MDH Minnesota Department of Health

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:	Report Number:	Date of Visit:
Three Links Care Center	H5450021	June 8 and 9, 2017
Facility Address:	**Time of Visit:**	**Date Concluded:**
815 Forest Avenue	8:30 a.m. to 3:00 p.m.	December 29, 2017
Facility City:	**Investigator's Name and Title:**	
Northfield	Rita Lucking, RN, Special Investigator	

State:	ZIP:	County:
Minnesota	55057	Rice

☒ **Nursing Home**

Allegation(s):
It is alleged that a resident was neglected when an alleged perpetrator (AP) failed to follow the resident's care plan and transferred the resident without a gait belt/transfer belt. The resident fell and hit his/her head against the wall, sustaining a massive brain bleed. The resident never regained consciousness.

- ☒ 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 the evidence, neglect occurred when the alleged perpetrator (AP) failed to follow the resident's care plan and use a gait belt with the resident when the resident was ambulating with his/her walker. The resident lost his/her balance and fell, hitting his/her head on the wall, and sustained a subdural hematoma as a result of the fall. The resident subsequently passed away as a result of the injuries.

The resident had a history of decreased balance and impaired coordination. The resident's care plan indicated one staff member was to assist the resident with ambulation and provide hands on assist with the use a gait belt while providing assistance and walking with the resident.

The resident informed the AP that s/he needed to go to the bathroom. The AP assisted the resident with his/her walker and walked to the bathroom, the resident washed his/her hands, and walked out of the bathroom. The AP claimed s/he was in the bathroom with the resident, but that s/he did not use a transfer belt with the resident while in the bathroom or at any time the resident was ambulating. The AP stated s/he walked behind the resident with a wheelchair after the resident walked out of the bathroom. After walking out of the bathroom, the resident stood with his/her walker in their room and waited for the AP to change

the resident's oxygen tubing. While standing, the resident lost his/her balance and hit his/her head on the wall during the fall to the floor. The AP did not have a transfer belt with him/her when s/he was assisting the resident prior to, and at the time the resident fell.

The death certificate was reviewed. The immediate cause of death was listed as a closed head injury which resulted from the fall that occurred at the nursing home.

When interviewed, the AP s/he stated s/he did not use a transfer belt with the resident prior to the fall. The AP said s/he left his/her transfer belt in another resident's room prior to entering the resident's room. The AP admitted s/he should have been using a transfer belt with the resident. The AP stated the facility provided him/her and other staff with ongoing training related to the need to use transfer belts with residents prior to the fall and after the fall.

The facility's transfer belt policy was reviewed. It stated a transfer belt is required at all times when staff are walking residents or assisting with transfers.

The facility placed the AP on administrative leave for five days after the fall. In addition, the facility provided re-education to the AP and other nursing staff related to the need to use a transfer belt when assisting residents with mobility needs.

Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557)

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

☐ Abuse ☒ Neglect ☐ Financial Exploitation

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

Mitigating Factors:

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

☐ Abuse ☒ Neglect ☐ Financial Exploitation. This determination was based on the following:

The facility provided the AP with appropriate training related to the facility's transfer belt policy and the requirement to use a transfer belt when walking with and transferring residents. The AP failed to follow the facility policy.

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

Compliance:

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

Deficiencies are issued on form 2567: ☒ Yes ☐ No

(The 2567 will be available on the MDH website.)

State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) - Compliance Not Met
The requirements under State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) were not met.

State licensing orders were issued: ☒ Yes ☐ No

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

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

State licensing orders were issued: ☒ Yes ☐ No

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

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

State licensing orders were issued: ☒ Yes ☐ No

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

Compliance Notes:

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

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

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

The Investigation included the following:

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

- [x] Medical Records
- [x] Care Guide
- [x] Medication Administration Records
- [x] Nurses Notes
- [x] Assessments
- [x] Physician Orders
- [x] Treatment Sheets
- [x] Physician Progress Notes
- [x] Care Plan Records
- [x] Facility Incident Reports
- [x] Laboratory and X-ray Reports
- [x] ADL (Activities of Daily Living) Flow Sheets

Other pertinent medical records:

- [x] Hospital Records
- [x] Death Certificate

Additional facility records:

- [x] Staff Time Sheets, Schedules, etc.
- [x] Facility Internal Investigation Reports
- [x] Personnel Records/Background Check, etc.
- [x] Facility In-service Records
- [x] Facility Policies and Procedures

Number of additional resident(s) reviewed: Two

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

Specify: _____

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

○ Yes ◉ No ○ N/A

Specify: Deceased

Interviews: The following interviews were conducted during the investigation:

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

Specify: _____

If unable to contact reporter, attempts were made on:

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

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

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

○ Yes ◉ No ○ N/A Specify: Deceased

Did you interview additional residents? ◉ Yes ○ No

Total number of resident interviews: Two

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

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: Five

Physician Interviewed: ○ Yes ◉ No

Nurse Practitioner Interviewed: ○ Yes ◉ No

Physician Assistant Interviewed: ○ Yes ◉ No

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

Attempts to contact:

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

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

Were contacts made with any of the following:

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

Observations were conducted related to:

- [x] Personal Care
- [x] Nursing Services
- [x] Call Light
- [x] Infection Control
- [x] Cleanliness
- [x] Dignity/Privacy Issues
- [x] Safety Issues
- [x] Facility Tour

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

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

Were photographs taken: ○ Yes ◉ No Specify: _____

cc:

Health Regulation Division - Licensing & Certification

Minnesota Board of Examiners for Nursing Home Administrators

The Office of Ombudsman for Long-Term Care

Rice County Medical Examiners

Northfield Police Department

Rice County Attorney

Northfield City Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245450	A. BUILDING _____ B. WING _____	R-C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE LINKS CARE CENTER	**815 FOREST AVENUE NORTHFIELD, MN 55057**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS A Post Certification revisit was conducted on 7/28/17, to follow up on deficiencies issued related to complaint #H5450021. Three Links Care Center is in compliance with 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Akllthough no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	{F 000}		

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

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.

Minnesota Department of Health

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	00564	A. BUILDING: _____ B. WING _____	R-C 07/28/2017

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{2 000}	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: A licensing order follow-up was completed to follow up on correction orders issued related to complaint #H5450021. Three Links Care Center was found in compliance with state regulations. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first	{2 000}		

Minnesota Department of Health

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{2 000}	Continued From page 1 page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	{2 000}		

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	245450	A. BUILDING _____ B. WING _____	C 06/09/2017

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F 000	INITIAL COMMENTS An abbreviated standard survey was conducted to investigate cases #H5450021 and #H5450022. As a result, the following deficiency is issued related to case #H5450021. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567. Electronic submission of the POC will be used as verification of compliance.	F 000		
F 323 SS=G	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced	F 323		

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

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F 323	Continued From page 1	F 323		

by:
Based on interview, and record review, the facility failed to provide adequate supervision and assistance when staff did not use a gait belt with ambulation for 1 of 3 residents reviewed, R1, with a risk of falls. This resulted in actual harm when R1 sustained a subdural hematoma when she was walking without a gait belt and fell and hit her head on the wall.

Findings include:

R1's medical record was reviewed. R1 was cognitively impaired, weak and had decreased balance and impaired coordination. R1's care plan indicated R1 was dependent on staff to assist with activities of daily living. R1's care plan indicated one staff was to assist with R1's mobility needs and provide contact guard assistance. Staff were to use a gait belt and walker, and one staff was to walk with R1 when R1 was ambulating with her walker and one staff was to push the wheelchair with oxygen. R1 was receiving hospice care while at the facility.

A nursing progress note dated 5/10/17 at 5:37 p.m. indicated R1 was walking in the hallway and lost her balance and fell at 5:00 p.m. The note indicated a nursing assistant was present and witnessed the fall. The note stated a transfer belt/gait belt was not being used when R1 fell.

The facility's incident report and internal investigation of the incident, dated 5/10/17, were reviewed. They indicated R1 was using her walker and was walking out of her room. Nursing Assistant (NA)-B was present and pushing R1's wheelchair behind R1. NA-B was attempting to change R1's oxygen tubing, and R1 lost her

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F 323	Continued From page 2	F 323		

balance, fell sideways into the wall and hit her head. R1 sustained an injury to the top of her head. R1 was alert and oriented after the fall and stated she was fine. The internal investigation indicated NA-B was not using a transfer belt with R1 at the time of the fall.

A nursing progress note dated 5/11/17 at 10:48 a.m. stated R1 refused breakfast and complained of a headache and then became unresponsive. R1 was transferred to the emergency room per physician's order.

A nursing progress note dated 5/11/17 at 3:16 p.m. stated emergency room staff told the facility that R1 had a massive brain bleed and that R1 would be transferred back to the facility for R1's end of life.

R1's death worksheet indicated R1 died on 5/15/17, and it listed the manner of death as an accident. The immediate cause of death was a closed head injury which resulted from a fall that occurred at the nursing home.

When interviewed on 6/8/17 at 8:30 a.m., director of nursing (DON)-A stated NA-B was not using a gait belt with R1 at the time of R1's fall on 5/10/17. NA-B was placed on administrative leave following the incident. In addition, NA-B was provided counseling and re-education related to R1's fall and NA-B's failure to use a gait belt.

NA-B was interviewed on 6/8/17 at 12:20 p.m.and she stated she was working with R1 at the time of the 5/10/17 fall. She said she was very familiar with R1. She said she did not have the transfer belt with her when she was working with R1 on 5/10/17 because she left the transfer belt in

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F 323	Continued From page 3 another resident's room prior to entering R1's room. Prior to the fall, R1 walked to the bathroom with her walker, went to the bathroom, washed her hands and used her walker to walk from the bathroom. NA-B said she was walking behind R1 with the wheelchair but was not using a gait belt to hold on to R1. R1 lost her balance after she walked back from the bathroom and was standing with her walker in the room while waiting for NA-B to transfer the oxygen tubing to the portable oxygen tank. When R1 fell, she hit her head against the wall. NA-B said she was placed on administrative leave following the incident and returned to work on 5/15/17. The facility has provided her with ongoing re-education related to gait belts since the incident occurred. The facility has also provided re-education related to using gait belts to additional staff. The facility policy titled "Transfer Belts" dated April 2009, indicated all nursing assistants are required to use a transfer belt while on duty and to use a transfer belt when assisting residents. The use of of a transfer belt is required at all times when walking residents or with assisted transfers.	F 323		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

January 29, 2018

Ms. Deanna Pierzina, Administrator
Three Links Care Center
815 Forest Avenue
Northfield, MN 55057

Re: Project Number H5450021

Dear Ms. Pierzina:

On June 9, 2017, an investigation 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 and state regulations. The investigator found federal deficiencies and violations.

The CMS form 2567 and state licensing order was sent to you previously. The investigative report is now completed and a copy is enclosed.

If you have questions related to this investigation, please contact the investigator identified in the report.

Thank you for your cooperation.

Sincerely,

Lindsey L Krueger

Lindsey Krueger, Interim Assistant Director
Health Regulation Division
Office of Health Facility Complaints
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone: (651) 201-4135 Fax: (651) 281-9796
General Information: (651) 201-4201 - 1-800-369-7994

Enclosure

LK/tn

Minnesota Department of Health

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: A complaint investigation was conducted to investigate complaint #H5450021 and #H5450022. As a result, the following correction order is issued for complaint #H5450021. The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health	2 000		

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

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2 000	Continued From page 1 Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. Then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000		
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure 1 of 3 residents reviewed, R1, was free from maltreatment when staff did not provide adequate supervision and assistance and did not use a gait belt with ambulation for R1. This resulted in actual harm when R1 sustained a subdural hematoma when she was walking without a gait belt and fell and hit her head on the wall.	21810		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE LINKS CARE CENTER	815 FOREST AVENUE NORTHFIELD, MN 55057

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21810	Continued From page 2 Findings include: R1's medical record was reviewed. R1 was cognitively impaired, weak and had decreased balance and impaired coordination. R1's care plan indicated R1 was dependent on staff to assist with activities of daily living. R1's care plan indicated one staff was to assist with R1's mobility needs and provide contact guard assistance. Staff were to use a gait belt and walker, and one staff was to walk with R1 when R1 was ambulating with her walker and one staff was to push the wheelchair with oxygen. R1 was receiving hospice care while at the facility. A nursing progress note dated 5/10/17 at 5:37 p.m. indicated R1 was walking in the hallway and lost her balance and fell at 5:00 p.m. The note indicated a nursing assistant was present and witnessed the fall. The note stated a transfer belt/gait belt was not being used when R1 fell. The facility's incident report and internal investigation of the incident, dated 5/10/17, were reviewed. They indicated R1 was using her walker and was walking out of her room. Nursing Assistant (NA)-B was present and pushing R1's wheelchair behind R1. NA-B was attempting to change R1's oxygen tubing, and R1 lost her balance, fell sideways into the wall and hit her head. R1 sustained an injury to the top of her head. R1 was alert and oriented after the fall and stated she was fine. The internal investigation indicated NA-B was not using a transfer belt with R1 at the time of the fall. A nursing progress note dated 5/11/17 at 10:48 a.m. stated R1 refused breakfast and complained of a headache and then became unresponsive.	21810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00564	A. BUILDING: _____ B. WING _____	C 06/09/2017

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21810	Continued From page 3 R1 was transferred to the emergency room per physician's order. A nursing progress note dated 5/11/17 at 3:16 p.m. stated emergency room staff told the facility that R1 had a massive brain bleed and that R1 would be transferred back to the facility for R1's end of life. R1's death worksheet indicated R1 died on 5/15/17, and it listed the manner of death as an accident. The immediate cause of death was a closed head injury which resulted from a fall that occurred at the nursing home. When interviewed on 6/8/17 at 8:30 a.m., director of nursing (DON)-A stated NA-B was not using a gait belt with R1 at the time of R1's fall on 5/10/17. NA-B was placed on administrative leave following the incident. In addition, NA-B was provided counseling and re-education related to R1's fall and NA-B's failure to use a gait belt. NA-B was interviewed on 6/8/17 at 12:20 p.m.and she stated she was working with R1 at the time of the 5/10/17 fall. She said she was very familiar with R1. She said she did not have the transfer belt with her when she was working with R1 on 5/10/17 because she left the transfer belt in another resident's room prior to entering R1's room. Prior to the fall, R1 walked to the bathroom with her walker, went to the bathroom, washed her hands and used her walker to walk from the bathroom. NA-B said she was walking behind R1 with the wheelchair but was not using a gait belt to hold on to R1. R1 lost her balance after she walked back from the bathroom and was standing with her walker in the room while waiting for NA-B to transfer the oxygen tubing to the portable oxygen tank. When R1 fell, she hit her head	21810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21810	Continued From page 4 against the wall. NA-B said she was placed on administrative leave following the incident and returned to work on 5/15/17. The facility has provided her with ongoing re-education related to gait belts since the incident occurred. The facility has also provided re-education related to using gait belts to additional staff. The facility policy titled "Transfer Belts" dated April 2009, indicated all nursing assistants are required to use a transfer belt while on duty and to use a transfer belt when assisting residents. The use of of a transfer belt is required at all times when walking residents or with assisted transfers. SUGGESTED METHOD OF CORRECTION: The administrator and/or designee could re-educate staff regarding the importance of following the resident's care plan. The administrator and/or designee could provide monitoring for compliance and effectiveness of the policies regarding following a resident's care plan as necessary in accordance with current standards of practice. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21810		