This document has been re-scanned to the MDH website.

The compliance revisit was completed on 1/8/2016.

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility:
St. Cloud Carefree Living
1225 Division Street East
St. Cloud, MN 56304
Benton County

Report #: HL21030021

Date: November 20, 2015

Date of Visit: September 14, 2015
Time of Visit: 10:00 a.m. – 4:00 p.m.

By: Carrie Euerle, R.N., Special Investigator

Type of Facility: ☐ Nursing Home ☐ HHA ☐ Home Care Provider/Assisted Living
☐ SLF ☐ ICF/IID ☐ Home Care
☐ Hospital ☒ Other: Comprehensive Home Care Provider

☐ Facility Self Report ☒ Complaint

Allegation(s): **It is alleged** that a client was neglected when s/he was unsupervised while in the bathroom and suffered a fall resulting in a femur fracture.

An unannounced visit was made at this facility and an investigation was conducted under:

☐ Federal Regulations for Hospital Conditions of Participation (42 CFR, Part 482)
☐ Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
☐ Federal Regulations for ICF/IID (42 CFR Part 483, subpart I)
☐ Federal Regulations for HHA (Home Health Agencies) (42 CFR, Part 484)
☐ Federal Regulations for CAH (Critical Access Hospital) (42 CFR, Part 485)
☐ Federal Regulations for EMTALA (42 CFR Part 489)
☐ State Licensing Rules for Boarding Care Homes (MN Rules Chapter 4655)
☐ State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)
☐ State Licensing Rules for Supervised Living Facilities (MN Rules Chapter 4665)

☐ State Licensing Rules for Home Care (MN Rules Chapter 4668)
☐ State Statutes for Maltreatment of Minors (MN Statutes, section 626.556)
☑ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
☑ State Statutes Chapters 144 and 144A

Conclusion:
Minnesota Vulnerable Adults Act (MN 626.557)

Under the Minnesota Vulnerable Adults Act (MN. 626.557):

☐ Abuse ☑ Neglect ☐ Financial Exploitation was:

◉ Substantiated ○ Not Substantiated ○ Inconclusive based on the following information:

Based on a preponderance of evidence, neglect occurred when the client's care plan was not followed, the client was left unattended in the bathroom and fell and sustained a fracture of the right hip.

The client received services from the facility that included physical assistance with toileting, safety checks and medication management. The client's service plan indicated to staff when to provide toileting assistance to the client and included that staff were to stay with the client while in the bathroom.

The day the client fell, the client had attended an activity and was walked back to his/her room by Employee A. Employee A supervised the client as s/he went into the bathroom and ensured that the client was seated on the toilet. Employee A left the client's bathroom and told Employee B that the client was in the bathroom. Employee B went to the client's bathroom and told the client to call for assistance when needed. Employee B then left the client's bathroom. The client's phone rang while s/he was in the bathroom and the client attempted to self-transfer to answer the phone, and the client fell. The client's call light was on, and the client was found on the floor in the bedroom by staff shortly after Employee B left the bathroom. Initially, the client had no complaints of pain, however 30-45 minutes later the client had severe pain and was transferred via ambulance to the hospital and admitted. Hospital records indicated that the resident was diagnosed with a fracture of the right hip.

Employee A was interviewed and stated s/he was not trained to assist clients with direct care including toileting. Employee A stated that s/he was unaware of the client's service plan, but told Employee B (who was trained in providing direct care and toileting) that the client was in the bathroom immediately after leaving the client's room.

Employee B was interviewed and stated that she was unaware of the client's service plan which indicated to stay with the client when in the bathroom. Employee B stated she left the client's room as the client did not have gloves in the room. Employee B stated that s/he thought that the client was fine, as the client is alert and oriented and able to follow direction. Employee B had directed the client to call for assistance when needed.

The client's family was interviewed and stated that when the client admitted to the facility, administrative staff ensured that the client's service plan would indicate that the client would be supervised in the bathroom. The client's family stated that they were called when the resident had a fall and were told that the client was left alone in the bathroom.

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:

Although the facility had policy and procedures in place to ensure client service plans were followed, the facility failed to ensure that staff followed and implemented the policy 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 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 If no, specify: _____

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

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

State licensing orders were issued: ☒ Yes ☐ No If no, specify: _____

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

Facility Corrective Action:

The facility took the following corrective action(s):

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:

☒ Medical Records
☒ Medication Administration Records
☒ Facility Incident Reports
☒ ADL (Activities of Daily Living) Flow Sheets
☒ Physician Orders
☒ Nurses Notes
☐ Activities Reports
☐ Therapy and/or Ancillary Services Records
☐ Skin Assessments
☒ Care Guide
☒ Treatment Sheets
☒ Physician Progress Notes
☒ Laboratory and X-ray Reports
☐ Social Service Notes
☒ Meal Intake Records
☐ Weight Records
☒ Assessments
☒ Care Plan Records

Other pertinent medical records:

☒ Hospital Records ☐ Ambulance/Paramedics ☐ Medical Examiner Records ☐ Death Certificate

☐ Police Report

Additional facility records:

☐ Resident/Family Council Minutes

☐ Personnel Records/Background Check, etc.

☒ Staff Time Sheets, Schedules, etc.

☐ Facility In-service Records

☒ Facility Internal Investigation Reports

☒ Facility Policies and Procedures

☐ Call Light Audits

☐ Other, specify: _____

Number of additional resident(s) reviewed: 4

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 complainant(s): ◉ Yes ○ No ○ N/A Specify: _____

If unable to contact complainant, 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: Not in facility at time of investigation

Did you interview additional residents: ◉ Yes ○ No

Total number of resident interviews: 4

Interview with staff: ◉ Yes ○ No ○ N/A Specify: 5

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: 7

Physician interviewed: ○ Yes ◉ No

Nurse Practitioner 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:

☐ Wound Care	☐ Medication Pass	☐ Meals
☐ Personal Care	☐ Dignity/Privacy Issues	☐ Restorative Care
☒ Nursing Services	☐ Safety Issues	☒ Facility Tour
☐ Infection Control	☐ Cleanliness	☒ Injury
☐ Use of Equipment	☐ Transfers	☐ Incontinence
☒ Call Light	☐ Other: _____	

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: _____

xc: Division of Compliance Monitoring – Home Care and Assisted Living Providers
St. Cloud City Police Department
St. Cloud County Attorney
St. Cloud City Attorney

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H21030	A. BUILDING: _____ B. WING _____	C 10/20/2015

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SPECTRUM COMMUNITY HEALTH INC	6205 CROSSMAN LANE INVER GROVE HEIGHTS, MN 55076

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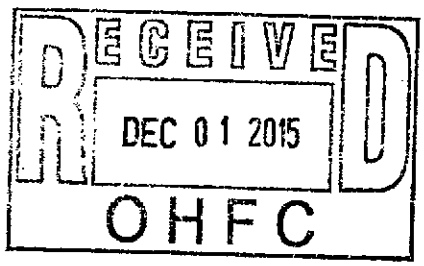
0 000	Initial Comments *****ATTENTION****** HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with 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 9/14/15, a complaint investigation was initiated to investigate complaint #HL21030021. At the time of the survey, there were 63 clients that were receiving services under the comprehensive license. The following correction orders are 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.	
0 315	144A.44, Subd. 1(12) Served by People Who Are Competent Subdivision 1. Statement of rights. A person who receives home care services has these rights: (12) the right to be served by people who are properly trained and competent to perform their duties;	0 315		

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0 315	Continued From page 1 This MN Requirement is not met as evidenced by: Based on interview and document review the licensee failed to ensure that a client received care and services from staff who were competent to perform their duties when a client's service plan was not followed for 1 of 3 (C1) clients reviewed for falls. C1 was left unsupervised in the bathroom and fell, which resulted in a fracture of the right hip. This practice resulted in a level 3 violation (a violation that has the potential to lead to serious injury, impairment, or death). and is issued at an isolated scope (1 or a limited number of clients are affected). Findings include: C1's medical record was reviewed and revealed that C1 was readmitted to the facility from the hospital on 7/10/15 with diagnosis of dementia. C1's service plan dated 7/10/15 included safety checks, physical assistance by staff for dressing, grooming, bathing and stand-by physical assistance for toileting. C1 ambulated with a walker and staff assistance. C1's assisted living assessment dated 7/10/15 indicated that C1 was incontinent and required physical assistance to the bathroom. C1's July 2015 Service Check-off list indicated that C1 required hourly safety checks and stand by physical assist to the bathroom. Under the toileting section of the check-off list was included to assist C1 "to and from the bathroom, stay with her while she is in the bathroom. Also assist with pulling pants up and down related to weakness". An incident report dated 7/31/15 at 17:40 (5:40 p.m.) revealed that C1 had a fall at 3:20 p.m. and 45-60 minutes later C1 complained of right leg and hip pain. C1's pain continued despite pain medication. 911 was called and C1's family was notified. C1 was sent to the emergency room via	0 315		

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0 315	Continued From page 2 ambulance. C1 was admitted to the hospital and later diagnosed with a femur fracture. An interview with license practical nurse (LPN)-A on 9/24/15 at 12:00 p.m. revealed that LPN-A had been working in the nursing office on 7/31/15 (unknown time in the afternoon) when she was informed by the social worker (SW) that C1 was in the bathroom. LPN-A stated that she then went in to check on C1 in the bathroom, while in the bathroom, LPN-A noticed C1's bathroom did not have gloves and LPN-A then stepped out of C1's bathroom and room to get gloves and call for another staff member to assist C1 in the bathroom. LPN-A stated that she was not concerned for C1's safety in the bathroom and left C1 unattended, as C1 was alert and oriented and able to use her call light. LPN-A told C1 to put on her call light when she was done using the bathroom. LPN-A stated that C1 fell shortly after she left C1's room. LPN-A stated that C1's call light was on when she fell and when a staff member when in to answer it, C1 was found on the floor. LPN-A could not recall who informed her about C1's fall. LPN-A stated that she did not assist with C1's fall. LPN-A stated that she was unclear about what C1's service plan was, stating that after C1 returned from the hospital, staff was staying with C1 in the bathroom as a precaution but it was a "grey area" and she had never been directly told to supervise C1 in the bathroom. An interview with the SW on 9/24/15 at 2:55 p.m. revealed that she assisted C1 to the bathroom on 7/31/15 around 3:30-4:00 p.m. The SW stated that she assisted C1 from an activity, back to her room and into the bathroom. When in the bathroom, the SW made sure C1 was seated on the toilet, and told C1 to stay there and that she would get help for C1. The SW then left C1 unattended on the toilet, when she went to find assistance for C1. The SW then found LPN-A,	0 315		

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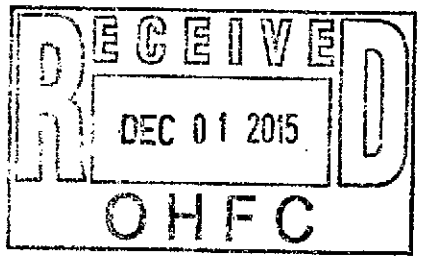
0 315	Continued From page 3 30-40 feet outside of C1's room, and told LPN-A that C1 was in the bathroom. The SW stated LPN-A informed her that she would "take care of it". The SW later heard that C1 had a fall that day when C1's phone rang when C1 was on the toilet and she attempted to get up to answer the phone. The SW stated that she does not usually take clients to the bathroom, has not been trained to provide direct care to clients, and was not aware of C1's service plan. An interview with LPN-B on 9/24/15 at 3:00 p.m. revealed that LPN-B worked on 7/31/15 and was called into C1's room by another staff member and found C1 on the floor. LPN-B stated that C1 was on the floor of her room, between the recliner and the bed around 3:30 pm. C1 told LPN-B that she heard her phone ringing and attempted to answer the phone when she fell. C1 initially did not have complaints of pain but 30-40 minutes later C1 complained of pain. Pain medication was not effective and LPN-B later sent C1 to the hospital for an evaluation between 4:30 - 5:00 p.m. LPN-B stated that no staff witnessed C1 fall and was unsure if C1 was in the bathroom prior to her fall. LPN-B stated that he would expect staff to supervise C1 in the bathroom. An interview with registered nurse (RN)-C on 9/25/15 at 1:22 p.m. confirmed that C1's service plan directed staff to stay in the bathroom with C1. RN-C stated that the SW is not aware of client service plans and does not provide direct care to clients. RN-C also stated that she would expect staff to stay with C1 in the bathroom as indicated on C1's service plan. RN-C confirmed that both the SW and LPN-A left C1 unattended in the bathroom. An interview with the executive director on 9/25/15 at 1:40 p.m. revealed that C1 was left unattended in the bathroom by the SW and LPN-A. The executive director confirmed that the	0 315		

Minnesota Department of Health

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0 315	Continued From page 4 SW was not trained to provide direct care to clients and was unaware of C1's service plan. The executive director also stated that she expected LPN-A to be aware of C1's service plan and should have stayed with C1 in the bathroom. C1's family (F-D) was interviewed on 9/23/15 at 11:51 a.m. who revealed that prior to C1's readmission to the facility on 7/10/15 it was discussed with administrative staff that C1 needed additional assistance and supervision in the bathroom and wanted this added to C1's plan of care. F-D stated that the facility ensured that this was added to C1's care plan. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 315		
0 325	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 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 clients were free from neglect when 1 of 1 clients (C1) reviewed for maltreatment did not receive care and services in accordance with the service plan. C1 was left unsupervised in the bathroom and fell, which resulted in a fracture of the right hip. This practice resulted in a level 3 violation (a violation that has the potential to lead to serious injury, impairment, or death) and is issued at an	0 325		

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0 325	Continued From page 5 isolated scope (1 or a limited number of clients are affected). Findings include: C1's medical record was reviewed and revealed that C1 was readmitted to the facility from the hospital on 7/10/15 with diagnosis of dementia. C1's service plan dated 7/10/15 included safety checks, physical assistance by staff for dressing, grooming, bathing and stand-by physical assistance for toileting. C1 ambulated with a walker and staff assistance. C1's assisted living assessment dated 7/10/15 indicated that C1 was incontinent and required physical assistance to the bathroom. C1's July 2015 Service Check-off list indicated that C1 required hourly safety checks and stand by physical assist to the bathroom. Under the toileting section of the check-off list was included to assist C1 "to and from the bathroom, stay with her while she is in the bathroom. Also assist with pulling pants up and down related to weakness". An incident report dated 7/31/15 at 17:40 (5:40 p.m.) revealed that C1 had a fall at 3:20 p.m. and 45-60 minutes later C1 complained of right leg and hip pain. C1's pain continued despite pain medication. 911 was called and C1's family was notified. C1 was sent to the emergency room via ambulance. C1 was admitted to the hospital and later diagnosed with a femur fracture. An interview with license practical nurse (LPN)-A on 9/24/15 at 12:00 p.m. revealed that LPN-A had been working in the nursing office on 7/31/15 (unknown time in the afternoon) when she was informed by the social worker (SW) that C1 was in the bathroom. LPN-A stated that she then went in to check on C1 in the bathroom, while in the bathroom, LPN-A noticed C1's bathroom did not have gloves and LPN-A then stepped out of C1's bathroom and room to get gloves and call for	0 325		

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0 325	Continued From page 6 another staff member to assist C1 in the bathroom. LPN-A stated that she was not concerned for C1's safety in the bathroom and left C1 unattended, as C1 was alert and oriented and able to use her call light. LPN-A told C1 to put on her call light when she was done using the bathroom. LPN-A stated that C1 fell shortly after she left C1's room. LPN-A stated that C1's call light was on when she fell and when a staff member when in to answer it, C1 was found on the floor. LPN-A could not recall who informed her about C1's fall. LPN-A stated that she did not assist with C1's fall. LPN-A stated that she was unclear about what C1's service plan was, stating that after C1 returned from the hospital, staff was staying with C1 in the bathroom as a precaution but it was a "grey area" and she had never been directly told to supervise C1 in the bathroom. An interview with the SW on 9/24/15 at 2:55 p.m. revealed that she assisted C1 to the bathroom on 7/31/15 around 3:30-4:00 p.m. The SW stated that she assisted C1 from an activity, back to her room and into the bathroom. When in the bathroom, the SW made sure C1 was seated on the toilet, and told C1 to stay there and that she would get help for C1. The SW then left C1 unattended on the toilet, when she went to find assistance for C1. The SW then found LPN-A, 30-40 feet outside of C1's room, and told LPN-A that C1 was in the bathroom. The SW stated LPN-A informed her that she would "take care of it". The SW later heard that C1 had a fall that day when C1's phone rang when C1 was on the toilet and she attempted to get up to answer the phone. The SW stated that she does not usually take clients to the bathroom, has not been trained to provide direct care to clients, and was not aware of C1's service plan. An interview with LPN-B on 9/24/15 at 3:00 p.m. revealed that LPN-B worked on 7/31/15 and was	0 325		

Minnesota Department of Health

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0 325	Continued From page 7 called into C1's room by another staff member and found C1 on the floor. LPN-B stated that C1 was on the floor of her room, between the recliner and the bed around 3:30 pm. C1 told LPN-B that she heard her phone ringing and attempted to answer the phone when she fell. C1 initially did not have complaints of pain but 30-40 minutes later C1 complained of pain. Pain medication was not effective and LPN-B later sent C1 to the hospital for an evaluation around 4:30 - 5:00 p.m. LPN-B stated that no staff witnessed C1 fall and was unsure if C1 was in the bathroom prior to her fall. LPN-B stated that he would expect staff to supervise C1 in the bathroom. An interview with registered nurse (RN)-C on 9/25/15 at 1:22 p.m. confirmed that C1's service plan directed staff to stay in the bathroom with C1. RN-C stated that the SW is not aware of client service plans and does not provide direct care to clients. RN-C also stated that she would expect staff to stay with C1 in the bathroom as indicated on C1's service plan. RN-C confirmed that both the SW and LPN-A left C1 unattended in the bathroom. An interview with the executive director on 9/25/15 at 1:40 p.m. revealed that C1 was left unattended in the bathroom by the SW and LPN-A. The executive director confirmed that the SW was not trained to provide direct care to clients and was unaware of C1's service plan. The executive director also stated that she expected LPN-A to be aware of C1's service plan and should have stayed with C1 in the bathroom. C1's family (F-D) was interviewed on 9/23/15 at 11:51 a.m. who revealed that prior to C1's readmission to the facility on 7/10/15 it was discussed with administrative staff that C1 needed additional assistance and supervision in the bathroom and wanted this added to C1's plan of care. F-D stated that the facility ensured that	0 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H21030	A. BUILDING: _____ B. WING _____	C 10/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPECTRUM COMMUNITY HEALTH INC	6205 CROSSMAN LANE INVER GROVE HEIGHTS, MN 55076

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0 325	Continued From page 8 this was added to C1's care plan. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	0 325		
0 865	144A.4791, Subd. 9(a-e) Service Plan, Implementation & Revisions Subd. 9. Service plan, implementation, and revisions to service plan. (a) No later than 14 days after the initiation of services, a home care provider shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the home care provider and by the client or the client's representative documenting agreement on the services to be provided. The service plan must be revised, if needed, based on client review or reassessment under subdivisions 7 and 8. The provider must provide information to the client about changes to the provider's fee for services and how to contact the Office of the Ombudsman for Long-Term Care. (c) The home care provider must implement and provide all services required by the current service plan. (d) The service plan and revised service plan must be entered into the client's record, including notice of a change in a client's fees when applicable.	0 865		

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0 865	Continued From page 9 (e) Staff providing home care services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interviews and document review, the licensee failed to implement and provide services in accordance with the service plan for 1 of 3 (C1) clients reviewed for falls. C1 was left unsupervised in the bathroom and fell, which resulted in a fracture of the right hip. . This practice resulted in a level 3 violation (a violation that has the potential to lead to serious injury, impairment, or death). and is issued at an isolated scope (1 or a limited number of clients are affected). Findings include: C1's medical record was reviewed and revealed that C1 was readmitted to the facility from the hospital on 7/10/15 with diagnosis of dementia. C1's service plan dated 7/10/15 included safety checks, physical assistance by staff for dressing, grooming, bathing and stand-by physical assistance for toileting. C1 ambulated with a walker and staff assistance. C1's assisted living assessment dated 7/10/15 indicated that C1 was incontinent and required physical assistance to the bathroom. C1's July 2015 Service Check-off list indicated that C1 required hourly safety checks and stand by physical assist to the bathroom. Under the toileting section of the check-off list was included to assist C1 "to and from the bathroom, stay with her while she is in the bathroom. Also assist with pulling pants up and down related to weakness". An incident report dated 7/31/15 at 17:40 (5:40 p.m.) revealed that C1 had a fall at 3:20 p.m. and 45-60 minutes later C1 complained of right leg	0 865		

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0 865	Continued From page 10 and hip pain. C1's pain continued despite pain medication. 911 was called and C1's family was notified. C1 was sent to the emergency room via ambulance. C1 was admitted to the hospital and later diagnosed with a femur fracture. An interview with license practical nurse (LPN)-A on 9/24/15 at 12:00 p.m. revealed that LPN-A had been working in the nursing office on 7/31/15 (unknown time in the afternoon) when she was informed by the social worker (SW) that C1 was in the bathroom. LPN-A stated that she then went in to check on C1 in the bathroom, while in the bathroom, LPN-A noticed C1's bathroom did not have gloves and LPN-A then stepped out of C1's bathroom and room to get gloves and call for another staff member to assist C1 in the bathroom. LPN-A stated that she was not concerned for C1's safety in the bathroom and left C1 unattended, as C1 was alert and oriented and able to use her call light. LPN-A told C1 to put on her call light when she was done using the bathroom. LPN-A stated that C1 fell shortly after she left C1's room. LPN-A stated that C1's call light was on when she fell and when a staff member when in to answer it, C1 was found on the floor. LPN-A could not recall who informed her about C1's fall. LPN-A stated that she did not assist with C1's fall. LPN-A stated that she was unclear about what C1's service plan was, stating that after C1 returned from the hospital, staff was staying with C1 in the bathroom as a precaution but it was a "grey area" and she had never been directly told to supervise C1 in the bathroom. An interview with the SW on 9/24/15 at 2:55 p.m. revealed that she assisted C1 to the bathroom on 7/31/15 around 3:30-4:00 p.m. The SW stated that she assisted C1 from an activity, back to her room and into the bathroom. When in the bathroom, the SW made sure C1 was seated on the toilet, and told C1 to stay there and that she	0 865		

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0 865	Continued From page 11 would get help for C1. The SW then left C1 unattended on the toilet, when she went to find assistance for C1. The SW then found LPN-A, 30-40 feet outside of C1's room, and told LPN-A that C1 was in the bathroom. The SW stated LPN-A informed her that she would "take care of it". The SW later heard that C1 had a fall that day when C1's phone rang when C1 was on the toilet and she attempted to get up to answer the phone. The SW stated that she does not usually take clients to the bathroom, has not been trained to provide direct care to clients, and was not aware of C1's service plan. An interview with LPN-B on 9/24/15 at 3:00 p.m. revealed that LPN-B worked on 7/31/15 and was called into C1's room by another staff member and found C1 on the floor. LPN-B stated that C1 was on the floor of her room, between the recliner and the bed around 3:30 pm. C1 told LPN-B that she heard her phone ringing and attempted to answer the phone when she fell. C1 initially did not have complaints of pain but 30-40 minutes later C1 complained of pain. Pain medication was not effective and LPN-B later sent C1 to the hospital for an evaluation around 4:30 - 5:00 p.m. LPN-B stated that no staff witnessed C1 fall and was unsure if C1 was in the bathroom prior to her fall. LPN-B stated that he would expect staff to supervise C1 in the bathroom. An interview with registered nurse (RN)-C on 9/25/15 at 1:22 p.m. confirmed that C1's service plan directed staff to stay in the bathroom with C1. RN-C stated that the SW is not aware of client service plans and does not provide direct care to clients. RN-C also stated that she would expect staff to stay with C1 in the bathroom as indicated on C1's service plan. RN-C confirmed that both the SW and LPN-A left C1 unattended in the bathroom. An interview with the executive director on	0 865		

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0 865	Continued From page 12 9/25/15 at 1:40 p.m. revealed that C1 was left unattended in the bathroom by the SW and LPN-A. The executive director confirmed that the SW was not trained to provide direct care to clients and was unaware of C1's service plan. The executive director also stated that she expected LPN-A to be aware of C1's service plan and should have stayed with C1 in the bathroom. C1's family (F-D) was interviewed on 9/23/15 at 11:51 a.m. who revealed that prior to C1's readmission to the facility on 7/10/15 it was discussed with administrative staff that C1 needed additional assistance and supervision in the bathroom and wanted this added to C1's plan of care. F-D stated that the facility ensured that this was added to C1's care plan. Time Period for Correction: Twenty-one (21) days	0 865		

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
H21030	A. Building B. Wing	1/8/2016

Name of Facility	Street Address, City, State, Zip Code
SPECTRUM COMMUNITY HEALTH INC	6205 CROSSMAN LANE INVER GROVE HEIGHTS, MN 55076

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix 00315 Reg. # 144A.44, Subd. 1(12) LSC	Correction Completed 01/06/2016	ID Prefix 00325 Reg. # 144A.44, Subd. 1(14) LSC	Correction Completed 01/06/2016	ID Prefix 00865 Reg. # 144A.4791, Subd. 9(a-e) LSC	Correction Completed 01/06/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 10/20/2015		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO