective action indicated NA-I was pulled from the floor following the incident while an investigation was completed. The investigation supported the incident was an accident. NA-I was educated on the importance of reading and following the care guides to prevent injuries. NA-I was suspended without pay for the remainder of his shift.

A nursing progress note dated September 27, 2017, after R1 returned to the facility, indicated R1's right eye socket and forehead above the eye were purple due to bruising, with a light purple hematoma on his right (R) forehead measuring approximately 6 centimeters (cm) by 5.5 cm, due to his fall on September 23rd. The hematoma was tender to the touch. The resident had a number of other bruises on his body and was at risk for bruising due to anticoagulant use and low platelets.

A nursing progress note dated October 1, 2017, indicated "Hematoma to R forehead above eyebrow has decreased in size," and a cold pack was intermittently placed on the hematoma throughout the shift.

During interview on October 23, 2017 at 10:40 a.m., R1 stated he'd had a bad fall with a bruise on his face and bump on his forehead. R1 stated "it was bad, you can see it was four weeks ago." Observation at that time showed R1 still had two small bumps above his right eyebrow and some

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2 565	Continued From page 5 bruising below his right eye. During interview on December 11, 2017 at 9:30 a.m., NA-I acknowledged he was the assigned NA for R1 on September 23, 2017 during the day shift, and was the last staff person to be with R1 before his fall. NA-I stated he and NA-G used a mechanical lift to move R1 from his bed to his lift chair. NA-I stated the lift chair was put in the flat or sitting position and may have been reclined. NA-I stated he gave R1 the call button and left the room. NA-I stated he did not recall if he had plugged in the lift chair or if it had already been plugged into the electrical outlet that morning. NA-I stated he heard a call on the radio and went to R1's room to assist. NA-I stated he saw R1 lying on the floor with a "goose egg" about "the size of a tennis ball" on his forehead. NA-I stated R1 showed a lot of discomfort at the time, NA-I did not see any bleeding. NA-I also stated during the interview that he did not think anything was said about safety precautions for R1 and his lift chair in morning report prior to the incident. NA-I acknowledged the care guide indicated not to leave R1's lift chair plugged in while R1 was in it, and stated he had not noticed the information. NA-I stated the information in the care guide may have been in bold print, but it did not stick out on the paper. NA-I stated staff reports any changes to the resident's plans that occur during the week, but once it gets to the weekend, it is not usually reported. NA-I asked, "If residents are not allowed to be in electric chairs, why are they provided with them?" NA-I stated he accepted responsibility for the incident, the information was in the care guide and staff should be reviewing the information every morning.	2 565		

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2 565	Continued From page 6 An undated policy titled, "Resident Care Plan Implementation Policy", indicates nursing staff will ensure a care plan is completed and made available to all nursing staff. The policy further indicated NA's are to use this information to provide appropriate care to residents, and nurse managers will update care plans and care guides as resident needs/situation changes. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written 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	21850		1/16/18

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21850	Continued From page 7 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 interview and document review, the facility failed to ensure 1 of 3 residents (R1) reviewed was free from maltreatment. R1 was neglected when staff failed to ensure the power to an electric lift chair was unplugged while the resident was seated in the chair and R1 had a fall. R1 sustained harm, was hospitalizat after the fall and sustained an acute, large soft-tissue hematoma overlying the right frontal bone of R1's face. Findings include: R1's Quarterly Review dated June 1, 2017 indicated the resident was cognitively intact. R1's Significant Change in Status Assessment dated September 13, 2017, indicated the resident required extensive assistance with most activities of daily living (ADL's), was totally dependent on staff for transfers and locomotion, and falls was a triggered care area. R1's care plan dated March 8, 2016, indicated the resident was at risk for falls due to limited mobility and dependence on staff for transfers. R1's care plan dated December 5, 2016 indicated a safety risk for the resident due to use of a recliner with a lift function. The care plan intervention for recliner use, dated September 20, 2017, indicated the resident was unable to get out of the chair independently or use the lift control, and to keep the lift chair unplugged except for use by staff. R1's Nursing Assistant (NA) care guide	21850	Fall interventions for R1 were implemented on 9/20/17 instructing staff to unplug the lift chair when in use. Care plan and care guides were updated 9/20/17. NAR caring for R1 was reeducated on care plan interventions on 9/23/17. All staff were reeducated on R1□s care plan interventions regarding lift chair safety by 10/1/17. All residents utilizing lift chairs will be reassessed for safety in utilizing lift chair independently by 1/12/18. Care plans and care guides will be updated based on the results of those assessments. Staff will be made aware of any changes by following the Care guide Knowledge and expectation policy dated 1/5/18. Policies and procedures were reviewed and revised to ensure that staff would be aware of the care plan for each resident and the importance of following that plan of care when providing care to residents. A new Care Guide Knowledge and Expectations policy was put into place on 1/5/18. The purpose of this policy is to ensure that at all times, the staff providing cares to the residents at Zumbrota Health Services will have and understand the most up to date information on each resident that they serve throughout their shift. This includes a shift to shift report for a minimum of one week for all new safety measures implemented for a resident as well as any downgrades in	

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(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) COMPLETE DATE
21850	Continued From page 8 (undated), a sheet of paper containing specific resident care information that NA's carried while providing resident care, directed staff to unplug the recliner when the resident was sitting in it. Facility staff completed a comprehensive assessment of R1 on September 14, 2017, as part of a Significant Change in Status Assessment. The assessment indicated, "Resident is assessed to be safe to utilize his lift chair control." A nurse progress note dated September 15, 2017, indicated R1 had fallen out of his wheelchair in a transportation van in front of the facility. The resident complained of right knee and left hip pain and was transported to the emergency room for evaluation. A nurse progress note dated September 20, 2017 at 2:30 a.m., indicated upon return from the hospital R1 was "very confused" and did not recognize staff in the room. The note indicates that later R1 became more oriented to his surroundings and people. A Fall Risk assessment completed on September 20, 2017 at 2:33 a.m. indicated the resident was at high risk for falls. The assessment indicated, "Consider environment risk factors in the resident's interventions. Consider addition or removal of balance mobility devices." A nursing progress note dated September 20, 2017 at 9:30 p.m., indicated R1 refused or was unable to participate with lift transfer from his recliner to his bed. A nursing progress note dated September 23, 2017, indicated R1 was transferred to his recliner	21850	status with regard to transfers, ambulation, and diet. The Director of Nursing or designee will do a minimum of 3 random audits of nursing staff per week for one month, then one per week for 3 months, and monthly thereafter to ensure that staff have all necessary information to competently care for their residents available to them, and that they are knowledgeable of changes in a resident□s status. The Director of Nursing or designee will also do weekly random audits of resident safety interventions to ensure that all are in place for that resident. This will be ongoing. All audit results will be brought to quarterly QAPI meeting to make recommendations for ongoing monitoring. Completion Date: January 16, 2018	

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	00917	A. BUILDING: _____ B. WING _____	C 12/19/2017

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21850	Continued From page 9 and last observed at 10:00 a.m. At 10:30 a.m., the resident was found lying prone on the floor in his room with his head under the foot of his bed. The recliner was in the maximum inclined position and the resident stated "no" when asked if he was okay. When asked what he was trying to do, the resident stated, "I don't know." The resident had a large hematoma on the right side of his forehead extending from above the right eyebrow to the resident's hairline and he complained of a severe headache rated 10/10. The remote to the lift chair was near the right arm of the chair and the chair was plugged into the electrical outlet and operational. Staff sent the resident to the hospital via ambulance. NA-G provided a written statement dated September 23, 2017 wherein she indicated she was walking by R1's room at about 10:30 a.m. and noticed the resident face down on the floor with his top half under the bed. NA-G stated, "His chair had been lifted up." NA-I provided a written statement dated September 23, 2017 wherein he indicated at approximately 10:00 a.m. R1's ADL's were completed and R1 was transferred to his lift chair. NA-I indicated, "Unbeknownst to myself the recliner was to be unplugged. There was a sign in room stating this and it was stated on the care guides." NA-I further indicated at 10:30 a.m. R1 was found face down on the floor between his recliner chair and bed, and the recliner was fully raised and plugged in at the time. R1's emergency room notes indicated R1 had an acute, large soft-tissue hematoma overlying the right frontal bone, without underlying fracture. R1 was admitted to the hospital for treatment of pneumonia. R1 returned to the facility four days	21850		

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21850	Continued From page 10 later. A Performance Improvement Plan (PIP) dated September 23, 2017 indicated NA-I met with Registered Nurse (RN)-C. RN-C documented NA-I had assisted the resident into his lift chair at 10:00 a.m., placed the recliner in the reclined position, and left the room. Thirty minutes later the resident was found on the floor and had used the remote to lift the chair to the standing position. The resident sustained a hematoma to his right forehead. The resident care guide stated to unplug the lift chair and that it was a new intervention in the past three days. Remarks indicated NA-I stated "I feel absolutely horrible about this." The incident was noted to be due to NA-I's carelessness and not following the care guide. Corrective action indicated NA-I was pulled from the floor following the incident while an investigation was completed. The investigation supported the incident was an accident. NA-I was educated on the importance of reading and following the care guides to prevent injuries. NA-I was suspended without pay for the remainder of his shift. A nursing progress note dated September 27, 2017, after R1 returned to the facility, indicated R1's right (R) eye socket and forehead above the eye were purple due to bruising, with a light purple hematoma on his right forehead measuring approximately 6 centimeters (cm) by 5.5 cm, due to his fall on September 23rd. The hematoma was tender to the touch. The resident had a number of other bruises on his body and was at risk for bruising due to anticoagulant use and low platelets. A nursing progress note dated October 1, 2017, indicated "Hematoma to R forehead above	21850		

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21850	Continued From page 11 eyebrow has decreased in size," and a cold pack was intermittently placed on the hematoma throughout the shift. During interview on October 23, 2017 at 10:40 a.m., R1 stated he had a bad fall with a bruise on his face and bump on his forehead. R1 stated "it was bad, you can see it was four weeks ago." Observation at that time showed R1 still had two small bumps above his right eyebrow and some bruising below his right eye. On October 23, 2017 at 1:00 p.m., it was observed that R1's electric lift chair was plugged into an electrical outlet. During interview on October 23, 2017 at 1:15 p.m., NA-A stated her understanding of the incident was R1 had his remote, lifted his chair up, and fell to the floor. NA-A stated a couple days prior she was told by the charge nurse to place a dark sign in R1's room that read (approximately), "Unplug at all times, staff to operate only." NA-A stated a brighter, laminated sign was placed in R1's room after the fall. NA-A stated no one witnessed the fall. NA-A stated her understanding is R1's lift chair is to be unplugged at all times, except for while staff are operating it. NA-A stated new information used to be in bold print on the care guide, but after the incident new information is now highlighted dark and more difficult to miss. During interview on October 23, 2017 at 2:14 p.m., NA-B stated she was aware R1 had used his remote to raise his lift chair as high as it would go and slid out of the chair. NA-B stated that after the fall everyone said R1's chair has to be unplugged. NA-B stated the care guide and shift-to-shift report are ways staff know what	21850		

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21850	Continued From page 12 safety precautions a resident requires. During interview on October 23, 2017 at 3:59 p.m., the Director of Nursing (DON) stated R1's cognition was variable and has steadily declined since his second diagnosis of leukemia in July. The DON stated the facility had implemented the lift chair precautions for R1 after a hospitalization since he was much less alert. The DON stated the signs on the wall for lift chair precautions are generic and staff look at the care guide for specifics. The DON stated some residents are mobile and need to have their lift chair unplugged at all times, whereas R1 was not mobile and only needed his lift chair unplugged while sitting in it. The DON stated NA-I told her the lift chair precaution for R1 was such a new intervention he was not used to doing it, NA-I walked out and simply forgot. The DON stated after the incident a second sign was put up and she reiterated to staff to include reminders in shift-to-shift report to unplug R1's chair when he was in it. During interview on November 27, 2017 at 3:31 p.m., medical doctor (MD)-E stated R1 had mild cognitive impairment with short-term memory problems. MD-E stated R1's fall did not result in a change in R1's health condition, but R1 had obvious bruising and discomfort from the fall, with no other known sequelae. MD-E stated there was no excuse for leaving the lift chair plugged in. During interview on November 29, 2017 at 10:15 a.m., family member (F)-F stated there was a sign put behind the lift chair to unplug it that was not followed. F-F stated another family member, F-H, visited R1 before the fall and saw R1 trying to use his lift chair. F-F stated F-H told staff there was a safety concern with R1 operating his lift chair.	21850		

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21850	Continued From page 13 During interview on November 30, 2017 at 3:25 p.m., NA-G stated on the day of the incident she was walking past R1's room and saw him lying on the floor with his lift chair raised up. NA-G stated R1's lift chair was plugged in. When asked if she knew R1 was not to have his chair plugged in when he was in it, NA-G stated, "I don't believe so." NA-G stated she was not working on the hall where R1 was located and did not have his care guide. NA-G stated after the incident the charge nurse informed all staff R1's lift chair needed to be unplugged. NA-G stated at the time of the fall she did not see the dark sign on the wall in R1's room indicating the chair was to be unplugged, but later went to check and saw the sign. NA-G stated for residents that are not to use the remote of their lift chair, staff usually leave the chair plugged in, and only unplug the chair once the resident is sitting in it. NA-G said the chair should have been unplugged to keep R1 from lifting it up, paying attention to the care guide. NA-G identified NA-I as the NA who had been caring for R1 prior to the fall. During interview on December 6, 2017 at 3:48 p.m., F-H stated he visited R1 in the facility for several consecutive days, a few days before the fall. F-H stated R1 was not very cognizant for the entire duration of his visit and they did not make an intellectual connection. F-H stated he watched R1 use the remote control of his lift chair to tip the chair up. F-H stated R1 was moving the chair to go all the way forward and all the way back and seemed to be enjoying it. F-H stated when R1 tipped the chair up, F-H held R1 in the lift chair and lowered it back to a sitting position. F-H stated he went to the hallway and grabbed a staff member and expressed his concern for R1's safety using the lift chair, and staff transferred the	21850		

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21850	Continued From page 14 resident back to his bed. F-H stated he came back to visit the next day and there was a paper sign on the wall behind the chair that read something like, "Don't operate without supervision," but the chair was plugged in. During interview on December 11, 2017 at 9:30 a.m., NA-I acknowledged he was the assigned NA for R1 on September 23, 2017 during the day shift, and was the last staff person to be with R1 before his fall. NA-I stated he and NA-G used a mechanical lift to move R1 from his bed to his lift chair. NA-I stated the lift chair was put in the flat or sitting position and may have been reclined. NA-I stated he gave R1 the call button and left the room. NA-I stated he did not recall if he had plugged in the lift chair or if it had already been plugged into the electrical outlet that morning. NA-I stated he heard a call on the radio and went to R1's room to assist. NA-I stated he saw R1 lying on the floor with a "goose egg" about "the size of a tennis ball" on his forehead. NA-I stated R1 showed a lot of discomfort at the time, NA-I did not see any bleeding. NA-I also stated during the interview that he did not think anything was said about safety precautions for R1 and his lift chair in morning report prior to the incident. NA-I acknowledged the care guide indicated not to leave R1's lift chair plugged in while R1 was in it, and stated he had not noticed the information. NA-I stated the information in the care guide may have been in bold print, but it did not stick out on the paper. NA-I stated staff reports any changes to the resident's plans that occur during the week, but once it gets to the weekend, it is not usually reported. NA-I asked, "If residents are not allowed to be in electric chairs, why are they provided with them?" NA-I stated he accepted	21850		

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21850	Continued From page 15 responsibility for the incident, the information was in the care guide and staff should be reviewing the information every morning. During interview on December 13, 2017 at 8:35 a.m., F-J stated he was the first to find R1 on the floor with a big welt on his head. F-J stated R1 was alone and he found a staff person and told them. F-J stated R1 had a black eye and even weeks later he could still see a bruise from R1's hairline to his eyebrow. F-J stated after the fall R1 had a difficult time focusing and the fall seemed to affect R1's ability to think. F-J stated he and R1 are/were both engineers and after the fall, R1 was no longer able to talk with him about technical things. F-J stated R1 told him his head hurt for weeks after the fall. A policy dated October 3, 2016, titled "Maltreatment Prohibition Policy", includes under the definition of neglect: "failure to prevent exposure to unsafe activities and environments." An undated policy titled, "Resident Care Plan Implementation Policy", indicates nursing staff will ensure a care plan is completed and made available to all nursing staff. The policy further states NA's are to use this information to provide appropriate care to residents, and nurse managers will update care plans and care guides as resident needs/situation changes. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could revise facility policies related to maltreatment. They could ensure all staff are aware of the importance of providing care for residents in accordance with their plans of care, and could establish a system to audit. They could report that information gathered from audits to the	21850		

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21850	Continued From page 16 quality assurance performance improvement (QAPI) committee, to ensure sustained correction and compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21850		