

### Office of Health Facility Complaints Investigative Report PUBLIC

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

Facility Name: Zumbrota Care Center Report Number: H5376014 and H5376015

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):

Financial Exploitation Inconclusive based on the following information:  526.557, subdivision 9c (c) were considered and it was is responsible for the tion. This determination was based on the following: implementing the safety precaution written on the are of, and following, the safety precaution on the esident for safety with his lift chair after a significant opeal the maltreatment finding. If the maltreatment is will be submitted to the nurse aide registry for and/or to the Minnesota Department of Human Services wisions of the background study requirements under
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t Statutes for Chapters 144 & 144A. No state licensing
CFR, Part 483, subpart B) - Compliance Not Met ong Term Care Facilities (42 CFR, Part 483, subpart B),
] No
napter 4658) - Compliance Not Met sing Homes (MN Rules Chapter 4658) were not met.
] No
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Facility Name: Zumbrota Care Center Report Number: H5376014 and H5376015

#### **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:

- | Medical Records
- Care Guide
- Nurses Notes
- **X** Assessments
- Care Plan Records
- Social Service Notes
- **X** Facility Incident Reports
- Therapy and/or Ancillary Services Records

Facility Name: Zumbrota Care Center Report Number: H5376014 and H5376015

Oth	ier pertinent medical records:
X	Hospital Records 🗵 Death Certificate
X	Police Report
Ado	ditional facility records:
X	Resident/Family Council Minutes
X	Staff Time Sheets, Schedules, etc.
X	Facility Internal Investigation Reports
X	Personnel Records/Background Check, etc.
X	Facility Policies and Procedures
Nui	mber of additional resident(s) reviewed: Two
We	re residents selected based on the allegation(s)?    Yes    No    N/A
•	ecify:
	re resident(s) identified in the allegation(s) present in the facility at the time of the investigation?
_	Yes O No N/A
Spe	ecify:
Int	erviews: The following interviews were conducted during the investigation:
AETABARATA	erview with reporter(s)    Yes   No   N/A
Spe	ecify:
lf u	nable to contact reporter, attempts were made on:
Da	te: Time: Date: Time: Date: Time:
Inte	erview with family:   Yes No N/A Specify:
Did	I you interview the resident(s) identified in allegation:
$\odot$	Yes
Did	l you interview additional residents?   Yes   No
To	tal number of resident interviews: Eight
Inte	erview with staff:   Yes   No   N/A Specify:
Te	nnessen Warnings
	nnessen Warning given as required:   Yes   No
To	tal number of staff interviews: Eight
Dhy	vsician Interviewed: • Yes • No

No Physician Assistant Interviewed: Yes No Interview with Alleged Perpetrator(s): 

Yes O No Attempts to contact: Time: Date: Time: Date: Time: Date: O No If unable to contact was subpoena issued: O Yes, date subpoena was issued Were contacts made with any of the following: ☐ Emergency Personnel 🗵 Police Officers ☐ Medical Examiner ☐ Other: Specify Observations were conducted related to: **X** Nursing Services **X** Call Light Infection Control **X** Use of Equipment ▼ Cleanliness ▼ Dignity/Privacy Issues Safety Issues **X** Meals **x** Facility Tour x Injury Was any involved equipment inspected: 

Yes  $\bigcirc$  N/A ○ No N/A Was equipment being operated in safe manner: Yes O No Specify: Were photographs taken: 

Yes O No cc: **Health Regulation Division - Licensing & Certification** The Office of Ombudsman for Long-Term Care **Zumbrota Police Department Goodhue County Attorney Zumbrota City Attorney** 

Facility Name: Zumbrota Care Center

Report Number: H5376014 and H5376015



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

Licensing and Certification Program Minnesota Department of Health

Kamala Fiske Downing

P.O. Box 64900

St. Paul. MN 55164-0900

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us

PRINTED: 03/02/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		E CONSTRUCTION		PLETED
		245376	B. WING			01/2	26/2018
	PROVIDER OR SUPPLIER			4	TREET ADDRESS, CITY, STATE, ZIP CODE 33 MILL STREET ZUMBROTA, MN 55992		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 000}	January 26, 2018, to issued related to condition the H5376015. Zumbro compliance with 42 requirements for Low The facility is enroll signature is not requage of the CMS-2 correction is require	revisit was conducted on to follow up on deficiencies omplaints H5376014 and ota Care Center is in the CFR Part 483, subpart B, ong Term Care Facilities.  Iled in ePOC and therefore a quired at the bottom of the first 567 form. Although no plan of ed, it is required that the facility pt of the electronic documents.	{F 0	00}			
LABORATOR	Y DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		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.



Protecting, Maintaining and Improving the Health of All Minnesotans

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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

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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

Licensing and Certification Program
Minnesota Department of Health

Kamala Fish Downing

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 He	alth				
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLI	
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		00917			, 0.,20	
NAME OF PRO	OVIDER OR SUPPLIER		DRESS, CITY, ST	TATE, ZIP CODE		
ZUMBROTA	A CARE CENTER	433 MILL 3 ZUMBRO	STREET TA, MN 55992			
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t	the Department wi	thin 15 days of receipt of a				
	notice of assessm	ent for non-compliance.				
	INITIAL COMMEN					
	A licensing order fo	ollow-up was completed to ction orders issued related to				
	complaints H5376	014 and H5376015. Zumbrota				
	Care Center was f regulations.	ound in compliance with state	!			
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Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

**Electronically Signed** 

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Minnesot	a Department of He	alth		CONCEDUCTION	X3) DATE SURVEY
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		00917	B. WING		01/26/2018
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ZUMBRO	TA CARE CENTER		TA, MN 5599	2	
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Minnesota Department of Health STATE FORM



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:

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

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

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

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

<u>Informal Dispute Resolution</u> - 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.

Zumbrota Care Center January 3, 2018 Page 2 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; <u>OR</u>
- 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) <u>AND</u> 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:

Zumbrota Care Center January 3, 2018 Page 3

• 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.

Zumbrota Care Center January 3, 2018 Page 4

### 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:

Zumbrota Care Center January 3, 2018 Page 5

> 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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc">http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc</a> 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

Minnesota Department of Health Licensing and Certification Program

Kumalu Fish Downing

Program Assurance Unit Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: <u>kamala.fiske-downing@state.mn.us</u>

cc: Licensing and Certification File

PRINTED: 03/02/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			MPLETED
		245376	B. WING			C 2/19/2017
	PROVIDER OR SUPPLIER			43	TREET ADDRESS, CITY, STATE, ZIP CODE  33 MILL STREET  UMBROTA, MN 55992	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC 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 COMMEN	TS	F0	00		
F 282 SS=D	to investigate case As a result, the following related to H537601 is enrolled in ePOC not required at the CMS-2567 form. EPOC will be used a SERVICES BY QU	andard survey was conducted #H5376014 and #H5376015. Dwing deficiencies are issued 4 and #H5376015. The facility 2 and therefore a signature is bottom of the first page of the Electronic submission of the is verification of compliance. ALIFIED PERSONS/PER 3)(ii)	F 2	:82		1/16/18
		ive Care Plans ded or arranged by the facility, comprehensive care plan,				
	accordance with eacare. This REQUIREME by: Based on interview facility failed to implifor safety precaution with a lift function, reviewed for falls. Findings include: R1's Quarterly Revindicated the residual significant Change September 13, 20'required extensive of daily living (ADL	qualified persons in ach resident's written plan of NT is not met as evidenced wand document review, the element care plan interventions ons for the use of a recliner for 1 of 3 residents (R1)  riew dated June 1, 2017 ent was cognitively intact. R1's in Status Assessment dated 17, indicated the resident assistance with most activities is, was totally dependent on and locomotion, and falls was a			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 risk 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 al residents as it relates to recliners with lift function. This re-education was completed by October 1, 2017. All residents utilizing recliners with lift	S
LABORATOR	V DIDECTORIS OR DROVA	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE	(X6) DATE

01/09/2018

**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.

Facility ID: 00917

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		245376	B. WING	·	12/1	9/2017
	PROVIDER OR SUPPLIER		. 4	STREET ADDRESS, CITY, STATE, ZIP CODE 133 MILL STREET ZUMBROTA, MN 55992	, .=	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 282	triggered care area  R1's care plan date resident was at risk and dependence o plan dated Decemil risk for the residen lift function. The ca use, dated Septem resident was unabl independently or u to keep the lift chais staff.  R1's Nursing Assis (a sheet of paper of care information th resident care), dire when the resident v  A nursing progress 2017 at 9:30 p.m., unable to participal recliner to his bed.  A nursing progress 2017, indicated R1 and last observed a note, at 10:30 a.m. prone on the floor i the foot of his bed. maximum inclined stated "no" when a asked what he was stated, "I don't know hematoma on the r extending from abo resident's hairline a	ed March 8, 2016, indicated the control for falls due to limited mobility in staff for transfers. R1's care per 5, 2016 indicated a safety to due to use of a recliner with a preplan intervention for recliner ber 20, 2017, indicated the eto get out of the chair se the lift control, and for staff runplugged except for use by tant (NA) undated care guide ontaining specific resident at NA's carried while providing cted staff to unplug the recliner	F 282	function are at risk for deficient prain this area. Care guides with recchanges of information were immelhighlighted to bring to greater atter important changes to resident □s pocare. New signage was put in the be more likely to draw the attention staff members.  Policies and procedures were reviewand revised to ensure that staff wo aware of the care plan for each resident importance of following the of care when providing care to resident A new Care Guide Knowledge and Expectations policy was put into place. A new Care Guide Knowledge and Expectations policy was put into place. The purpose of this policy ensure that at all times, the staff procares to the residents at Zumbrota Services will have and understand most up to date information on each resident that they serve throughous shift. This includes a shift to shift for a minimum of one week for all resident as well as any downgrade status with regard to transfers, ambulation, and diet. The Director of Nursing or designed a minimum of 3 random audits nursing staff per week for one more then one per week for 3 months, a monthly thereafter to ensure that shave all necessary information to competently care for their resident available to them, and that they are knowledgeable of changes in a resident □s status. The Director of Nursing or designee will also do we random audits of resident safety	ent diately ntion plan of room to n of all ewed puld be sident at plan idents. ace on is to roviding Health the the the es in ee will of nth, nd taff se	

NAME OF PROVIDER OR SUPPLIER  ZUMBROTA CARE CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE  433 MILL STREET  ZUMBROTA, MN 55992  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X COMPLETE) (FACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION		E SURVEY PLETED
ZUMBROTA CARE CENTER    A33 MILL STREET   ZUMBROTA, MN 55992			245376	B. WING				
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 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					43	33 MILL STREET		
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	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI	1	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	(X5) COMPLETION DATE
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	F 282	was near the right a was plugged into the operational. Staff sivia ambulance.  NA-G provided a was eptember 23, 201 was walking by R1 and noticed the reswith his top half unchair had been lifted.  NA-I provided a was eptember 23, 201 approximately 10:0 completed and R1 NA-I indicated, "Un recliner was to be a room stating this arguides." NA-I furthed was found face down recliner chair and braised and plugged.  R1's emergency roacute, large soft-tisting the frontal bone, was admitted to the pneumonia. R1 retilater.  A Performance Impose the proposed in the proposed in the pneumonia in the pneumonia in the pneumonia. R1 retilater.  A Performance Imposed in the pneumonia in the pn	arm of the chair and the chair are electrical outlet and ent the resident to the hospital ritten statement dated 7 wherein she indicated she s room at about 10:30 a.m. sident face down on the floor der the bed. NA-G stated, "His d up." itten statement dated 7 wherein he indicated at 0 a.m. R1's ADL's were was transferred to his lift chair. beknownst to myself the anplugged. There was a sign in and it was stated on the care er indicated at 10:30 a.m. R1 who on the floor between his ed, and the recliner was fully a in at the time.  Som notes indicated R1 had an esue hematoma overlying the without underlying fracture. R1 is hospital for treatment of turned to the facility four days brovement Plan (PIP) dated 7 indicated NA-I met with RN)-C. RN-C documented the resident into his lift chair at the recliner in the reclined	F 2	282	for that resident. This will be ongoing All audit results will be brought to quality and the comment of the com	ing. uarterly lations	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA   IDENTIFICATION NUMBER: 	l ` '		ONSTRUCTION	СОМ	E SURVEY IPLETED
		245376	B. WING				C <b>19/2017</b>
	PROVIDER OR SUPPLIER			433 N	ET ADDRESS, CITY, STATE, ZIP CODE IILL STREET BROTA, MN 55992	1 12	10/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 282	his right forehead. to unplug the lift chintervention in the pindicated NA-I state about this." The incomplete NA-I's carelessness guide. Corrective a from the floor follow investigation was a supported the incideducated on the imfollowing the care gwas suspended with his shift.  A nursing progress 2017, after R1 returency after R1 re	ent sustained a hematoma to The resident care guide stated air and it was a new past three days. Remarks and "I feel absolutely horrible ident was noted to be due to a and not following the care action indicated NA-I was pulled ving the incident while an completed. The investigation ent was an accident. NA-I was portance of reading and ruides to prevent injuries. NA-I hout pay for the remainder of the facility, indicated et and forehead above the eye bruising, with a light purple ght (R) forehead measuring and ruimeters (cm) by 5.5 cm, due mber 23rd. The hematoma puch. The resident had a cuises on his body and was at a to anticoagulant use and low note dated October 1, 2017, and to R forehead above assed in size," and a cold pack alaced on the hematoma		282			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY PLETED
		245376	B. WING			1	C <b>19/2017</b>
	PROVIDER OR SUPPLIER  OTA CARE CENTER			4	STREET ADDRESS, CITY, STATE, ZIP CODE 133 MILL STREET ZUMBROTA, MN 55992		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROPROPROPROPROPROPROPROPROPROPROPRO	BE	(X5) COMPLETION DATE
F 282	small bumps above bruising below his reported. NA-I aske allowed to be in eleprovided with them responsibility for the special plans the control of the cont	his right eyebrow and some ight eye.  December 11, 2017 at 9:30 edged he was the assigned ember 23, 2017 during the day ast staff person to be with R1 stated he and NA-G used a ove R1 from his bed to his lift he lift chair was put in the flat had may have been reclined. ER1 the call button and left ed he did not recall if he had hair or if it had already been ectrical outlet that morning. If a call on the radio and went sist. NA-I stated he saw R1 the a "goose egg" about "the " on his forehead. NA-I stated discomfort at the time, NA-I	F 2	282			

NAME OF PROVIDER OR SUPPLIER  ZUMBROTA CARE CENTER   STREET ADDRESS, CITY, STATE, ZIP CODE  433 MILL STREET  ZUMBROTA, MN 55992   (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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 323 FREE OF ACCIDENT  STREET ADDRESS, CITY, STATE, ZIP CODE  433 MILL STREET  ZUMBROTA, MN 55992   STREET ADDRESS, CITY, STATE, ZIP CODE  433 MILL STREET  ZUMBROTA, MN 55992   F 2W PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF THE A		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
TAGE			245376	B. WING			1	
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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 323  FREE OF ACCIDENT  F 323  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  PREFIX TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  PREFIX TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  (EACH CORRECTIVE ACTION SHOULD SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  (EACH CORRECTIVE ACTION SHOULD SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  (EACH CORRECTIVE ACTION SHOULD SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  (EACH CORRECTIVE ACTION SHOULD	,,,				43	33 MILL STREET		
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 323  FREE OF ACCIDENT  F 323	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI	BE	COMPLETION
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		An undated policy of Implementation Poensure a care plan available to all nursindicated NA's are provide appropriate managers will updated as resident needs/sfree OF ACCIDE HAZARDS/SUPER CFR(s): 483.25(d)(d) Accidents. The facility must enfrom accident hazar (2) Each resident rand assistance device) (n) - Bed Rails. The appropriate alternated rail. If a bed of must ensure correct maintenance of beto the following electron bed rails prior (2) Review the risk the resident or resigniformed consent prior (2) Review the risk the resident or resigniformed consent prior (2) Review the risk the resident or resigniformed consent prior (2) Review the risk the resident or resigniformed consent prior (3) Review the risk the resident or resigniformed consent prior (4) Review the risk the resident or resigniformed consent prior (5) Review the risk the resident or resigniformed consent prior (6) Review the risk the resident or resignificant prior (7) Review the risk the resident or resignificant prior (8) Review the risk the resident or resignificant prior (8) Review the risk the resident or resignificant prior (8) Review the risk the resident or resignificant prior (9) Review the risk the resident or resignificant prior (9) Review the risk the resident or resignificant prior (9) Review the risk the resident or resignificant prior (9) Review the risk the resident or resident prior (9) Review the risk the resident or resident prior (1) Review the risk the risk the resident prior (1) Review the risk the risk the risk the risk the	titled, "Resident Care Plan licy", indicates nursing staff will is completed and made sing staff. The policy further to use this information to e care to residents, and nurse ate care plans and care guides situation changes.  NT (VISION/DEVICES (1)(2)(n)(1)-(3)  Insure that - Invironment remains as free ands as is possible; and ecceives adequate supervision vices to prevent accidents.  The facility must attempt to use atives prior to installing a side or r side rail is used, the facility continuous in the side of the facility of the installation, use, and drails, including but not limited ments.  Indent for risk of entrapment of to installation.  It is and benefits of bed rails with ident representative and obtain prior to installation.					1/16/18

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ' '	NG	) COM	PLETED
		245376	B. WING		1	C 1 <b>9/2017</b>
NAME OF PROVIDER OR SUPPLIER  ZUMBROTA CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 433 MILL STREET ZUMBROTA, MN 55992	· · · · · · · · · · · · · · · · · · ·	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	This REQUIREMED by: Based on interview facility failed to imp of 3 residents (R1) sustained harm, an hematoma overlyin face when staff faile electric lift chair wa was seated in the of Findings include: R1's Quarterly Rew indicated the reside Significant Change September 13, 201 required extensive of daily living (ADL staff for transfers a triggered care area R1's care plan date resident was at rish and dependence of plan dated Decemi risk for the residen lift function. The cause, dated Septem resident was unablindependently or u the lift chair unplug R1's Nursing Assis (undated), a sheet	resident's size and weight. NT is not met as evidenced v and document review, the element fall interventions for 1 reviewed for falls. R1 n acute, large soft-tissue g the right frontal bone of the ed to ensure the power to an as unplugged while the resident chair.  riew dated June 1, 2017 ent was cognitively intact. R1's e in Status Assessment dated 17, indicated the resident assistance with most activities 's), was totally dependent on and locomotion, and falls was a		Fall interventions for R1 were implemented on 9/20/17 instruct to unplug the lift chair when in plan and care guides were upon 9/20/17. NAR caring for R1 was reeducated on care plan interventions in chair safety by 10/1/17. All resutilizing lift chairs will be reassed safety in utilizing lift chair indep 1/12/18. Care plans and care be updated based on the result assessments. Staff will be materially and expectation points/18. Policies and procedures were and revised to ensure that staff aware of the care plan for each and the importance of following of care when providing care to A new Care Guide Knowledge Expectations policy was put in 1/5/18. The purpose of this polensure that at all times, the state cares to the residents at Zumb Services will have and understated the information on resident that they serve throug shift. This includes a shift to safety measures implemented resident as well as any downg status with regard to transfers,	use. Care ated as entions on ated on egarding lift idents essed for endently by guides will at sof those de aware of care guide dicy dated reviewed from the plan residents and are place on licy is to off providing rota Health and the each hout their chift report all new for a rades in	

	ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			COMPLETED	
		245376	B. WING			C 1 <b>9/2017</b>	
NAME OF PROVIDER OR SUPPLIER  ZUMBROTA CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CO 433 MILL STREET ZUMBROTA, MN 55992			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 323	assessment of R1 part of a Significant Assessment. The a "Resident is assess chair control."  A nurse progress in 2017, indicated R1 wheelchair in a traifacility. The resider left hip pain and was emergency room for A nurse progress in at 2:30 a.m., indicated R1 was "virecognize staff in the that later R1 became surroundings and particular in the surroundings and	eted a comprehensive on September 14, 2017, as a Change in Status assessment indicated, sed to be safe to utilize his lift of the dated September 15, had fallen out of his asportation van in front of the national complained of right knee and as transported to the or evaluation.  Oute dated September 20, 2017 ated upon return from the ery confused" and did not the room. The note indicates the more oriented to his people.  The assessment indicated, ment risk factors in the ions. Consider addition or	F3	The Director of Nursing or de do a minimum of 3 random a nursing staff per week for on then one per week for 3 mon monthly thereafter to ensure have all necessary informatic competently care for their resavailable to them, and that the knowledgeable of changes in resident status. The Direct Nursing or designee will also random audits of resident sa interventions to ensure that a for that resident. This will be All audit results will be broug QAPI meeting to make recorfor ongoing monitoring. Completion Date: January 16	udits of e month, ths, and that staff on to sidents ey are a a ctor of do weekly fety all are in place ongoing. ht to quarterly nmendations		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING				COMPLETED		
		245376	B. WING			12/1	) 19/2017	
NAME OF PROVIDER OR SUPPLIER  ZUMBROTA CARE CENTER				STREET ADDRESS, CIT 433 MILL STREET ZUMBROTA, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	X (EACH CORRI CROSS-REFERE	'S PLAN OF CORRECTION ECTIVE ACTION SHOULD ENCED TO THE APPROPS DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 323	The recliner was in position and the resif he was okay. What to do, the resident is resident had a large of his forehead exteyebrow to the resident had a set to the remote to the lof the chair and the electrical outlet and resident to the hospon NA-G provided a was walking by R1' and noticed the reswith his top half und chair had been lifted NA-I provided a was september 23, 201 approximately 10:0 completed and R1 NA-I indicated, "Un recliner was to be a room stating this arguides." NA-I further was found face down recliner chair and braised and plugged R1's emergency roacute, large soft-tis right frontal bone, was admitted to the	the maximum inclined sident stated "no" when asked en asked what he was trying stated, "I don't know." The enhematoma on the right side ending from above the right dent's hairline and he were headache rated 10/10. ift chair was near the right arm endir chair was plugged into the disperational. Staff sent the bottal via ambulance.  Tritten statement dated 7 wherein she indicated she is room at about 10:30 a.m. sident face down on the floor der the bed. NA-G stated, "His dip."  Itten statement dated 7 wherein he indicated at 0 a.m. R1's ADL's were was transferred to his lift chair, beknownst to myself the unplugged. There was a sign in the indicated at 10:30 a.m. R1 who in the floor between his led, and the recliner was fully	F	323				

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI.  ID PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING			COMPLETED		
		245376	B. WING		12	C :/ <b>19/2017</b>		
	PROVIDER OR SUPPLIER  OTA CARE CENTER		ı	STREET ADDRESS, CITY, STATE, ZIP C 433 MILL STREET ZUMBROTA, MN 55992				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COI X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE		
F 323	A Performance Imp September 23, 201 Registered Nurse ( NA-I had assisted to 10:00 a.m., placed position, and left the the resident was for the remote to lift the position. The resident his right forehead, to unplug the lift chain intervention in the principal indicated NA-I state about this." The incomplete the incidence of the investigation was consupported the incidence of the incidence of the imposition of the impositio	orovement Plan (PIP) dated 7 indicated NA-I met with RN)-C. RN-C documented the resident into his lift chair at the recliner in the reclined e room. Thirty minutes later und on the floor and had used e chair to the standing ent sustained a hematoma to The resident care guide stated air and that it was a new past three days. Remarks ed "I feel absolutely horrible eddent was noted to be due to and not following the care ction indicated NA-I was pulled wing the incident while an ompleted. The investigation tent was an accident. NA-I was aportance of reading and guides to prevent injuries. NA-I thout pay for the remainder of	F3	23				
	2017, after R1 retu R1's right (R) eye s eye were purple du purple hematoma of measuring approxi 5.5 cm, due to his to hematoma was ten had a number of of was at risk for bruis and low platelets.	note dated September 27, rned to the facility, indicated socket and forehead above the se to bruising, with a light on his right forehead mately 6 centimeters (cm) by fall on September 23rd. The der to the touch. The resident her bruises on his body and sing due to anticoagulant use						
	indicated "Hemator	note dated October 1, 2017, na to R forehead above eased in size," and a cold pack						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED		
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NAME OF PROVIDER OR SUPPLIER  ZUMBROTA CARE CENTER				4	STREET ADDRESS, CITY, STATE, ZIP CODE 133 MILL STREET ZUMBROTA, MN 55992	, ·		
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F 323	throughout the shi  During interview of a.m., R1 stated her his face and bump was bad, you can Observation at the small bumps above bruising below his  On October 23, 20 observed that R1's into an electrical of During interview of p.m., NA-A stated incident was R1 has up, and fell to the days prior she was place a dark sign if (approximately), "If operate only." NA-sign was placed in stated no one with understanding is Fat all times, excep NA-A stated new if print on the care goinformation is now difficult to miss.  During interview of p.m., NA-B stated his remote to raise go and slid out of the fall everyone sunplugged. NA-B	placed on the hematoma ft.  n October 23, 2017 at 10:40 had a bad fall with a bruise on on his forehead. R1 stated "it see it was four weeks ago." It time showed R1 still had two e his right eyebrow and some right eye.  17 at 1:00 p.m., it was a electric lift chair was plugged		323				

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY IPLETED
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.,, ,,,	NAME OF PROVIDER OR SUPPLIER  ZUMBROTA CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP C 433 MILL STREET ZUMBROTA, MN 55992		
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F 323	safety precautions  During interview or p.m., the Director of cognition was variated in the DON stated the lift chair precaution since he was much the signs on the was generic and staff to specifics. The DON mobile and need to at all times, where an eeded his lift chair The DON stated N precaution for R1 was not used to do simply forgot. The second sign was performed to include reminded unplug R1's chair was not used to do simply forgot. The second sign was performed to include reminded unplug R1's chair was not used to do simply forgot. The second sign was performed to include reminded unplug R1's chair was not used to do simply forgot. The second sign was performed to include reminded unplug R1's chair was not used to do simply forgot. The second sign was performed to include reminded unplug R1's chair was not used to do simply forgot. The second sign was performed to include reminded unplug R1's chair was not used to do simply forgot. The second sign was performed to include reminded unplug R1's chair was not used to do simply forgot.	a resident requires.  n October 23, 2017 at 3:59 of Nursing (DON) stated R1's able and has steadily declined itagnosis of leukemia in July. e facility had implemented the s for R1 after a hospitalization in less alert. The DON stated all for lift chair precautions are sook at the care guide for in stated some residents are on have their lift chair unplugged as R1 was not mobile and only if unplugged while sitting in it. A-I told her the lift chair was such a new intervention he soing it, NA-I walked out and DON stated after the incident a ut up and she reiterated to staff irs in shift-to-shift report to		323		
	a.m., family memb sign put behind the not followed. F-F s F-H, visited R1 bet to use his lift chair.	er (F)-F stated there was a elift chair to unplug it that was tated another family member, fore the fall and saw R1 trying . F-F stated F-H told staff there ern with R1 operating his lift				

	TEMENT OF DEFICIENCIES O PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			COMPLETED		
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F 323	chair.  During interview or p.m., NA-G stated was walking past R the floor with his lift R1's lift chair was pknew R1 was not to when he was in it, so." NA-G stated swhere R1 was local guide. NA-G stated nurse informed all be unplugged. NA-she did not see the room indicating the but later went to chair lift chair, staplugged in, and on resident is sitting in have been unplugged paying attention to NA-I as the NA who to the fall.  During interview or p.m., F-H stated R1 entire duration of han intellectual conference R1 use the remote chair up. F-H statego all the way forw seemed to be enjotipped the chair up and lowered it bac	n November 30, 2017 at 3:25 on the day of the incident she at 's room and saw him lying on a chair raised up. NA-G stated blugged in. When asked if she is have his chair plugged in NA-G stated, "I don't believe he was not working on the hall ated and did not have his care after the incident the charge staff R1's lift chair needed to G stated at the time of the fall a dark sign on the wall in R1's a chair was to be unplugged, as that are not to use the remote aff usually leave the chair ly unplug the chair once the it. NA-G said the chair should ged to keep R1 from lifting it up, the care guide. NA-G identified to had been caring for R1 prior in December 6, 2017 at 3:48 are visited R1 in the facility for the was not very cognizant for the was not very cognizant for the was not very cognizant for the draft and all the way back and ying it. F-H stated when R1 are the lift chair to a sitting position. F-H he hallway and grabbed a staff he hallway and grabbed a staff		323				

	PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED		
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F 323	member and expresafety using the lift resident back to his back to visit the nesign on the wall be something like, "Do supervision," but the During interview or a.m., NA-I acknowl NA for R1 on Septeshift, and was the Ibefore his fall. NA-mechanical lift to mechanical lift to mechanical lift to rotair. NA-I stated to rsitting position a NA-I stated he gave the room. NA-I stated he plugged into the ele NA-I stated he heat to R1's room to assilying on the floor wisize of a tennis bal R1 showed a lot of did not see any ble NA-I also stated du not think anything with precautions for R1 report prior to the interpret prior to the interpret prior to the interpret prior to the interpret prior to the information in the cold print, but it did NA-I stated staff reresident's plans the resident's plans the	ssed his concern for R1's chair, and staff transferred the sbed. F-H stated he came at day and there was a paper hind the chair that read on't operate without he chair was plugged in.  In December 11, 2017 at 9:30 dedged he was the assigned ember 23, 2017 during the day ast staff person to be with R1 is stated he and NA-G used a nove R1 from his bed to his lift he lift chair was put in the flat and may have been reclined. He he did not recall if he had hair or if it had already been extrical outlet that morning. The radio and went sist. NA-I stated he saw R1 ith a "goose egg" about "the I" on his forehead. NA-I stated discomfort at the time, NA-I	F 3	23				

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ) PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED		
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F 323	reported. NA-I asked allowed to be in eleprovided with them responsibility for the in the care guide at the information even buring interview on a.m., F-J stated he floor with a big welt was alone and he fithem. F-J stated Riweeks later he coun hairline to his eyebhad a difficult time to affect R1's ability are/were both enging was no longer able technical things. F-hurt for weeks after A policy dated Octo "Maltreatment Profithe definition of necessaries" An undated policy Implementation Poensure a care plan available to all nurs states NA's are to appropriate care to appropriate care to a states and the states are to appropriate care to a states and the states are to a states and the states are to appropriate care to states and the states are to appropriate care to states and the states are to a states and the states are to appropriate care to state and the states are to appropriate care to state and the states are to a states are to appropriate care to state and the states are to appropriate care to state and the states are to appropriate care to state and the states are to appropriate care to state and the states are to state and the states are to state and the states are to states and the states are to state and the states are to states are to state and the states are to states are to states are to state and the states are to sta	ed, "If residents are not actric chairs, why are they?" NA-I stated he accepted incident, the information was not staff should be reviewing ry morning.  December 13, 2017 at 8:35 was the first to find R1 on the con his head. F-J stated R1 ound a staff person and told 1 had a black eye and even ld still see a bruise from R1's row. F-J stated after the fall R1 focusing and the fall seemed to to think. F-J stated he and R1 neers and after the fall, R1 to talk with him about J stated R1 told him his head rethe fall.  Ober 3, 2016, titled hibition Policy", includes under glect: "failure to prevent activities and environments."  Ititled, "Resident Care Plan licy", indicates nursing staff will is completed and made sing staff. The policy further use this information to provide a residents, and nurse ate care plans and care guides		323				

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Minnesota Department of Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ C B. WING 00917 12/19/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **433 MILL STREET ZUMBROTA CARE CENTER** ZUMBROTA, MN 55992 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) 2 000 Initial Comments 2 000 \*\*\*\*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

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE 01/09/18

FORM APPROVED Minnesota Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: C 12/19/2017 B. WING 00917 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **433 MILL STREET ZUMBROTA CARE CENTER** ZUMBROTA, MN 55992 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 000 Continued From page 1 2 000 Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/inf obul.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. 1/16/18 MN Rule 4658.0405 Subp. 3 Comprehensive 2 565 2 565 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 Zumbrota Health Services ensures that Based on interview and document review, the resident ☐s environment remains as free facility failed to implement care plan interventions from accident hazards as is possible and for safety precautions for the use of a recliner that each resident receives adequate with a lift function, for 1 of 3 residents (R1) supervision and assistive devices to reviewed for falls. prevent accidents by ensuring safety risks with regard to falls are comprehensively Findings include: assessed. Staff caring for R1 was re-educated on 9/23 of the care plan R1's Quarterly Review dated June 1, 2017 interventions. All staff were re-educated

Minnesota Department of Health STATE FORM

indicated the resident was cognitively intact. R1's

required extensive assistance with most activities

Significant Change in Status Assessment dated

September 13, 2017, indicated the resident

on the need to follow the care plan for all

residents as it relates to recliners with life

function. This re-education was

CL1P11

Minnesota Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: \_\_ С B. WING 12/19/2017 00917 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **433 MILL STREET ZUMBROTA CARE CENTER** ZUMBROTA, MN 55992 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 565 2 565 Continued From page 2 completed by October 1, 2017. All of daily living (ADL's), was totally dependent on residents utilizing recliners with lift function staff for transfers and locomotion, and falls was a are at risk for deficient practices in this triggered care area. area. Care guides with recent changes of information were immediately highlighted R1's care plan dated March 8, 2016, indicated the resident was at risk for falls due to limited mobility to bring to greater attention important changes to resident □s plan of care. New and dependence on staff for transfers. R1's care signage was put in the room to be more plan dated December 5, 2016 indicated a safety risk for the resident due to use of a recliner with a likely to draw the attention of all staff lift function. The care plan intervention for recliner members. Policies and procedures were reviewed use, dated September 20, 2017, indicated the and revised to ensure that staff would be resident was unable to get out of the chair aware of the care plan for each resident independently or use the lift control, and for staff and the importance of following that plan to keep the lift chair unplugged except for use by of care when providing care to residents. staff. A new Care Guide Knowledge and Expectations policy was put into place on R1's Nursing Assistant (NA) undated care guide 1/5/18. The purpose of this policy is to (a sheet of paper containing specific resident ensure that at all times, the staff providing care information that NA's carried while providing cares to the residents at Zumbrota Health resident care), directed staff to unplug the recliner Services will have and understand the when the resident was sitting in it. most up to date information on each resident that they serve throughout their A nursing progress note dated September 20, shift. This includes a shift to shift report 2017 at 9:30 p.m., indicated R1 refused or was unable to participate with lift transfer from his for a minimum of one week for all new safety measures implemented for a recliner to his bed. resident as well as any downgrades in A nursing progress note dated September 23, status with regard to transfers, ambulation, and diet. 2017, indicated R1 was transferred to his recliner The Director of Nursing or designee will do and last observed at 10:00 a.m. According to the a minimum of 3 random audits of nursing note, at 10:30 a.m., the resident was found lying staff per week for one month, then one per prone on the floor in his room with his head under week for 3 months, and monthly thereafter the foot of his bed. The recliner was in the to ensure that staff have all necessary maximum inclined position and the resident information to competently care for their stated "no" when asked if he was okay. When residents available to them, and that they asked what he was trying to do, the resident are knowledgeable of changes in a stated, "I don't know." The resident had a large resident □s status. The Director of hematoma on the right side of his forehead extending from above the right eyebrow to the Nursing or designee will also do weekly

resident's hairline and he complained of a severe

CL1P11

random audits of resident safety

Minnesota Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING: \_ C B. WING 12/19/2017 00917 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **433 MILL STREET ZUMBROTA CARE CENTER** ZUMBROTA, MN 55992 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 565 2 565 Continued From page 3 interventions to ensure that all are in place headache rated 10/10. The remote to the lift chair for that resident. This will be ongoing. was near the right arm of the chair and the chair All audit results will be brought to quarterly was plugged into the electrical outlet and QAPI meeting to make recommendations operational. Staff sent the resident to the hospital for ongoing monitoring. via ambulance. Date of Completion: January 16th, 2018 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

CL1P11

PRINTED: 03/02/2018 FORM APPROVED Minnesota Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_ C B. WING 12/19/2017 00917 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 433 MILL STREET **ZUMBROTA CARE CENTER** ZUMBROTA, MN 55992 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 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 quide. 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 eve 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 evebrow 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

CL1P11

Minnesota Department of Health (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: \_ С B. WING 12/19/2017 00917 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **433 MILL STREET ZUMBROTA CARE CENTER** ZUMBROTA, MN 55992 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 565 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.

Minnesota Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING: C 12/19/2017 B. WING 00917 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **433 MILL STREET ZUMBROTA CARE CENTER** ZUMBROTA, MN 55992 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 565 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 quides 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. 1/16/18 21850 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

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resident's physician for a specified and limited

Minnesota Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: C 12/19/2017 B. WING 00917 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **433 MILL STREET ZUMBROTA CARE CENTER** ZUMBROTA, MN 55992 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 21850 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 Fall interventions for R1 were Based on interview and document review, the implemented on 9/20/17 instructing staff to facility failed to ensure 1 of 3 residents (R1) unplug the lift chair when in use. Care reviewed was free from maltreatment. R1 was plan and care guides were updated neglected when staff failed to ensure the power to 9/20/17. NAR caring for R1 was an electric lift chair was unplugged while the reeducated on care plan interventions on resident was seated in the chair and R1 had a 9/23/17. All staff were reeducated on fall. R1 sustained harm, was hospitalizat after the R1□s care plan interventions regarding lift fall and sustained an acute, large soft-tissue chair safety by 10/1/17. All residents hematoma overlying the right frontal bone of R1's utilizing lift chairs will be reassessed for face. safety in utilizing lift chair independently by 1/12/18. Care plans and care guides will Findings include: be updated based on the results of those assessments. Staff will be made aware of R1's Quarterly Review dated June 1, 2017 any changes by following the Care guide indicated the resident was cognitively intact. R1's Knowledge and expectation policy dated Significant Change in Status Assessment dated September 13, 2017, indicated the resident 1/5/18. Policies and procedures were reviewed required extensive assistance with most activities and revised to ensure that staff would be of daily living (ADL's), was totally dependent on aware of the care plan for each resident staff for transfers and locomotion, and falls was a and the importance of following that plan triggered care area. of care when providing care to residents. A new Care Guide Knowledge and R1's care plan dated March 8, 2016, indicated the Expectations policy was put into place on resident was at risk for falls due to limited mobility 1/5/18. The purpose of this policy is to and dependence on staff for transfers. R1's care ensure that at all times, the staff providing plan dated December 5, 2016 indicated a safety cares to the residents at Zumbrota Health risk for the resident due to use of a recliner with a Services will have and understand the lift function. The care plan intervention for recliner most up to date information on each use, dated September 20, 2017, indicated the resident was unable to get out of the chair resident that they serve throughout their shift. This includes a shift to shift report independently or use the lift control, and to keep for a minimum of one week for all new the lift chair unplugged except for use by staff. safety measures implemented for a resident as well as any downgrades in

R1's Nursing Assistant (NA) care guide

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recliner to his bed.

2017 at 9:30 p.m., indicated R1 refused or was unable to participate with lift transfer from his

A nursing progress note dated September 23, 2017, indicated R1 was transferred to his recliner

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STATE FORM

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

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Minnesota Department of Health

indicated "Hematoma to R forehead above

FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_ C B. WING 00917 12/19/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 433 MILL STREET **ZUMBROTA CARE CENTER** ZUMBROTA, MN 55992 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 21850 Continued From page 11 21850 evebrow 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 eve. 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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chair.

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

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Minnesota Department of Health

safety using the lift chair, and staff transferred the

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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

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Minnesota Department of Health

report that information gathered from audits to the

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