MDH Minnesota Department of Health

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name: Good Samaritan Society Pipestone		**Report Number:** H5591011	**Date of Visit:** June 21, 2017
Facility Address: 1311 North Hiawatha		**Time of Visit:** 3:00 a.m. to 11:00 a.m.	**Date Concluded:** March 12, 2018
Facility City: Pipestone		**Investigator's Name and Title:** Pam Hovdet, RN, Special Investigator	
State: Minnesota	**ZIP:** 56164	**County:** Pipestone	

☒ **Nursing Home**

Allegation(s):
It is alleged that a resident was neglected when staff/alleged perpetrator (AP) failed to follow the resident's care plan. The resident had a fall and sustained multiple fractures.

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

Conclusion:
Based on a preponderance of evidence, neglect occurred when the alleged perpetrator (AP) failed to follow the resident's care plan and the resident fell. The resident sustained four fractures to his/her right hand because of the fall.

The resident was severely cognitively impaired and required assistance with all activities of daily living. The resident was at risk for falls due to a history of cerebrovascular accidents, weakness, and poor safety awareness. The resident was identified to be at risk for falls and the resident's care plan had fall interventions in place, including the alarm monitor to alert staff to the resident's movement, and to assist staff in monitoring movement.

The resident was sitting in his/her wheelchair with an alarm monitor attached when the resident requested to use the bathroom. The AP pushed the resident into the bathroom and unhooked the alarm monitor prior to transferring the resident to the toilet. The AP then left the resident in the bathroom alone on the toilet with no alarm on the resident, and went down the hallway to assist another resident. Shortly after the AP left the resident's room, a nurse in the hallway heard the resident scream and found the resident lying on his/her right side with his/her right arm tucked behind the resident. The resident had attempted to self

transfer from the toilet to the wheelchair and fell onto the bathroom floor. The nurse assessed the resident for injuries and notified the physician and family. Staff continued to monitor the resident and administered pain medication and ice as ordered by the physician. The following morning, the resident had an increase in pain and swelling in the right hand. The family was notified and the resident was taken to the clinic. X-rays indicated the resident had fractures of the second to fifth metacarpals (bones in the hand). An orthoplast splint (a device used to immobilize, protect, and support injuries such as fractures, sprains and strains) was applied to the resident's right hand.

When interviewed, the resident did not remember where the fall occurred, and stated staff tell him/her to ask for help instead of trying to do things on his/her own.

When interviewed, the AP stated s/he forgot and was not thinking when s/he stepped out of the resident's room to assist another resident.

The AP was immediately re-educated on following the resident's care plan after the incident. A corrective action notice indicated the staff was issued a written warning for failure to follow policy and procedure and failure to follow the care plan.

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 is responsible as they did not have policies and procedures sufficient to ensure safeguards and clear direction on how to implement fall interventions. In addition, the individual was responsible for failing to follow the care plan and corresponding facility policies and procedures.

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

Compliance:

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) – Compliance Met

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

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

Deficiencies are issued on form 2567: ☒ Yes ☐ No

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

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

State licensing orders were issued: ☒ Yes ☐ No

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

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

State licensing orders were issued: ☒ Yes ☐ No

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

Compliance Notes:

Definitions:

Minnesota Statutes, section 626.5572, subdivision 17 - Neglect

"Neglect" means:

(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and

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

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

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

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

The Investigation included the following:

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

- [x] Medical Records
- [x] Care Guide
- [x] Medication Administration Records
- [x] Weight 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] Therapy and/or Ancillary Services Records

Other pertinent medical records:

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: Four

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

Specify: _____

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

◉ Yes ○ No ○ N/A

Specify: _____

Interviews: The following interviews were conducted during the investigation:

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

Specify: _____

If unable to contact reporter, attempts were made on:

Date: _____ Time: _____ Date: _____ Time: _____ Date: _____ Time: _____

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

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

◉ Yes ○ No ○ N/A Specify: _____

Did you interview additional residents? ◉ Yes ○ No

Total number of resident interviews: Nine

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

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: Ten

Physician Interviewed: ○ Yes ◉ No

Nurse Practitioner Interviewed: ○ Yes ◉ No

Physician Assistant Interviewed: ○ Yes ◉ No

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

Attempts to contact:

Date: _____ Time: _____ Date: _____ Time: _____ Date: _____ Time: _____

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

Were contacts made with any of the following:

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

Observations were conducted related to:

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

Was any involved equipment inspected: ○ Yes ○ No ◉ N/A
Was equipment being operated in safe manner: ○ Yes ○ No ◉ N/A
Were photographs taken: ○ Yes ◉ No Specify: _____

cc:

Health Regulation Division - Licensing & Certification

Minnesota Board of Examiners for Nursing Home Administrators

The Office of Ombudsman for Long-Term Care

Pipestone Police Department

Pipestone City Attorney

Pipestone County Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245591	A. BUILDING _____ B. WING _____	R-C 08/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - PIPESTONE	1311 NORTH HIAWATHA PIPESTONE, MN 56164

(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 8/2/17, to follow up on deficiencies issued related to complaint H5591011. Good Samaritan Society Pipestone is in compliance with 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	{F 000}		

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

Electronically Signed | 10/09/2017

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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	00455	A. BUILDING: _____ B. WING _____	R-C 08/02/2017

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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 H5591011. Good Samaritan Society Pipestone was found in compliance with state regulations. The facility is enrolled in ePOC and therefore a	{2 000}		

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{2 000}	Continued From page 1 signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	{2 000}		

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	245591	A. BUILDING _____ B. WING _____	C 07/07/2017

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F 000	INITIAL COMMENTS An abbreviated standard survey was conducted to investigate case #H5591011. As a result, the following deficiency is issued. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance.	F 000		
F 323 SS=D	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced	F 323		7/25/17

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

Electronically Signed | 07/12/2017

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

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F 323	Continued From page 1 by: Based on interview and document review, the facility failed to provide adequate supervision for 1 of 5 residents (R1) reviewed for falls, when R1 was left alone on the toilet. R1 attempted to self transfer, fell to the floor, and sustained four fractures in the right hand. Findings include: R1's care plan dated 5/24/17, indicated R1 was at risk for falls related to weakness, history of cerebrovascular accident, and poor safety awareness. The care plan interventions for falls included motion detector down on the floor beside the bed when in bed and TABS (an alarm that is attached to the wheelchair and clips on the resident) to wheelchair used to alert staff to resident's movement and to assist staff in monitoring movement. The care plan indicated R1 had an activities of daily living (ADL) self care performance deficit related to weakness, activity intolerance and confusion. The care plan interventions included R1 required the assistance of one staff for transfers. R1's Admission Minimum Data Set (MDS) dated 5/30/17, indicated R1 was severely cognitively impaired and required the assistance of one staff for activities of daily living. R1's nursing assistant care guide dated 6/21/17, indicated R1 required the motions and TABS alarm and for staff to watch for self transferring. A fall scene huddle worksheet dated 5/29/17, at 1:30 p.m. indicated staff left R1 sitting on the toilet alone in the bathroom without the TAB alarm attached to R1. R1 attempted to self transfer	F 323	F323 Statement of Compliance: Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of state and federal law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center s allegation of compliance in accordance with section 7305 of the State Operations Manual. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements. 1. Resident (R1) careplan stated to have a tabs alarm on resident while in the wheelchair. Care plan was updated on 5/29/17 by the charge nurse to include staff supervision while on the toilet. 2. All residents that are a fall risk and use a tabs alarm. 3. Initial certified nursing assistant was interviewed and received a corrective action. Re-education in regards to following standard of care, policy and procedures and prevention of falls was given to the CNA s/NA by DON at the mandatory meeting on July 13th and those who could not attend will have	

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F 323	Continued From page 2 from the toilet to the wheelchair and fell to the floor injuring R1's right fingers. A nursing progress note dated 5/29/17, at 2:03 p.m. indicated R1 was given Acetaminophen 650 milligrams (mg) for pain to the right hand. A nursing progress note dated 5/29/17, at 2:41 p.m. indicated the physician was notified of the fall and the second and third fingers were swollen and hard to bend but the swelling had gone down. A nursing progress note dated 5/29/17, at 6:33 p.m. indicated R1 was given Acetaminophen 650 mg for pain. A nursing progress note dated 5/29/17, at 11:08 p.m. indicated R1's right hand was swollen and warm to the touch. R1 was able to move fingers freely with minimal pain and denied any other discomfort. A nursing progress note dated 5/30/17, at 8:41 a.m. indicated R1's right hand pain and swelling had increased. Family was notified and R1 was scheduled for a medical appointment. A nursing progress note dated 5/30/17, at 9:20 a.m. indicated R1 was given Acetaminophen 650 mg for pain. A physicians progress note dated 5/30/17, at 2:10 p.m. indicated R1 had fractures of the 2nd through 5th metacarpals (bones in the hand). A splint was applied and R1 was referred to an orthopedic surgeon for further evaluation. The physician ordered Tramadol 50 mg four times a day as needed for break through pain along with the Acetaminophen, ice, and elevation.	F 323	watched video by July 25th or prior to their next scheduled shift. All new hire nursing assistants will be educated on the use of Kardex and a checklist of clinical performance will be conducted by the staff development coordinator before the CNA/NA can work independently. 4. To monitor performance and ensure that solutions are sustained, audits will be conducted by the Director of Nursing/designee of certified nursing assistants providing care to residents with tab alarms, 1 x per week for 4 weeks and then 1 x per month for 3 months. The results will be brought to the QAPI committee for review and or recommendations. 5. Date: 7/25/17	

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F 323	Continued From page 3 A nursing progress note dated 5/30/17, at 5:04 p.m. indicated Acetaminophen 650 mg was given to R1 for pain and at 7:00 p.m. Tramadol 50 mg was given to R1 for severe pain. A nursing progress note dated 5/31/17, at 7:19 a.m. indicated an ice pack was given to R1 and arm elevated on pillow. R1 stated her right arm was not too painful. A nursing progress note dated 5/31/17, at 9:24 a.m. indicated Tramadol 50 mg was given to R1 for severe pain in right hand at 9:24 a.m., 1:42p.m., 7:07p.m. and at 8:50 p.m. indicated Acetaminophen 650 mg was given to R1 for breakthrough pain in right hand. A nursing progress note dated 6/1/17, indicated Tramadol 50 mg was given to R1 for severe wrist pain and a headache at 12:53 p.m. and again at 6:34 p.m. for severe right hand pain, and Acetaminophen 650 mg was given to R1 for right hand pain. Nursing progress notes dated 6/2/17, indicated R1 received Tramadol 50 mg for severe right hand pain at 6:32 p.m. and it was effective. Nursing progress notes dated 6/3/17, indicated R1 received Acetaminophen 650 mg at 8:49 a.m., Tramadol 50 mg at 2:00 p.m. and 6: 41 p.m. and Acetaminophen 650 mg at 9:17 p.m. for right hand pain and all were effective. Nursing progress notes dated 6/4/17, indicated R1 received Acetaminophen 650 mg at 6:40 a.m. and Tramadol 50 mg at 1:28 p.m. and 6:19 p.m. for right hand pain and all were effective.	F 323		

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F 323	Continued From page 4 Nursing progress notes dated 6/5/17, indicated R1 received Tramadol 50 mg at 6:14 p.m. and Acetaminophen 650 mg at 9:26 p.m. for right hand pain and both were effective. A nursing progress note dated 6/6/17, at 11:51 a.m. indicated R1 was seen by the orthopedic surgeon and an orthoplast splint (a device used to immobilize, protect and support injuries such as fractures, sprains and strains) was applied and to follow up in four weeks. Nursing progress notes dated 6/6/17, indicated R1 received Tramadol 50 mg at 6:31 p.m. for throbbing right hand pain and it was effective. Nursing progress notes dated 6/7/17, indicated no pain medication was given to R1. Nursing progress notes dated 6/8/17, indicated R1 received Acetaminophen 650 mg at 8:49 a.m. for pain and it was effective. At 10:43 a.m. the physician was faxed a request for the Acetaminophen to be scheduled three times a day and as needed to help with pain management due to R1's reluctance to request pain medication. At 6:13 p.m. R1 received Tramadol 50 mg for severe pain and it was effective. Nursing progress notes dated 6/9/17, indicated R1 received Tramadol 50 mg at 10:01 a.m. for severe pain and it was effective. At 11:56 a.m. the physician faxed an order for Tylenol 650 mg three times a day related to pain for right hand fractures. Nursing progress notes dated 6/11/17, indicated R1 received Tramadol 50 mg at 4:30 p.m. for	F 323		

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GOOD SAMARITAN SOCIETY - PIPESTONE	1311 NORTH HIAWATHA PIPESTONE, MN 56164

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F 323	Continued From page 5 severe pain and it was effective. A corrective action notice dated 6/9/17, indicated the director of nursing (DON) issued a written warning to nursing assistant (NA)-E, due to failure to follow policy and procedure and failure to follow R1's care plan for TABS use. An interview with R1 was conducted on 6/21/17, at 6:45 a.m. R1 stated she did not remember where the fall occurred, but staff told R1 to wait for staff to help and not try to do things on her own. An interview with NA-E was conducted on 6/21/17, at 8:35 a.m. NA-E stated after putting R1 on the toilet NA-E left R1's room and went to another resident's room a couple of doors down the hall from R1's room. NA-E stated she took the TABS alarm off R1 before transferring R1 to the toilet, and did not put the TABS alarm back on R1 once R1 was on the toilet. NA-E stated she forgot and wasn't thinking and had received training on the policy and knew R1 was not to be left alone when the TABS alarm was not attached to R1. NA-E stated after leaving R1 alone in the bathroom, R1 fell and the licensed practical nurse (LPN)-D found R1 on the floor. An interview with registered nurse (RN)-B was conducted on 6/21/17, at 9:15 a.m. RN-B stated NA-E did not follow R1's care plan when NA-E left R1 alone on the toilet without the TABS alarm. RN-B stated she would have expected NA-E to follow the care plan. An interview with LPN-D was conducted on 6/21/17, at 11:00 a.m. LPN-D stated she was in the hallway and heard R1 scream and found R1	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245591	A. BUILDING _____ B. WING _____	C 07/07/2017

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F 323	Continued From page 6 responsive and lying on the floor in the bathroom on R1's right side. R1 told LPN-D she was trying to get up off the toilet and fell. LPN-D stated R1 had pain in the right hand but was moving the fingers and rotating the wrist. LPN-D notified the physician and family and was instructed to monitor the hand and notify the physician if R1's condition worsened. LPN-D stated NA-E admitted to leaving R1 unattended on the toilet, and R1 should not have been left alone without the TABS alarm. An interview with the DON was conducted on 7/5/17, at 11:40 a.m. The DON stated staff are trained to stay with a resident that is assessed as a fall risk when on the toilet, or if the TABS monitor is not connected to the resident. The DON stated it is the standard of care, and NA-E told the DON she should not have left R1 alone and did not follow the care plan. The DON stated she would have expected NA-E to follow the interventions on the care plan. The facilty policy titled Fall Prevention and Management revised 5/16, indicated an avoidable accident means that an accident occurred because the location failed to implement interventions, including adequate supervision, consistent with a resident's needs, goals, plan of care and current standards of practice in order to reduce the risk of an accident.	F 323		

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: ***REVISED*** A complaint investigation was conducted to investigate complaint #H5591011. As a result, the following correction orders are issued. The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the	2 000		

Minnesota Department of Health

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2 000	Continued From page 1 Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. Then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide adequate supervision for 1 of 5 residents (R1) reviewed for falls, when R1 was left alone on the toilet. R1 attempted to self	2 830	corrected	7/13/17

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2 830	Continued From page 2 transfer, fell to the floor, and sustained four fractures in the right hand. Findings include: R1's care plan dated 5/24/17, indicated R1 was at risk for falls related to weakness, history of cerebrovascular accident, and poor safety awareness. The care plan interventions for falls included motion detector down on the floor beside the bed when in bed and TABS (an alarm that is attached to the wheelchair and clips on the resident) to wheelchair used to alert staff to resident's movement and to assist staff in monitoring movement. The care plan indicated R1 had an activities of daily living (ADL) self care performance deficit related to weakness, activity intolerance and confusion. The care plan interventions included R1 required the assistance of one staff for transfers. R1's Admission Minimum Data Set (MDS) dated 5/30/17, indicated R1 was severely cognitively impaired and required the assistance of one staff for activities of daily living. R1's nursing assistant care guide dated 6/21/17, indicated R1 required the motions and TABS alarm and for staff to watch for self transferring. A fall scene huddle worksheet dated 5/29/17, at 1:30 p.m. indicated staff left R1 sitting on the toilet alone in the bathroom without the TAB alarm attached to R1. R1 attempted to self transfer from the toilet to the wheelchair and fell to the floor injuring R1's right fingers. A nursing progress note dated 5/29/17, at 2:03 p.m. indicated R1 was given Acetaminophen 650 milligrams (mg) for pain to the right hand.	2 830		

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2 830	Continued From page 3 A nursing progress note dated 5/29/17, at 2:41 p.m. indicated the physician was notified of the fall and the second and third fingers were swollen and hard to bend but the swelling had gone down. A nursing progress note dated 5/29/17, at 6:33 p.m. indicated R1 was given Acetaminophen 650 mg for pain. A nursing progress note dated 5/29/17, at 11:08 p.m. indicated R1's right hand was swollen and warm to the touch. R1 was able to move fingers freely with minimal pain and denied any other discomfort. A nursing progress note dated 5/30/17, at 8:41 a.m. indicated R1's right hand pain and swelling had increased. Family was notified and R1 was scheduled for a medical appointment. A nursing progress note dated 5/30/17, at 9:20 a.m. indicated R1 was given Acetaminophen 650 mg for pain. A physicians progress note dated 5/30/17, at 2:10 p.m. indicated R1 had fractures of the 2nd through 5th metacarpals (bones in the hand). A splint was applied and R1 was referred to an orthopedic surgeon for further evaluation. The physician ordered Tramadol 50 mg four times a day as needed for break through pain along with the Acetaminophen, ice, and elevation. A nursing progress note dated 5/30/17, at 5:04 p.m. indicated Acetaminophen 650 mg was given to R1 for pain and at 7:00 p.m. Tramadol 50 mg was given to R1 for severe pain. A nursing progress note dated 5/31/17, at 7:19	2 830		

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2 830	Continued From page 4 a.m. indicated an ice pack was given to R1 and arm elevated on pillow. R1 stated her right arm was not too painful. A nursing progress note dated 5/31/17, at 9:24 a.m. indicated Tramadol 50 mg was given to R1 for severe pain in right hand at 9:24 a.m., 1:42p.m., 7:07p.m. and at 8:50 p.m. indicated Acetaminophen 650 mg was given to R1 for breakthrough pain in right hand. A nursing progress note dated 6/1/17, indicated Tramadol 50 mg was given to R1 for severe wrist pain and a headache at 12:53 p.m. and again at 6:34 p.m. for severe right hand pain, and Acetaminophen 650 mg was given to R1 for right hand pain. Nursing progress notes dated 6/2/17, indicated R1 received Tramadol 50 mg for severe right hand pain at 6:32 p.m. and it was effective. Nursing progress notes dated 6/3/17, indicated R1 received Acetaminophen 650 mg at 8:49 a.m., Tramadol 50 mg at 2:00 p.m. and 6: 41 p.m. and Acetaminophen 650 mg at 9:17 p.m. for right hand pain and all were effective. Nursing progress notes dated 6/4/17, indicated R1 received Acetaminophen 650 mg at 6:40 a.m. and Tramadol 50 mg at 1:28 p.m. and 6:19 p.m. for right hand pain and all were effective. Nursing progress notes dated 6/5/17, indicated R1 received Tramadol 50 mg at 6:14 p.m. and Acetaminophen 650 mg at 9:26 p.m. for right hand pain and both were effective. A nursing progress note dated 6/6/17, at 11:51 a.m. indicated R1 was seen by the orthopedic	2 830		

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2 830	Continued From page 5 surgeon and an orthoplast splint (a device used to immobilize, protect and support injuries such as fractures, sprains and strains) was applied and to follow up in four weeks. Nursing progress notes dated 6/6/17, indicated R1 received Tramadol 50 mg at 6:31 p.m. for throbbing right hand pain and it was effective. Nursing progress notes dated 6/7/17, indicated no pain medication was given to R1. Nursing progress notes dated 6/8/17, indicated R1 received Acetaminophen 650 mg at 8:49 a.m. for pain and it was effective. At 10:43 a.m. the physician was faxed a request for the Acetaminophen to be scheduled three times a day and as needed to help with pain management due to R1's reluctance to request pain medication. At 6:13 p.m. R1 received Tramadol 50 mg for severe pain and it was effective. Nursing progress notes dated 6/9/17, indicated R1 received Tramadol 50 mg at 10:01 a.m. for severe pain and it was effective. At 11:56 a.m. the physician faxed an order for Tylenol 650 mg three times a day related to pain for right hand fractures. Nursing progress notes dated 6/11/17, indicated R1 received Tramadol 50 mg at 4:30 p.m. for severe pain and it was effective. A corrective action notice dated 6/9/17, indicated the director of nursing (DON) issued a written warning to nursing assistant (NA)-E, due to failure to follow policy and procedure and failure to follow R1's care plan for TABS use. An interview with R1 was conducted on 6/21/17,	2 830		

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2 830	Continued From page 6 at 6:45 a.m. R1 stated she did not remember where the fall occurred, but staff told R1 to wait for staff to help and not try to do things on her own. An interview with NA-E was conducted on 6/21/17, at 8:35 a.m. NA-E stated after putting R1 on the toilet NA-E left R1's room and went to another resident's room a couple of doors down the hall from R1's room. NA-E stated she took the TABS alarm off R1 before transferring R1 to the toilet, and did not put the TABS alarm back on R1 once R1 was on the toilet. NA-E stated she forgot and wasn't thinking and had received training on the policy and knew R1 was not to be left alone when the TABS alarm was not attached to R1. NA-E stated after leaving R1 alone in the bathroom, R1 fell and the licensed practical nurse (LPN)-D found R1 on the floor. An interview with registered nurse (RN)-B was conducted on 6/21/17, at 9:15 a.m. RN-B stated NA-E did not follow R1's care plan when NA-E left R1 alone on the toilet without the TABS alarm. RN-B stated she would have expected NA-E to follow the care plan. An interview with LPN-D was conducted on 6/21/17, at 11:00 a.m. LPN-D stated she was in the hallway and heard R1 scream and found R1 responsive and lying on the floor in the bathroom on R1's right side. R1 told LPN-D she was trying to get up off the toilet and fell. LPN-D stated R1 had pain in the right hand but was moving the fingers and rotating the wrist. LPN-D notified the physician and family and was instructed to monitor the hand and notify the physician if R1's condition worsened. LPN-D stated NA-E admitted to leaving R1 unattended on the toilet, and R1 should not have been left alone without	2 830		

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2 830	Continued From page 7 the TABS alarm. An interview with the DON was conducted on 7/5/17, at 11:40 a.m. The DON stated staff are trained to stay with a resident that is assessed as a fall risk when on the toilet, or if the TABS monitor is not connected to the resident. The DON stated it is the standard of care, and NA-E told the DON she should not have left R1 alone and did not follow the care plan. The DON stated she would have expected NA-E to follow the interventions on the care plan. The facilty policy titled Fall Prevention and Management revised 5/16, indicated an avoidable accident means that an accident occurred because the location failed to implement interventions, including adequate supervision, consistent with a resident's needs, goals, plan of care and current standards of practice in order to reduce the risk of an accident. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review policy and procedures on implementing fall interventions according to the plan of care. The director of nursing or designee could conduct random audits of staff providing resident care to ensure cares are being provided according to the plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights Subd. 14. Freedom from maltreatment.	21850		

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21850	Continued From page 8 Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. This MN Requirement is not met as evidenced by: Based on interview and document review, facility staff failed to ensure 1 of 5 residents reviewed, (R1), was free from maltreatment when R1 was neglected when staff left R1 alone on the toilet, and R1 attempted to self transfer and fell to the floor. This resulted in actual harm when R1 sustained four fractures in the right hand. Findings include: R1's care plan dated 5/24/17, indicated R1 was at risk for falls related to weakness, history of cerebrovascular accident, and poor safety awareness. The care plan interventions for falls included motion detector down on the floor beside the bed when in bed and TABS (an alarm that is attached to the wheelchair and clips on the resident) to wheelchair used to alert staff to resident's movement and to assist staff in monitoring movement. The care plan indicated R1 had an activities of daily living (ADL) self care performance deficit related to weakness, activity	21850		

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21850	Continued From page 9 intolerance and confusion. The care plan interventions included R1 required the assistance of one staff for transfers. R1's Admission Minimum Data Set (MDS) dated 5/30/17, indicated R1 was severely cognitively impaired and required the assistance of one staff for activities of daily living. R1's nursing assistant care guide dated 6/21/17, indicated R1 required the motions and TABS alarm and for staff to watch for self transferring. A fall scene huddle worksheet dated 5/29/17, at 1:30 p.m. indicated staff left R1 sitting on the toilet alone in the bathroom without the TAB alarm attached to R1. R1 attempted to self transfer from the toilet to the wheelchair and fell to the floor injuring R1's right fingers. A nursing progress note dated 5/29/17, at 2:03 p.m. indicated R1 was given Acetaminophen 650 milligrams (mg) for pain to the right hand. A nursing progress note dated 5/29/17, at 2:41 p.m. indicated the physician was notified of the fall and the second and third fingers were swollen and hard to bend but the swelling had gone down. A nursing progress note dated 5/29/17, at 6:33 p.m. indicated R1 was given Acetaminophen 650 mg for pain. A nursing progress note dated 5/29/17, at 11:08 p.m. indicated R1's right hand was swollen and warm to the touch. R1 was able to move fingers freely with minimal pain and denied any other discomfort. A nursing progress note dated 5/30/17, at 8:41	21850		

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21850	Continued From page 10 a.m. indicated R1's right hand pain and swelling had increased. Family was notified and R1 was scheduled for a medical appointment. A nursing progress note dated 5/30/17, at 9:20 a.m. indicated R1 was given Acetaminophen 650 mg for pain. A physicians progress note dated 5/30/17, at 2:10 p.m. indicated R1 had fractures of the 2nd through 5th metacarpals (bones in the hand). A splint was applied and R1 was referred to an orthopedic surgeon for further evaluation. The physician ordered Tramadol 50 mg four times a day as needed for break through pain along with the Acetaminophen, ice, and elevation. A nursing progress note dated 5/30/17, at 5:04 p.m. indicated Acetaminophen 650 mg was given to R1 for pain and at 7:00 p.m. Tramadol 50 mg was given to R1 for severe pain. A nursing progress note dated 5/31/17, at 7:19 a.m. indicated an ice pack was given to R1 and arm elevated on pillow. R1 stated her right arm was not too painful. A nursing progress note dated 5/31/17, at 9:24 a.m. indicated Tramadol 50 mg was given to R1 for severe pain in right hand at 9:24 a.m., 1:42 p.m., 7:07 p.m. and at 8:50 p.m. indicated Acetaminophen 650 mg was given to R1 for breakthrough pain in right hand. A nursing progress note dated 6/1/17, indicated Tramadol 50 mg was given to R1 for severe wrist pain and a headache at 12:53 p.m. and again at 6:34 p.m. for severe right hand pain, and Acetaminophen 650 mg was given to R1 for right hand pain.	21850		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - PIPESTONE	1311 NORTH HIAWATHA PIPESTONE, MN 56164

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21850	Continued From page 11 Nursing progress notes dated 6/2/17, indicated R1 received Tramadol 50 mg for severe right hand pain at 6:32 p.m. and it was effective. Nursing progress notes dated 6/3/17, indicated R1 received Acetaminophen 650 mg at 8:49 a.m., Tramadol 50 mg at 2:00 p.m. and 6: 41 p.m. and Acetaminophen 650 mg at 9:17 p.m. for right hand pain and all were effective. Nursing progress notes dated 6/4/17, indicated R1 received Acetaminophen 650 mg at 6:40 a.m. and Tramadol 50 mg at 1:28 p.m. and 6:19 p.m. for right hand pain and all were effective. Nursing progress notes dated 6/5/17, indicated R1 received Tramadol 50 mg at 6:14 p.m. and Acetaminophen 650 mg at 9:26 p.m. for right hand pain and both were effective. A nursing progress note dated 6/6/17, at 11:51 a.m. indicated R1 was seen by the orthopedic surgeon and an orthoplast splint (a device used to immobilize, protect and support injuries such as fractures, sprains and strains) was applied and to follow up in four weeks. Nursing progress notes dated 6/6/17, indicated R1 received Tramadol 50 mg at 6:31 p.m. for throbbing right hand pain and it was effective. Nursing progress notes dated 6/7/17, indicated no pain medication was given to R1. Nursing progress notes dated 6/8/17, indicated R1 received Acetaminophen 650 mg at 8:49 a.m. for pain and it was effective. At 10:43 a.m. the physician was faxed a request for the Acetaminophen to be scheduled three times a	21850		

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21850	Continued From page 12 day and as needed to help with pain management due to R1's reluctance to request pain medication. At 6:13 p.m. R1 received Tramadol 50 mg for severe pain and it was effective. Nursing progress notes dated 6/9/17, indicated R1 received Tramadol 50 mg at 10:01 a.m. for severe pain and it was effective. At 11:56 a.m. the physician faxed an order for Tylenol 650 mg three times a day related to pain for right hand fractures. Nursing progress notes dated 6/11/17, indicated R1 received Tramadol 50 mg at 4:30 p.m. for severe pain and it was effective. A corrective action notice dated 6/9/17, indicated the director of nursing (DON) issued a written warning to nursing assistant (NA)-E, due to failure to follow policy and procedure and failure to follow R1's care plan for TABS use. An interview with R1 was conducted on 6/21/17, at 6:45 a.m. R1 stated she did not remember where the fall occurred, but staff told R1 to wait for staff to help and not try to do things on her own. An interview with NA-E was conducted on 6/21/17, at 8:35 a.m. NA-E stated after putting R1 on the toilet NA-E left R1's room and went to another resident's room a couple of doors down the hall from R1's room. NA-E stated she took the TABS alarm off R1 before transferring R1 to the toilet, and did not put the TABS alarm back on R1 once R1 was on the toilet. NA-E stated she forgot and wasn't thinking and had received training on the policy and knew R1 was not to be left alone when the TABS alarm was not attached to R1. NA-E stated after leaving R1 alone in the	21850		

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21850	Continued From page 13 bathroom, R1 fell and the licensed practical nurse (LPN)-D found R1 on the floor. An interview with registered nurse (RN)-B was conducted on 6/21/17, at 9:15 a.m. RN-B stated NA-E did not follow R1's care plan when NA-E left R1 alone on the toilet without the TABS alarm. RN-B stated she would have expected NA-E to follow the care plan. An interview with LPN-D was conducted on 6/21/17, at 11:00 a.m. LPN-D stated she was in the hallway and heard R1 scream and found R1 responsive and lying on the floor in the bathroom on R1's right side. R1 told LPN-D she was trying to get up off the toilet and fell. LPN-D stated R1 had pain in the right hand but was moving the fingers and rotating the wrist. LPN-D notified the physician and family and was instructed to monitor the hand and notify the physician if R1's condition worsened. LPN-D stated NA-E admitted to leaving R1 unattended on the toilet, and R1 should not have been left alone without the TABS alarm. An interview with the DON was conducted on 7/5/17, at 11:40 a.m. The DON stated staff are trained to stay with a resident that is assessed as a fall risk when on the toilet, or if the TABS monitor is not connected to the resident. The DON stated it is the standard of care, and NA-E told the DON she should not have left R1 alone and did not follow the care plan. The DON stated she would have expected NA-E to follow the interventions on the care plan. The facilty policy titled Fall Prevention and Management revised 5/16, indicated an avoidable accident means that an accident occurred because the location failed to implement	21850		

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21850	Continued From page 14 interventions, including adequate supervision, consistent with a resident's needs, goals, plan of care and current standards of practice in order to reduce the risk of an accident. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review policy and procedures on implementing fall interventions according to the plan of care. The director of nursing or designee could conduct random audits of staff providing resident care to ensure cares are being provided according to the plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21850		