DEPARTMENT OF HEALTH

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:
Heritage Haven INC

Facility Address:
4512 London Road

Facility City:
Duluth

State: Minnesota | **ZIP:** 55804 | **County:** Saint Louis

Report Number:
HL20035006

Time of Visit:
5:00 p.m. to 8:15 p.m.
8:00 a.m. to 5:15 p.m.
9:00 a.m. to 10:30 a.m.

Date of Visit:
May 3, 4, and 5, 2017

Date Concluded:
December 18, 2017

Investigator's Name and Title:
Jane Aandal, RN, Special Investigator

☒ **Home Care Provider/Assisted Living**

Allegation(s):

It is alleged that a client was neglected when the client fell multiple times, sustaining multiple injuries.

☒ State Statutes for Home Care Providers (MN Statutes, section 144A.43 - 144A.483)
☒ 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 facility failed to ensure staff implemented fall interventions for the client according to the care plan and the client sustained multiple injuries.

The client was diagnosed with Alzheimer's disease and ambulated with a walker. The client's service plan indicated staff would assist with ambulation during the night shift, in the morning for cares, and as needed. The client's care plan indicated the client was at risk for falls related to weakness, cognitive difficulties, and impaired vision. The client was to receive assistance to the toilet every two hours. Fall interventions included keeping the bed in the lowest position, motion sensor in room, staff to check on client every two hours, tab alarm on the client at all times, and staff to answer alarms immediately.

Documentation indicated the client had seven falls in a 12-month period and sustained injuries during each fall. During the first fall, the client was found on the floor facing the bathroom. The client sustained two

bruises on his/her right knee, 3 centimeters (cm) by 2 cm, and 1 cm by 1 cm. The client's fall interventions were followed according to the care plan at the time of the fall.

During the second fall, the staff was in another client's room and did not hear the client's motion sensor or tab alarm sound. Staff entered the room and the client was on the floor. The client sustained a 1.5 centimeter (cm) round abrasion to the left knee, a 4 cm abrasion to the left calf, and a 4 cm abrasion to the left rib cage. The client's every two-hour toileting schedule was not followed at the time of the fall.

During the third fall, staff heard the client's tab alarm, and found the client standing about three feet from a chair, the client reached for the alarm string on his/her shirt, lost his/her balance, and fell onto his/her right side. The client sustained a reddened area to the right hip and a bump to the right side of the head. The hourly checks were not documented during this fall.

During the fourth fall, the client was found on the floor in his/her room facing the hallway. The client stated his/her head hurt and back hurt. The client's fall interventions of hourly checks, and every two-hour toileting were not documented.

During the fifth fall, staff was in a room with another client and heard the client's tab alarm sound. Staff ran to the client's room and found him/her on the floor. The client sustained a 1 cm by .5 cm skin tear to his/her left forearm, two 1 cm by .5 cm bruises to the right hand, and a .5 cm bruise to the right knee. Plastic strips were applied to the skin tear. The client's two-hour toileting schedule was not documented per the care plan.

During the sixth fall, the tab alarm sounded, staff ran to the room, and found the client on the floor with his/her head against the wall. The client stated his/her head hurt. The client's two-hour toileting schedule was not documented per the care plan.

During the seventh fall, the client was found on the floor at the end of his/her bed. The client sustained a large hematoma to the back of the head, a 1.5 cm by 2 cm bruise on the buttocks, and a swollen area on the low back. The client's tab alarm and motion sensor did not sound and his/her bed was not in the low position. The hourly checks and two-hour toileting schedule were not documented.

Staff stated during interview that after the client's third fall, hourly checks were implemented, however; this was not added to the client's care plan. Staff stated during interviews that when the last fall occurred, the client had set off the tab alarm at 3:30 p.m., 3:35 p.m., and 4:10 p.m. prior to the fall at 4:45 p.m. Staff had offered the toilet, given the client a drink of water, and a piece of gum. Staff stated when the fall happened the tab alarm and motion sensor did not sound and the bed was not in the lowest position.

Family was interviewed and stated they did not want diagnostic tests done after the final fall since the client was receiving hospice services.

The death certificate indicated the client died seven days after the final fall from Alzheimer's Disease.

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 did not have a system in place to ensure the fall prevention policy was followed to ensure client safety when staff were to implement the clients care planned fall interventions.

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

Compliance:

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

State Statutes for Maltreatment of Minors Act (MN Statutes, section 626.556) - Compliance Not Met
The requirements under the State Statutes for Maltreatment of Minors (MN Statutes, section 626.556) 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] Nurses Notes
- [x] Assessments
- [x] Physician Orders
- [x] Care Plan Records
- [x] Facility Incident Reports
- [x] Service Plan

Other pertinent medical records:

☒ Death Certificate

Additional facility records:

☒ Staff Time Sheets, Schedules, etc.

☒ Personnel Records/Background Check, etc.

☒ Facility Policies and Procedures

Number of additional resident(s) reviewed: One

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: Four

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

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: Six

Physician Interviewed: ○ Yes ◉ No

Nurse Practitioner Interviewed: ○ Yes ◉ No

Physician Assistant Interviewed: ○ Yes ◉ No

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

Attempts to contact:

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

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

Were contacts made with any of the following:

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

Observations were conducted related to:

☒ Nursing Services

☒ 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 - Home Care & Assisted Living Program

Minnesota Board of Nursing

The Office of Ombudsman for Long-Term Care

Duluth Police Department

Saint Louis County Attorney

Duluth City Attorney

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

February 14, 2018

Ms. Suzanne Taylor, Administrator
Heritage Haven Inc
4512 London Road
Duluth, MN 55804

RE: Complaint Number HL20035006

Dear Ms. Taylor :

On January 25, 2018 an investigator of the Minnesota Department of Health, Office of Health Facility Complaints completed a re-inspection of your facility, to determine correction of orders found on the complaint investigation completed on October 31, 2017. At this time these correction orders were found corrected.

You are encouraged to retain this document for your records. 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,

Annette Winters, BSN, RN, PHN
Health Regulations Division
Office of Health Facility Complaints
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone: (651) 201-4204 Fax: (651) 281-9796

AW/tn

Enclosure

cc: Home Health Care Assisted Living File
St. Louis County Adult Protection
Office of Ombudsman
MN Department of Human Services

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail Number: 70151660000041498228

November 7, 2017

Ms. Suzanne Taylor, Administrator
Heritage Haven Inc
4512 London Road
Duluth, MN 55804

RE: Complaint Number HL20035006 REVISED LETTER AND STATE FORM

Dear Ms. Taylor :

This letter is to replace any previous correspondence regarding HL20035006, dated June 15, 2017.

A complaint investigation (#HL20035006) of the Home Care Provider named above was completed on May 15, 2017, for the purpose of assessing compliance with state licensing regulations. At the time of the investigation, the investigator from the Minnesota Department of Health, Office of Health Facility Complaints, noted one or more violations of these regulations. These state licensing orders were issued in accordance with Minnesota Statutes Sections 144A.43 to 144A.482.

State licensing orders are delineated on the attached amended State Form with an amended exit date of October 31, 2017. This state form replaces the state form dated May 15, 2017.

The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by."

A written plan for correction of licensing orders is not required. Per Minnesota State Statute 144A.474 Subd. 8(c), the home care provider must document in the provider's records any action taken to comply with the correction order. A copy of this document of the home care provider's action may be requested at future surveys.

A licensed home care provider may request a correction order reconsideration regarding any

correction order issued to the provider. The reconsideration must be in writing and received within 15 calendar days. Reconsiderations should be addressed to:

Renae Dressel, Health Program Rep. Sr
Home Care Assisted Living Program
Minnesota Department of Health
P.O. Box 3879
85 East Seventh Place
St. Paul, MN 55101

It is your responsibility to share the information contained in this letter and the results of the visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

A. Winters

Annette Winters, BSN, RN, PHN
Health Regulations Division
Supervisor Office of Health Facility Complaints
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone: (651) 201-4204 Fax: (651) 281-9796

MN

Enclosure

cc: Home Health Care Assisted Living File
St. Louis County Adult Protection
Office of Ombudsman
MN Department of Human Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H20035	A. BUILDING: _____ B. WING _____	C 10/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HAVEN INC	4512 LONDON ROAD DULUTH, MN 55804

(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
0 000	Initial Comments *****ATTENTION AMENDED STATE FORM****** THESE STATE ORDERS REPLACE THE STATE ORDERS EXITED ON 5/15/2017 AND MAILED ON HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: On May 3, 2017, a complaint investigation was initiated to investigate complaint #HL20035006. At the time of the survey, there were 37 clients that were receiving services under the comprehensive license. The following correction order is issued.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER ' S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144A.474 SUBDIVISION 11 (b)(1)(2)	
0 265 SS=D	144A.44, Subd. 1(2) Up-To-Date Plan/Accepted Standards Practice Subdivision 1. Statement of rights. A person who	0 265		

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0 265	Continued From page 1 receives home care services has these rights: (2) the right to receive care and services according to a suitable and up-to-date plan, and subject to accepted health care, medical or nursing standards, to take an active part in developing, modifying, and evaluating the plan and services; This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to provide care and services to acceptable medical or nursing standards for 1 of 2 clients (C1) reviewed with a history of seven falls in 12 months. The registered nurse failed to re-evaluate the client after the falls to assess for causal factors in an attempt to decrease the risk of further falls and injury. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings include: C1's medical record was reviewed. C1's care conference note dated 10/22/16, indicated C1 was diagnosed with Alzheimer's dementia and anxiety. C1's Fall Risk Assessment dated 11/7/16, indicated C1 was at high risk for falls.	0 265		

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0 265	Continued From page 2 C1's undated care plan indicated C1 was at risk for falls related to weakness, cognitive difficulties and impaired vision. Interventions included an every two hour toileting schedule, motion sensor, tab alarm, and bed in low position. C1's incident report dated 1/18/16, at 4:45 p.m. indicated C1 was found on her left side facing the bathroom. C1's tab alarm sounded. C1 had left her walker by the bed. C1 sustained a sore right knee, with two bruises 3 centimeters (cm) by 2 cm, and 1 cm by 1 cm. C1's care plan interventions were followed at the time of the fall. C1's incident report dated 4/3/16, at 5:15 a.m. indicated C1 was on the floor on her left side by the bed. The only night staff was in another client's room and did not hear C1's tab alarm sound. C1 sustained a 1.5 cm abrasion on her left knee, a 4 cm abrasion to the left calf, and a 4 cm abrasion to her left rib cage. According to C1's toileting documentation she was last toileted at 2:30 a.m. and not every two hours according to her care plan. C1's incident report dated 10/25/16, at 10:00 a.m. indicated staff was in another client's room and heard C1's tab alarm sound. C1 was approximately three feet away from a chair when she reached for the alarm string on her shirt, lost her balance and fell onto her right side. C1 sustained a bump to the right side of her head and a red area to her right hip. C1's toileting documentation on 10/25/16, indicated C1 was last toileted at 5:00 a.m. and not every two hours according to her care plan. C1's incident report dated 11/7/16, at 10:15 p.m. indicated C1 was on the floor next to her bed. C1	0 265		

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0 265	Continued From page 3 complained of her head and back hurting. C1 had a spine X-Ray which was negative for any fractures. C1's toileting documentation on 11/7/16, indicated C1 was last toileted at 8:45 a.m. and not every two hours according to her care plan. C1's nurses notes dated 12/5/16, at 4:00 a.m. indicated staff was in another client's room and heard C1's tab alarm sound. C1 was found on the floor a couple of steps from the bed. C1 complained of right knee pain. C1 sustained a 1 cm by .5 cm bruise on her left forearm with a .5 cm skin tear, a 1 cm by .5 cm bruise on her right knee, and a 1 cm by .5 cm bruise on her right hand. C1's toileting documentation on 12/5/16, indicated C1 was last toileted at 1:15 a.m. and not every two hours according to her care plan. C1's incident report dated 1/4/17, at 9:15 p.m. indicated C1 was on the floor seated outside the bathroom door with her head against the wall. C1 stated her head hurt. C1's toileting documentation on 1/4/17, lacked any toileting times for the day and evening shift. C1's incident report dated 1/24/17, at 4:45 p.m. indicated C1 was on the floor in her room on her left side at the end of the bed. C1 sustained a large hematoma (a collection of blood outside the blood vessel) on the back of her head, a 1.5 cm by 2 cm bruise on her left buttock, and a swollen area to her low back. C1's toileting documentation was lacking for 1/24/17. An interview was conducted with the registered nurse (RN) on 5/4/17, at 9:04 a.m. The RN stated she was aware C1 had not been toileted according to her care plan when falls occurred. The RN stated she verbally counseled the staff	0 265		

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0 265	Continued From page 4 that were working at the time of the falls and instructed them on following C1's care plan. The RN stated C1 was identified at high risk for falls. The RN stated she had not completed a comprehensive assessment after C1's falls to identify any patterns or trends. An interview was conducted with unlicensed personnel (ULP)-D on 5/4/17, at 2:03 p.m. ULP-D stated C1 was at serious risk for falls. ULP-D stated when C1 fell on 1/4/17, she was in another client's room receiving instructions form her co-worker on how to use a sit to stand lift when the fall occurred. ULP-D stated she should have received this training at another time since there were only two staff assigned on the evening shift. An interview was conducted with the house manager on 5/4/17, at 4:21 p.m. The house manager stated C1's low bed was implemented on 1/5/17. However, the 1/24/17, incident report did not address whether the bed was in the low position at the time of the fall or whether the tab alarm and motion sensor were sounding. An interview was conducted with ULP-E on 5/9/17, at 2:15 p.m. ULP-E stated she worked on 11/7/16, when C1 fell. ULP-E stated she arrived at work at 10:00 p.m. and had not had an opportunity to check on the resident. When she entered the room at 10:15 p.m. she found C1 on the floor. The motion sensor was tipped over and the tab alarm was not attached to C1 so neither device sounded. ULP-E stated there were occasions when the motion sensor would be facing C1's couch making it ineffective. An interview was conducted with the RN on 5/10/17, at 2:04 p.m. The RN stated stated she would revise the fall prevention policy to include	0 265		

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0 265	Continued From page 5 identification of causal factors, patterns, trends, and effectiveness of current interventions. An interview was conducted with ULP-H on 5/10/17, at 3:44 p.m. ULP-H stated she was working on 1/24/17, when the client fell. ULP-H stated at 3:30 p.m. the tab alarm sounded and she offered the client the bathroom which was refused. At 3:35 p.m. the tab alarm sounded again and ULP-H gave the client a piece of gum. At 4:10 p.m. the tab alarm sounded again and the client refused the bathroom. ULP-H stated the motion sensor sounded on all three occasions. ULP-H stated when the client fell at 4:45 p.m. neither the tab alarm or the motion sensor sounded. ULP-H stated the bed was not in the lowest position which gave the client the ability to stand up on her own. The licensee's Falls Prevention policy revised May 2015, indicated after a fall the staff were to notify the nurse, document in the progress notes, and complete an incident report. The nurse would notify the family and the physician of the fall. The nurse would complete a fall prevention care plan and implement interventions to assist with resident safety. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 265		
0 325 SS=G	144A.44, Subd. 1(14) Free From Maltreatment Subdivision 1. Statement of rights. A person who receives home care services has these rights: (14) the right to be free from physical and verbal abuse, neglect, financial exploitation, and all forms	0 325		

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0 325	Continued From page 6 of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act; This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure that 1 of 1 client, (C1), was free from maltreatment when the client sustained seven falls in 12 months. The registered nurse failed to re-evaluate the client after the falls to assess for causal factors in an attempt to decrease the risk of further falls and injury. This practice resulted in a level four violation (a violation that results in serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings include: The licensee's Vulnerable Adult and Abuse Prevention policy dated January 2010, indicated the licensee would protect vulnerable adults that were susceptible to maltreatment and would require reporting of the suspected maltreatment. C1's medical record was reviewed. C1's care conference note dated 10/22/16, indicated C1 was diagnosed with Alzheimer's dementia and anxiety. C1's Fall Risk Assessment dated 11/7/16, indicated C1 was at high risk for falls. C1's undated care plan indicated C1 was at risk for falls related to weakness, cognitive difficulties	0 325		

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	H20035	A. BUILDING: _____ B. WING _____	C 10/31/2017

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0 325	Continued From page 7 and impaired vision. Interventions included an every two hour toileting schedule, motion sensor, tab alarm, and bed in low position. C1's incident report dated 1/18/16, at 4:45 p.m. indicated C1 was found on her left side facing the bathroom. C1's tab alarm sounded. C1 had left her walker by the bed. C1 sustained a sore right knee, with two bruises 3 centimeters (cm) by 2 cm, and 1 cm by 1 cm. C1's care plan interventions were followed at the time of the fall. C1's incident report dated 4/3/16, at 5:15 a.m. indicated C1 was on the floor on her left side by the bed. The only night staff was in another client's room and did not hear C1's tab alarm sound. C1 sustained a 1.5 cm abrasion on her left knee, a 4 cm abrasion to the left calf, and a 4 cm abrasion to her left rib cage. According to C1's toileting documentation she was last toileted at 2:30 a.m. and not every two hours according to her care plan. C1's incident report dated 10/25/16, at 10:00 a.m. indicated staff was in another client's room and heard C1's tab alarm sound. C1 was approximately three feet away from a chair when she reached for the alarm string on her shirt, lost her balance and fell onto her right side. C1 sustained a bump to the right side of her head and a red area to her right hip. C1's toileting documentation on 10/25/16, indicated C1 was last toileted at 5:00 a.m. and not every two hours according to her care plan. C1's incident report dated 11/7/16, at 10:15 p.m. indicated C1 was on the floor next to her bed. C1 complained of her head and back hurting. C1 had a spine X-Ray which was negative for any fractures. C1's toileting documentation on	0 325		

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0 325	Continued From page 8 11/7/16, indicated C1 was last toileted at 8:45 a.m. and not every two hours according to her care plan. C1's nurses notes dated 12/5/16, at 4:00 a.m. indicated staff was in another client's room and heard C1's tab alarm sound. C1 was found on the floor a couple of steps from the bed. C1 complained of right knee pain. C1 sustained a 1 cm by .5 cm bruise on her left forearm with a .5 cm skin tear, a 1 cm by .5 cm bruise on her right knee, and a 1 cm by .5 cm bruise on her right hand. C1's toileting documentation on 12/5/16, indicated C1 was last toileted at 1:15 a.m. and not every two hours according to her care plan. C1's incident report dated 1/4/17, at 9:15 p.m. indicated C1 was on the floor seated outside the bathroom door with her head against the wall. C1 stated her head hurt. C1's toileting documentation on 1/4/17, lacked any toileting times for the day and evening shift. C1's incident report dated 1/24/17, at 4:45 p.m. indicated C1 was on the floor in her room on her left side at the end of the bed. C1 sustained a large hematoma (a collection of blood outside the blood vessel) on the back of her head, a 1.5 cm by 2 cm bruise on her left buttock, and a swollen area to her low back. C1's toileting documentation was lacking for 1/24/17. The facility failed to re-evaluate the causal factors after each fall to determine what fall interventions were not implemented. An interview was conducted with the registered nurse (RN) on 5/4/17, at 9:04 a.m. The RN stated she was aware C1 had not been toileted according to her care plan when falls occurred.	0 325		

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0 325	Continued From page 9 The RN stated she verbally counseled the staff that were working at the time of the falls and instructed them on following C1's care plan. The RN stated C1 was identified at high risk for falls. The RN stated she had not completed a comprehensive assessment after C1's falls to identify any patterns or trends. An interview was conducted with unlicensed personnel (ULP)-D on 5/4/17, at 2:03 p.m. ULP-D stated C1 was at serious risk for falls. ULP-D stated when C1 fell on 1/4/17, she was in another client's room receiving instructions form her co-worker on how to use a sit to stand lift when the fall occurred. ULP-D stated she should have received this training at another time since there were only two staff assigned on the evening shift. An interview was conducted with the house manager on 5/4/17, at 4:21 p.m. The house manager stated C1's low bed was implemented on 1/5/17. However, the 1/24/17, incident report did not address whether the bed was in the low position at the time of the fall or whether the tab alarm and motion sensor were sounding. An interview was conducted with ULP-E on 5/9/17, at 2:15 p.m. ULP-E stated she worked on 11/7/16, when C1 fell. ULP-E stated she arrived at work at 10:00 p.m. and had not had an opportunity to check on the resident. When she entered the room at 10:15 p.m. she found C1 on the floor. The motion sensor was tipped over and the tab alarm was not attached to C1 so neither device sounded. ULP-E stated there were occasions when the motion sensor would be facing C1's couch making it ineffective. An interview was conducted with the RN on 5/10/17, at 2:04 p.m. The RN stated stated she	0 325		

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0 325	Continued From page 10 would revise the fall prevention policy to include identification of causal factors, patterns, trends, and effectiveness of current interventions. An interview was conducted with ULP-H on 5/10/17, at 3:44 p.m. ULP-H stated she was working on 1/24/17, when the client fell. ULP-H stated at 3:30 p.m. the tab alarm sounded and she offered the client the bathroom which was refused. At 3:35 p.m. the tab alarm sounded again and ULP-H gave the client a piece of gum. At 4:10 p.m. the tab alarm sounded again and the client refused the bathroom. ULP-H stated the motion sensor sounded on all three occasions. ULP-H stated when the client fell at 4:45 p.m. neither the tab alarm or the motion sensor sounded. ULP-H stated the bed was not in the lowest position which gave the client the ability to stand up on her own. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 325		