DEPARTMENT OF HEALTH

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:
Ebenezer Home Care

Facility Address:
2722 Park Avenue South

Facility City:
Minneapolis

State: Minnesota | **ZIP:** 55407 | **County:** Hennepin

Report Number:
HL27108013

Date of Visit:
September 26 and 27, 2017

Time of Visit:
9:30 a.m.to 4:30 p.m.
5:40 a.m. to 7:30 a.m.

Date Concluded:
December 13, 2017

Investigator's Name and Title:
William Nelson, RN, Special Investigator

☒ **Home Care Provider/Assisted Living**

Allegation(s):
It is alleged that a client was neglected when facility staff failed to check on the client after the client called for assistance after a fall. The client was on the floor from 11:10 p.m. to 8:45 a.m. the next morning.

☒ 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. The client fell around 11:00 a.m. and was not assisted off the floor for about ten hours. The home care provider failed to provide multiple services which would have resulted in finding and assisting the client sooner. First, the facility had an alarm system in place that was to notify the staff by cell phone when a client got out of bed. The client's bed sensor alarmed at the time of the fall, but there is no documentation any staff member responded. Second, the client's service plan included continence care at midnight and 7:00 a.m., which was not provided. Third, the assignment sheet for the shift indicated all clients were to receive a safety check around 3:00 a.m., and this was not completed. The client's medical and mental condition declined after the fall and the resident died 26 days later.

The client's diagnoses included Alzheimer's disease, coronary artery disease, and Raynaud's Disease. The client ambulated with the assistance of a walker until the fall; after the fall the client could not ambulate without the assistance of two staff and the walker and the resident experienced significant pain while ambulating. The client required assistance with all activities of daily living including eating, bathing, toileting, dressing, and bed mobility. Prior to the fall, the resident had the ability to ambulate to and from the bathroom without assistance during the day. The client's bed had a pressure sensitive alarm. The

client's service plan indicated the staff were to respond and assist with continence care when the bed alarm activated. The service plan also indicated continence care would be provided at midnight and 7:00 a.m.; staff were to enter the room at those times and determine if the client was awake, and if so, assist the client to the bathroom.

The facility had an alarm system in place for clients, which allowed the living room chair, bed, and toilet to be equipped with pressure sensors and the refrigerator and entry door to be alarmed with a sensor to notify staff when the client opened the doors. Each client's room had only the alarms turned on or installed that were identified in the client's service plan. When one of the sensors was activated, the staff were notified through a cell phone. If the first staff member that gets the call cannot go to the client's room to assist, the call rolled over to the second staff member on duty, if they cannot go the call is rolled over to the third staff, and so on. If the notification rolls through all of the staff, the call starts over with the first one again. The night shift have different phone numbers, and when they come on duty, the evening staff are to plug in their phones to charge for the day shift. The phones from the evening staff are programmed to roll their calls over to the night staff. No call can get canceled without the staff going to the client's apartment and pushing a cancellation button on the wall. This button was located outside the client's door at the time of the client's fall.

On the night of the fall, the client's pressure sensing alarm on the bed alarmed that the client exited the bed. The alarm records indicated that the notification to the staff phones went at 11:10 p.m. Based on interviews and document review, no staff member went into the client's room in response to this alarm.

The client had a scheduled continence care service on the service plan agreement at midnight and again at 7:00 a.m. During these two scheduled services, the service plan required that the staff member check the client; if the client was not awake, staff were not to wake the client, but if the client was awake, staff were to assist the client. In addition, the assignment sheet for the night shift indicated a safety check was to be conducted at 3:00 a.m. to check on all clients. The staff member assigned to the client did not enter the client's room the entire shift.

The client was found on the floor next to the client's bed by the day shift the following morning at approximately 8:45 a.m. The client was incontinent of urine, confused, and in pain. Tylenol was administered. The facility obtained x-rays, which were negative for fractures. The client could not ambulate with a walker independently after the fall. The client expressed pain whenever the staff moved the client. The client required a wheelchair for mobility and a mechanical lift for transfers to and from the bed. The client was transferred to the hospital on the tenth day after the fall, was diagnosed with a urinary tract infection, and hospitalized for five days. The hospital completed a CT scan of the pelvis and ruled out any fractures of the pelvis area. The client was transferred to hospice with antibiotics and pain control options, and passed away ten days later. The cause of death was listed as bronchopneumonia; the hospital record indicated the client experienced an aspiration during the hospitalization.

During interviews, direct care staff who were on duty 11:00 a.m. to 7:00 a.m. stated they did not enter the client's room at any time during the shift, because they typically did not enter the client's room unless the client's bed alarm activated. No staff person recalled pressing the alarm cancellation button outside the

client's room. One direct care staff member stated s/he did not normally enter the client's room except when there was an out-of-bed alarm.

During an interview, the staff who found the client on the floor indicated the client reported significant leg pain due to the fall, and was unable to bear weight.

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 home care provider is responsible for the neglect, because the home care provider failed to ensure staff provided the services on the service plan and the assignment sheet. As a result, although there were four different occasions between the fall and the time the client was found where a staff member should have entered the client's room and found the client, none of these occurred and the client remained on the floor until morning.

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 Home Care Providers (MN Statutes section 144A.43 - 144A.483) - Compliance Not Met
The requirements under State Statutes for Home Care Providers (MN Statutes, section 144A.43 - 144A.483) 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:

- ☒ Medical Records
- ☒ Medication Administration Records
- ☒ Nurses Notes
- ☒ Physician Orders

☒ Physician Progress Notes
☒ Facility Incident Reports
☒ Laboratory and X-ray Reports
☒ Service Plan

Other pertinent medical records:

Additional facility records:

☒ Staff Time Sheets, Schedules, etc.
☒ Facility Policies and Procedures
☒ Other, specify: Complaint form with facility response

Number of additional resident(s) reviewed: None

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: Deceased

Did you interview additional residents? ○ Yes ◉ No

Total number of resident interviews: None

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

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: Five

Physician Interviewed: ○ Yes ◉ No

Nurse Practitioner Interviewed: ○ Yes ◉ No

Physician Assistant Interviewed: ○ Yes ◉ No

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

Attempts to contact:

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

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

Were contacts made with any of the following:

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

Observations were conducted related to:

☒ 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

The Office of Ombudsman for Long-Term Care

Orono Police Department

Hennepin County Attorney

Orono City Attorney

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

February 20, 2018

Ms. Erin Hilligan, Administrator
Ebenezer Home Care
2722 Park Avenue South
Minneapolis, MN 55407

RE: Complaint Number HL27108013

Dear Ms. Hilligan :

On January 8, 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 November 6, 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,

Matthew Heffron

Matthew Heffron, JD, NREMT
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) 201-4221 Fax: (651) 281-9796

MLH

Enclosure

cc: Home Health Care Assisted Living File
Hennepin County Adult Protection
Office of Ombudsman for Long Term Care
MN Department of Human Services

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Certified Mail Number: 7015 1660 0000 4149 8464

December 6, 2017

Ms. Erin Hilligan, Administrator
Ebenezer Home Care
2722 Park Avenue South
Minneapolis, MN 55407

RE: Complaint Number HL27108013

Dear Ms. Hilligan:

A complaint investigation (#HL27108013) of the Home Care Provider named above was completed on November 6, 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 are issued in accordance with Minnesota Statutes Sections 144A.43 to 144A.482.

State licensing orders are delineated on the attached State Form. 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,

Matthew Heffron

Matthew Heffron, JD, NREMT
Health Regulations Division
Supervisor Office of Health Facility Complaints
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
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MLH

Enclosure

cc: Home Health Care Assisted Living File
Hennepin County Adult Protection
Office of Ombudsman for Long Term Care
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
	H27108	A. BUILDING: _____ B. WING _____	C 11/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EBENEZER HOME CARE	2722 PARK AVENUE SOUTH MINNEAPOLIS, MN 55407

(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****** 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: A complaint investigation was conducted to investigate complaint #HL27108013. 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/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings, which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and 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/RULES.	
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:	0 325		

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0 325	Continued From page 1 (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 a client was free from maltreatment (neglect), for 1 of 1 clients reviewed (C1), when the client had a fall and was on the floor for about ten hours. C1's service plan called for continence care at midnight, which was not completed; the service plan also indicated C1 should have received continence care when the staff received an out-of-bed call, the client's sensor system had alarmed about 11:10 p.m., and there was no documentation that any staff had responded to that call; and the assignment sheet for the shift indicated a safety check should have been completed at 3:00 a.m., but it was not completed. This practice resulted in a level 3 violation (a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and is 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 records were reviewed. C1's diagnoses included Alzheimer's disease, coronary artery disease, and Raynaud's disease. C1's service plan agreement, dated 1/1/2017,	0 325		

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0 325	Continued From page 2	0 325		

identified continence care at midnight and 7:00 a.m. The service agreement also identified continence care to be done whenever the staff receive an out-of-bed call and/or during safety checks.

The Memory Care Attendant II assignment sheet for 8/15/2017 night shift was reviewed. C1 was identified as requiring continence care at 12:00 a.m. The instructions stated: Assist resident with continence cares during the night. Do not awaken resident to use the bathroom. Assist resident with continence cares when receiving an out of bed call and/or during safety checks. Notify nurse if incontinent.

The Memory Care Attendant II assignment sheet for 8/15/2017 night shift also stated that at 3:00 a.m., safety checks were to be completed. The instructions stated: Make rounds at this time and check on all residents.

A fall note dated 8/16/2017 at 10:13 a.m. was reviewed. The note indicated, "resident found on the floor of her apartment at 9 am.... Not sure how long resident was on the floor prior to being found. No out of bed call was received and last time healthsense had a call the resident off loaded at 11 pm. Resident was leaning against her bed frame with legs out in front of her with head and neck on metal bed frame. Resident was unable to recall the incident and unable to respond to questions of pain or distress. No signs of visual injury that would indicate a head injury. Resident pupils however are different sizes with the right being smaller than the left. Grasps are equal and no facial dropping noted. Three staff used gait belt to help resident to her feet but she was unable to bear weight on either leg so she was placed in a chair. Resident was very

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0 325	Continued From page 3	0 325		

confused about the situation so staff allowed time for the resident to orient prior to trying to transfer again. Resident was still unable to stand or transfer, resident transfer and standing baseline is independent with walker. Resident was transferred back into bed with three staff and gait belt. Resident also provided continence care in bed which resulted in the resident to complain of pain with turning and transfer. Staff reported that before they left the room the resident began to twitch in bed and puffed cheek breathing. BP 160/109, P-90, T98.1 R-16. Quarter sized bruise found on right shoulder blade. Family does not wish to send resident to the ER instead would like lab work and x-ray done in house. Nursing to investigate the health sense records further. Staff to continue to respond to pendent and health sense calls in timely manner. Provide clutter free and well lit areas."

A Fall follow up note dated 8/17/2017 was reviewed. The note indicated C1 had told the nurse that she had some pain, but was unable to specify where. C1 had difficulty swallowing water and was unable to take medications, but later, at meals, was able to swallow liquids. C1's vital signs were stable and within her baseline, speech was baseline, and C1's grasps were equal. However, C1's ability to bear weight was inconsistent, ranging from not at all to attempting to self-transfer. C1 had significant difficulty pivoting. C1's x-rays indicated no fractures. C1 had a 1 x 1.5 cm bruise over the right scapula, and two small bruises to the right of the coccyx that are each less than 1 cm in size. Morphine had been ordered for C1, but C1's family had asked not to use it, so Tylenol had been given, which was effective when C1 was at rest. C1 continued to have pain when bearing weight. The note indicated staff were to answer C1's call light

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0 325	Continued From page 4 in a prompt manner, anticipate C1's needs, keep frequently used items near C1's bedside, staff to make sure sheets are properly made before C1 got into bed, perform protocol 3:00 am safety rounds on all clients, and keep client's light on above the kitchen sink at night. A Progress note dated 8/19/2017 was reviewed. The note indicated, "Care attendants reported to the nurse that the resident has been having pain this morning, especially when transferring. Pain at the time appeared to be in the right knee.....placed cold compress over the knee. Later in the day, care attendants reported that the resident was in a lot of pain in the legs bilaterally while transferring and screamed and would say "ow" when the care attendants tried taking off her socks. Nurse instructed them to give her PRN Tylenol and ice and elevate the legs." A Progress note dated 8/21/2017 was reviewed; the note was titled Fall investigation and indicated that no environmental factors contributed to the fall. Resident factors included- use of assistive devices, history of falls, gait/balance disorder, impaired cognition diagnosis, impaired decision making, and resistive to cares. Medical factors- Predisposing medical condition, pain/discomfort, bladder dysfunction and takes four or more medications. Resident follow up- Nursing assessment/evaluation, level of care change, documentation on client service notes, fall risk assessment, vulnerability assessment, referred to community exercise program, recommended increase in level of care. Environmental modifications-none needed. Wheelchair added due to unsteady gait and inability to follow instructions to use walker. Fall reduction interventions, items of need within reach, staff assistance with ADL's. Wear shoes/non-skid	0 325		

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0 325	Continued From page 5 slippers/non-skid socks at all times while out of bed. Health Sense monitoring/ increased monitoring. Encourage community exercise program. Encourage hydration. Remove clutter, rugs. Provide lighting/night light, educate family/client on environment safety. Referred to safety and QA committees. Safety checks added at 11:15 p.m. and 3:00 a.m. Wording for safety check also modified to state "make sure to comment on the resident's status. Will continue to reiterate importance of increasing level of care to daughter. Staff to respond to out of bed calls promptly, check on resident before accepting/canceling call. The cancel button for the alarm was moved to inside C1's room, beside her bathroom door. A Progress note dated 8/23/2017 was reviewed. The note indicated that C1 required toileting assistance every 2-3 hours and required the assistance of 2 staff. A chair sensor was added as C1 was then using a wheelchair for transport. A Progress note dated 8/24/2017 was reviewed. The note indicated C1 was assisted by three staff that day when transferring from the bed to the wheelchair. C1 complained of pain in bilateral legs up to thigh/hip area with gentle touch, and screamed out in pain during ADL's and transfers. The client also needed assistance eating. A Progress note dated 8/24/2017 was reviewed and indicated physical therapy completed an evaluation of C1., Visit from PT today for transfer training and fall prevention. The note indicated that PT completed an evaluation. Physical therapy staff indicated C1 was guarding her right leg significantly, and based on ability that day, would benefit from Hoyer transfer.	0 325		

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0 325	Continued From page 6 A Progress note dated 8/26/2017 10:20 a.m. was reviewed. The note indicated C1's daughter was present for C1's morning transfer from bed, and was greatly worried about the level of pain C1 was still experiencing. C1 had received two doses of gabapentin with no signs of relief. Staff reported that C1's pain generally occurred with transfers in bed, applying shoes and socks and during Hoyer lift. A Progress note dated 8/26//201712:48 p.m. was reviewed. The note indicated that the physician group had responded to C1's daughter's request to have C1 seen in the ER, and agreed to have C1 sent to the emergency room for evaluation. A Progress note dated 8/28/20175:09 p.m. was reviewed. The note indicated that C1's daughter called and notified the home care provider that C1 would not be coming back to the facility, as C1 required a higher level of care. An Emergency Room Note, titled Final Impression/Plan and dated 8/26/2017, indicated C1 presented for ongoing right leg pain after a fall two weeks prior, where C1 was found after laying on the ground all night. C1 had been unable to ambulate since the fall but prior to it was ambulatory with walker. A CT scan of the hip did not show any acute fracture. X-ray of humerus and tibula and fibula were atraumatic. C1 continued to have severe pain with movement, but with no apparent bony injury; it was assessed as likely muscular pain. C1 was noted to have fairly advanced dementia. Urinalysis appeared consistent with UTI. Urine culture was ordered and intravenous antibiotics were ordered. During an interview on 9/26/2017 at 3:05 p.m., Registered Nurse (RN)-A stated RN-A contacted	0 325		

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	H27108	A. BUILDING: _____ B. WING _____	C 11/06/2017

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0 325	Continued From page 7 the alarm company, and the alarm company reported that the last alarm for C1 was a bed alarm at 11:00 p.m. on 8/15/2017. The alarm company confirmed that the alarm system (bed alarm) was working for C1's system. RN-A said that she was called to C1's room after C1 was found on the floor. RN-A said that C1 was assisted to her bed and that C1's physician and family member was notified of the situation. The decision was made to have x-rays and lab work done at the facility rather than send to the emergency room. The x-rays were negative for any fractures. Prior to the fall and being on the floor for 10 hours, C1 ambulated with the assistance of a walker. RN-A said that they attempted to use an EZ-Stand with C1 after the incident on 8/15/2017, however C1 could not follow directions due to the advanced level of dementia. The facility then started utilizing a Hoyer lift to transfer C1 from bed to a wheelchair and back. RN-A reported that after the fall, C1 had pain in her legs all the time and the pain increased when C1 was transferred. The nurse practitioner encouraged the family to send the resident to the emergency room for further testing due to the continued pain and the limitations of the testing at the facility. The family agreed to send to the emergency room on 8/26/2016. During an interview on 9/26/2017 at 2:10 p.m., Resident Assistant (RA)-B stated RA-B found C1 on the floor in C1's apartment at 8:45 a.m. on 8/16/2017. RA-B said that she would typically get into C1's room between 7:30 and 8:30 a.m. but the unit was short staffed that morning so she was late. RA-B had not received any calls indicating that C1 was out of bed or had pushed the call button. RA-B found C1 on the floor, next to the bed, facing the bathroom door with her back and bottom on the floor. C1's shoulders and	0 325		

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0 325	Continued From page 8 head were resting on the metal frame of the bed and C1's legs were straight out towards the bathroom. RA-B said that C1 was awake, denied pain at first, until she was moved. RA-B said she did not move the resident, she called RN-A. RN-A came in and assessed C1, and with the help of a third staff member they moved C1 to a chair. C1 reported a lot of pain in her legs with the movement and C1 could not bear weight when standing. RA-B said that the bed sensor is automatically re-loaded when C1 gets back in bed. RA-B said that after the fall, C1 had a lot of pain during her cares, even simple activities of daily living cares. RA-B said that most of C1's pain was in her legs, her legs were very sensitive to touch and movement after the fall. During an interview on 9/27/2017 at 5:45 a.m., Resident Assistant (RA)-D stated RA-D did not get any out of bed calls on C1 on the 8/15/2017 to 8/16/2017 11:00 p.m. to 7:00 a.m. shift. RA-D said that she did not get any calls, so she did not go into C1's room. RA-D said that she did not go into C1's room except when there was an out of bed call. RA-D said that C1 did not have any safety checks. RA-D said she did not push the cancellation button next to C1's hallway door. RA-D did not look at the evening shift's phone that night and would only look at the phone she is assigned to. During an interview on 9/27/2017 at 6:10 a.m., Resident Assistant (RA)-E said that RA-E did not have any contact with C1 on the night shift of 8/15/2017 to 8/16/2017 11:00 p.m. to 7:00 a.m. RA-E knew C1 well, and described her as being independent prior to the fall. C1 could ambulate with the use of a walker and was considered a low fall risk prior to fall. RA-E was assigned a different group of clients and C1 would not have	0 325		

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0 325	Continued From page 9 been a client that required the assistance of two. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 325		
0 865 SS=G	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	0 865		

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0 865	Continued From page 10 applicable. (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 interview and document review, the facility failed to ensure that client services were provided according to the service plan, for 1 of 1 clients reviewed (C1). The client's service plan called for continence care at midnight, which was not completed, and the client was found 10 hours later, next to her bed. In addition, the service plan indicated the client should have received continence care when the staff received an out-of-bed call, the client's sensor system had alarmed about 11:10 p.m., and there was no documentation that any staff had responded to that call. This practice resulted in a level 3 violation (a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and is 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 records were reviewed. C1's diagnoses included Alzheimer's disease, coronary artery disease, and Raynaud's disease. C1's service plan agreement, dated 1/1/2017, identified continence care at midnight and 7:00 a.m. The service agreement also identified	0 865		

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0 865	Continued From page 11 continence care to be done whenever the staff receive an out-of-bed call and/or during safety checks. The Memory Care Attendant II assignment sheet for 8/15/2017 night shift was reviewed. C1 was identified as requiring continence care at 12:00 a.m. The instructions stated: Assist resident with continence cares during the night. Do not awaken resident to use the bathroom. Assist resident with continence cares when receiving an out of bed call and/or during safety checks. Notify nurse if incontinent. The Memory Care Attendant II assignment sheet for 8/15/2017 night shift also stated that at 3:00 a.m., safety checks were to be completed. The instructions stated: Make rounds at this time and check on all residents. A fall note dated 8/16/2017 at 10:13 a.m. was reviewed. The note indicated, "resident found on the floor of her apartment at 9 am.... Not sure how long resident was on the floor prior to being found. No out of bed call was received and last time healthsense had a call the resident off loaded at 11 pm. Resident was leaning against her bed frame with legs out in front of her with head and neck on metal bed frame. Resident was unable to recall the incident and unable to respond to questions of pain or distress. No signs of visual injury that would indicate a head injury. Resident pupils however are different sizes with the right being smaller than the left. Grasps are equal and no facial dropping noted. Three staff used gait belt to help resident to her feet but she was unable to bear weight on either leg so she was placed in a chair. Resident was very confused about the situation so staff allowed time for the resident to orient prior to trying to transfer	0 865		

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0 865	Continued From page 12 again. Resident was still unable to stand or transfer, resident transfer and standing baseline is independent with walker. Resident was transferred back into bed with three staff and gait belt. Resident also provided continence care in bed which resulted in the resident to complain of pain with turning and transfer. Staff reported that before they left the room the resident began to twitch in bed and puffed cheek breathing. BP 160/109, P-90, T98.1 R-16. Quarter sized bruise found on right shoulder blade. Family does not wish to send resident to the ER instead would like lab work and x-ray done in house. Nursing to investigate the health sense records further. Staff to continue to respond to pendent and health sense calls in timely manner. Provide clutter free and well lit areas." A Fall follow up note dated 8/17/2017 was reviewed. The note indicated C1 had told the nurse that she had some pain, but was unable to specify where. C1 had difficulty swallowing water and was unable to take medications, but later, at meals, was able to swallow liquids. C1's vital signs were stable and within her baseline, speech was baseline, and C1's grasps were equal. However, C1's ability to bear weight was inconsistent, ranging from not at all to attempting to self-transfer. C1 had significant difficulty pivoting. C1's x-rays indicated no fractures. C1 had a 1 x 1.5 cm bruise over the right scapula, and two small bruises to the right of the coccyx that are each less than 1 cm in size. Morphine had been ordered for C1, but C1's family had asked not to use it, so Tylenol had been given, which was effective when C1 was at rest. C1 continued to have pain when bearing weight. The note indicated staff were to answer C1's call light in a prompt manner, anticipate C1's needs, keep frequently used items near C1's bedside, staff to	0 865		

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0 865	Continued From page 13 make sure sheets are properly made before C1 got into bed, perform protocol 3:00 am safety rounds on all clients, and keep client's light on above the kitchen sink at night. A Progress note dated 8/19/2017 was reviewed. The note indicated, "Care attendants reported to the nurse that the resident has been having pain this morning, especially when transferring. Pain at the time appeared to be in the right knee.....placed cold compress over the knee. Later in the day, care attendants reported that the resident was in a lot of pain in the legs bilaterally while transferring and screamed and would say "ow" when the care attendants tried taking off her socks. Nurse instructed them to give her PRN Tylenol and ice and elevate the legs." A Progress note dated 8/21/2017 was reviewed; the note was titled Fall investigation and indicated that no environmental factors contributed to the fall. Resident factors included- use of assistive devices, history of falls, gait/balance disorder, impaired cognition diagnosis, impaired decision making, and resistive to cares. Medical factors- Predisposing medical condition, pain/discomfort, bladder dysfunction and takes four or more medications. Resident follow up- Nursing assessment/evaluation, level of care change, documentation on client service notes, fall risk assessment, vulnerability assessment, referred to community exercise program, recommended increase in level of care. Environmental modifications-none needed. Wheelchair added due to unsteady gait and inability to follow instructions to use walker. Fall reduction interventions, items of need within reach, staff assistance with ADL's. Wear shoes/non-skid slippers/non-skid socks at all times while out of bed. Health Sense monitoring/ increased	0 865		

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0 865	Continued From page 14 monitoring. Encourage community exercise program. Encourage hydration. Remove clutter, rugs. Provide lighting/night light, educate family/client on environment safety. Referred to safety and QA committees. Safety checks added at 11:15 p.m. and 3:00 a.m. Wording for safety check also modified to state "make sure to comment on the resident's status. Will continue to reiterate importance of increasing level of care to daughter. Staff to respond to out of bed calls promptly, check on resident before accepting/canceling call. The cancel button for the alarm was moved to inside C1's room, beside her bathroom door. A Progress note dated 8/23/2017 was reviewed. The note indicated that C1 required toileting assistance every 2-3 hours and required the assistance of 2 staff. A chair sensor was added as C1 was then using a wheelchair for transport. A Progress note dated 8/24/2017 was reviewed. The note indicated C1 was assisted by three staff that day when transferring from the bed to the wheelchair. C1 complained of pain in bilateral legs up to thigh/hip area with gentle touch, and screamed out in pain during ADL's and transfers. The client also needed assistance eating. A Progress note dated 8/24/2017 was reviewed and indicated physical therapy completed an evaluation of C1., Visit from PT today for transfer training and fall prevention. The note indicated that PT completed an evaluation. Physical therapy staff indicated C1 was guarding her right leg significantly, and based on ability that day, would benefit from Hoyer transfer. A Progress note dated 8/26/2017 10:20 a.m. was reviewed. The note indicated C1's daughter was	0 865		

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0 865	Continued From page 15 present for C1's morning transfer from bed, and was greatly worried about the level of pain C1 was still experiencing. C1 had received two doses of gabapentin with no signs of relief. Staff reported that C1's pain generally occurred with transfers in bed, applying shoes and socks and during Hoyer lift. A Progress note dated 8/26//201712:48 p.m. was reviewed. The note indicated that the physician group had responded to C1's daughter's request to have C1 seen in the ER, and agreed to have C1 sent to the emergency room for evaluation. A Progress note dated 8/28/20175:09 p.m. was reviewed. The note indicated that C1's daughter called and notified the home care provider that C1 would not be coming back to the facility, as C1 required a higher level of care. An Emergency Room Note, titled Final Impression/Plan and dated 8/26/2017, indicated C1 presented for ongoing right leg pain after a fall two weeks prior, where C1 was found after laying on the ground all night. C1 had been unable to ambulate since the fall but prior to it was ambulatory with walker. A CT scan of the hip did not show any acute fracture. X-ray of humerus and tibula and fibula were atraumatic. C1 continued to have severe pain with movement, but with no apparent bony injury; it was assessed as likely muscular pain. C1 was noted to have fairly advanced dementia. Urinalysis appeared consistent with UTI. Urine culture was ordered and intravenous antibiotics were ordered. During an interview on 9/26/2017 at 3:05 p.m., Registered Nurse (RN)-A stated RN-A contacted the alarm company, and the alarm company reported that the last alarm for C1 was a bed	0 865		

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0 865	Continued From page 16 alarm at 11:00 p.m. on 8/15/2017. The alarm company confirmed that the alarm system (bed alarm) was working for C1's system. RN-A said that she was called to C1's room after C1 was found on the floor. RN-A said that C1 was assisted to her bed and that C1's physician and family member was notified of the situation. The decision was made to have x-rays and lab work done at the facility rather than send to the emergency room. The x-rays were negative for any fractures. Prior to the fall and being on the floor for 10 hours, C1 ambulated with the assistance of a walker. RN-A said that they attempted to use an EZ-Stand with C1 after the incident on 8/15/2017, however C1 could not follow directions due to the advanced level of dementia. The facility then started utilizing a Hoyer lift to transfer C1 from bed to a wheelchair and back. RN-A reported that after the fall, C1 had pain in her legs all the time and the pain increased when C1 was transferred. The nurse practitioner encouraged the family to send the resident to the emergency room for further testing due to the continued pain and the limitations of the testing at the facility. The family agreed to send to the emergency room on 8/26/2016. During an interview on 9/26/2017 at 2:10 p.m., Resident Assistant (RA)-B stated RA-B found C1 on the floor in C1's apartment at 8:45 a.m. on 8/16/2017. RA-B said that she would typically get into C1's room between 7:30 and 8:30 a.m. but the unit was short staffed that morning so she was late. RA-B had not received any calls indicating that C1 was out of bed or had pushed the call button. RA-B found C1 on the floor, next to the bed, facing the bathroom door with her back and bottom on the floor. C1's shoulders and head were resting on the metal frame of the bed and C1's legs were straight out towards the	0 865		

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0 865	Continued From page 17 bathroom. RA-B said that C1 was awake, denied pain at first, until she was moved. RA-B said she did not move the resident, she called RN-A. RN-A came in and assessed C1, and with the help of a third staff member they moved C1 to a chair. C1 reported a lot of pain in her legs with the movement and C1 could not bear weight when standing. RA-B said that the bed sensor is automatically re-loaded when C1 gets back in bed. RA-B said that after the fall, C1 had a lot of pain during her cares, even simple activities of daily living cares. RA-B said that most of C1's pain was in her legs, her legs were very sensitive to touch and movement after the fall. During an interview on 9/27/2017 at 5:45 a.m., Resident Assistant (RA)-D stated RA-D did not get any out of bed calls on C1 on the 8/15/2017 to 8/16/2017 11:00 p.m. to 7:00 a.m. shift. RA-D said that she did not get any calls, so she did not go into C1's room. RA-D said that she did not go into C1's room except when there was an out of bed call. RA-D said that C1 did not have any safety checks. RA-D said she did not push the cancellation button next to C1's hallway door. RA-D did not look at the evening shift's phone that night and would only look at the phone she is assigned to. During an interview on 9/27/2017 at 6:10 a.m., Resident Assistant (RA)-E said that RA-E did not have any contact with C1 on the night shift of 8/15/2017 to 8/16/2017 11:00 p.m. to 7:00 a.m. RA-E knew C1 well, and described her as being independent prior to the fall. C1 could ambulate with the use of a walker and was considered a low fall risk prior to fall. RA-E was assigned a different group of clients and C1 would not have been a client that required the assistance of two.	0 865		

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