Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL31955029M
Compliance #: HL31955030C

Date Concluded: February 8, 2020

Name, Address, and County of Licensee Investigated:
Maple Hill Senior Living
3030 Southlawn Drive East
Maplewood, MN 55109
Ramsey County

Facility Type: Home Care Provider

Investigator's Name: Peggy Boeck, RN
Special Investigator

Finding: Substantiated, facility responsibility

Nature of Visit:
An investigator from the Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Allegation(s):
It is alleged: The facility neglected to supervise a client who had multiple falls. It is also alleged that the facility neglected to provide the client with clean sheets or the correct medications.

Investigative Findings and Conclusion:
Neglect was substantiated. The facility was responsible for the neglect. The client had a fall that resulted in a broken facial bone and required hospitalization. When the client returned from the hospital, a nurse assessed the client to be a high fall risk, but failed to implement fall prevention interventions because the client was on the memory care unit and received hourly checks.

The family noted one instance of dirty sheets on the client's bed, and it was inconclusive if that was an ongoing situation. The client's medication record did not indicate the client received incorrect medications.

The investigation included interviews with facility staff, including administrative staff, nursing staff, and unlicensed staff. In addition, the investigator contacted family. The investigator toured the facility, including the client's former room. The investigator observed staff performing cares, passing medications, staff to client interactions and client-to-client interactions. The investigator reviewed the client's record, call light reports, and facility policies regarding assessments, changes in condition, falls, medication management, service plans, and supervision of unlicensed personnel.

The client moved in to the facility's memory care unit due to diagnoses that included Alzheimer's disease and diabetes. The client received services from the home care provider that included assistance getting ready for bed, assistance getting up and ready in the morning, pain monitoring, reorientation, redirection, bathing, nursing assessments, housekeeping, laundry, medication administration, blood sugar checks, and safety checks (hourly).

At the time of admission, the nurse assessed the client and determined she was not a high fall risk.

One day the client had an unwitnessed fall in the bathroom, striking her face. Nursing sent the resident to the hospital where it was determined that the client had fractured the bone under her left eye. The client received pain medication and was hospitalized for several days.

When the client returned from the hospital, a nurse reassessed the client and determined she was a high fall risk and the client required the assistance of one staff for ambulation. The nurse did not change the client's service plan or provide staff with any fall prevention interventions.

Four days later the client had a fall resulting in a cut on the right side of her head. Later in the day, the client fell again. The client had scraped elbows and her head cut began to bleed again. Family was notified and they sent the client to the hospital. The cut on the client's head required staples to close and the client received pain medication. The client was admitted to the hospital.

During an interview, the nurse said that she did not add interventions to the client's service plan because the client lived on the memory care unit and received hourly safety checks.

During an interview an unlicensed personnel said that the staff did not usually get report from the previous shift staff, but would often find out later if a client had a fall.

During an interview another unlicensed personnel said that staff used an I-phone to get the information about cares for clients. The unlicensed personnel said the information came directly from the client's service plan.

During an interview, a family member said the client's falls were bad, the facility seemed short staffed, it took long for staff to respond to call lights, but the lack of cleanliness at the facility was the worst part of their experience.

In conclusion, neglect was substantiated.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"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

Vulnerable Adult interviewed: The client was deceased
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: N/A

Action taken by facility:
No action taken.

Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit: https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html, or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

The responsible party will be notified of their right to appeal the maltreatment finding.

cc: The Office of Ombudsman for Long-Term Care
Maplewood Police Department
Maplewood City Attorney
Ramsey County Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H31955	A. BUILDING: _____ B. WING _____	C 01/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HILL SENIOR LIVING	3030 SOUTH LAWN DRIVE MAPLEWOOD, MN 55109

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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, the Minnesota Department of Health issued a correction order(s) pursuant to a survey. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: On January 27, 2020, the Minnesota Department of Health initiated an investigation of complaint #HL31955030C/#HL31955029M and #HL31955032C/HL31955031M. At the time of the survey, there were 84 clients receiving services under the comprehensive license. The following correction orders are issued for #HL31955030C/#HL31955029M 0325, 0865, and 1080, and #HL31955032C/HL31955031M tag identification 0265, 0325, 0860.	0 000	The Minnesota Department of Health documents 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 requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. Per Minnesota Statute § 144A.474, Subd. 8(c), the home care provider must document any action taken to comply with the correction order. A copy of the provider's records documenting those actions may be requested for follow-up surveys. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider's Plan of Correction." The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144A.474, Subd. 11 (b).	
0 265 SS=G	144A.44, Subd. 1(2) Up-To-Date Plan/Accepted Standards Practice Subdivision 1. Statement of rights. (a) A person	0 265		

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0 265	Continued From page 1 who receives home care services has these rights: (2) receive care and services according to a suitable and up-to-date plan, and subject to accepted health care, medical or nursing standards and person-centered care, 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 to ensure the nursing standards and process was followed for one of one clients (C2) reviewed for falls. C2 had seven falls and the multiple licensed staff did not collected data, assess and analyze the data to identify problems, formulate goals and interventions, implement interventions, draw conclusions about the interventions, or modify C2's plan of care to reduce the risk of falls. This practice resulted in a level three 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 was issued at a 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: C2's medical record was reviewed. C2 moved in to the facility's memory care unit on July 16, 2018	0 265		

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0 265	Continued From page 2 due to diagnoses that included dementia, high blood pressure, and diabetes. C2's Fall Risk Assessment document dated April 22, 2019 indicated a total score of 10, and indicated that a total score of 10 or above represented a high risk (for falls). C2's service plan dated September 13, 2019 indicated C2 received services from the home care provider that included dressing, grooming, orientation, reminders to use pendant, hourly safety checks, stand by assistance for bathing, nursing assessments, reminders to use walker, vital signs, housekeeping, laundry, medication administration, escorts to meals, and toileting every two hours. C2's progress note by the director of nursing (DON)-B dated October 26, 2019 at 7:12 p.m. indicated that C2 had a fall on October 23, 2019 with a resulting bruise on C2's right arm. C2's progress note by DON-B dated October 27, 2019 at 9:41 a.m. indicated that staff found C2 on the floor after a fall which resulted in bleeding skin tears on C2's back and arm. The licensee called 911 but C2 declined to go to the emergency room. Staff cleansed the skin tears and left them open to air. C2's incident report reviewed by registered nurse (RN)-A dated November 11, 2019 at 1:25 a.m., indicated staff found C2 on the floor in his room after a fall. C2 had a skin tear on his right elbow. The incident report indicated interventions implemented were (previously implemented in C2's service plan) hourly safety checks for memory care clients.	0 265		

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0 265	Continued From page 3 C2's incident report reviewed by RN-A dated November 24, 2019 at 10:32 a.m. indicated staff found C2 sitting on the floor in front of his bed after a fall. C2 complained of back pain. The incident report indicated interventions implemented were (previously implemented in C2's service plan) hourly safety checks. C2's progress note by DON-B dated December 7, 2019 at 7:03 p.m. indicated staff found C2 on the floor, bleeding from his head. Staff called 911, C2 went to the hospital, and received staples to close the cut on the back of his head. C2 returned to the facility the same evening. C2's progress note by a licensed practical nurse dated December 21, 2019 at 4:43 p.m. indicated staff found C2 on the floor after falls two times during the night shift. The progress note indicated C2 had bleeding from the scalp and heels after the first fall and right shoulder pain after the second fall. C2's progress note by RN-A dated December 23, 2019 at 1:54 p.m. indicated registered nurse RN-A reviewed C2's services on December 11, 2019 and made no changes to the service plan. C2's medical record did not reflect nursing standards to reduce the risk of falls by collecting data, assess and analyze the data to identify problems, formulate goals and interventions, implement interventions, draw conclusions about the interventions, or modify C2's plan of care to reduce the risk of falls. During an interview on January 27, 2020 at 1:53 p.m., RN-A stated that she did not reassess C2 after his falls and did not add any new interventions for fall prevention. RN-A did not	0 265		

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0 265	Continued From page 4 state why. During an interview on January 27, 2020 at 3:56 p.m. DON-B stated that additional interventions should be in the service plan. DON-B stated that after a fall there should be some new interventions for staff to try. The Falls Policy and Procedure dated February 26, 2018 indicated the facility reported, assessed, documented, and investigated all fall occurrences. The policy further indicated the nurse was responsible for completing an investigation into the fall, developing a priority corrective action, and revising the client's service plan if required. TIME PERIOD FOR CORRECTION: Seven (7) days	0 265		
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 observations, interviews, and document review, the facility failed to ensure two of two clients reviewed (C1 and C2) was free from maltreatment. C1 and C2 were neglected.	0 325	No Plan of Correction (PoC) is required. Please refer to the public maltreatment reports for details.	

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0 325	Continued From page 5 Findings include: On February 8, 2020, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	0 325		
0 860 SS=G	144A.4791, Subd. 8 Comprehensive Assessment and Monitoring Subd. 8. Comprehensive assessment, monitoring, and reassessment. (a) When the services being provided are comprehensive home care services, an individualized initial assessment must be conducted in person by a registered nurse. When the services are provided by other licensed health professionals, the assessment must be conducted by the appropriate health professional. This initial assessment must be completed within five days after initiation of home care services. (b) Client monitoring and reassessment must be conducted in the client's home no more than 14 days after initiation of services. (c) Ongoing client monitoring and reassessment must be conducted as needed based on changes in the needs of the client and cannot exceed 90 days from the last date of the assessment. The monitoring and reassessment may be conducted at the client's residence or through the utilization of	0 860		

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0 860	Continued From page 6 telecommunication methods based on practice standards that meet the individual client's needs. This MN Requirement is not met as evidenced by: Based on interview and document review the licensee failed to reassess one of one clients (C2) reviewed for falls. C2 had a change in needs when C2 had repeated falls with injuries requiring hospitalization. This practice resulted in a level three 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 was issued at a 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: C2's medical record was reviewed. C2 moved in to the memory care unit on July 16, 2018 due to diagnoses that included dementia, high blood pressure, and diabetes. C2's Fall Risk Assessment document dated April 22, 2019 indicated a total score of 10, and indicated that a total score of 10 or above represented a high risk (for falls). C2's service plan dated September 13, 2019 indicated the client received services from the home care provider that included dressing, grooming, orientation, reminders to use pendant, hourly safety checks, stand by assistance for bathing, nursing assessments, reminders to use walker, vital signs, housekeeping, laundry,	0 860		

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0 860	Continued From page 7 medication administration, escorts to meals, and toileting every two hours. C2's progress note by the director of nursing (DON)-B dated October 26, 2019 at 7:12 p.m. indicated that C2 had a fall on October 23, 2019 with a resulting bruise on C2's right arm. C2's progress note by DON-B dated October 27, 2019 at 9:41 a.m. indicated that staff found C2 on the floor after a fall which resulted in bleeding skin tears on C2's back and arm. The licensee called 911 but C2 declined to go to the emergency room. Staff cleansed the skin tears and left them open to air. C2's incident report reviewed by registered nurse (RN)-A dated November 11, 2019 at 1:25 a.m., indicated staff found C2 on the floor in his room after a fall. C2 had a skin tear on his right elbow. The incident report indicated interventions implemented were implemented in C2's hourly safety checks for memory care clients. C2's incident report reviewed by RN-A dated November 24, 2019 at 10:32 a.m. indicated staff found C2 sitting on the floor in front of his bed after a fall. C2 complained of back pain. The incident report indicated interventions implemented were hourly safety checks. C2's progress note by DON-B dated December 7, 2019 at 7:03 p.m. indicated staff found C2 on the floor, bleeding from his head. Staff called 911, C2 went to the hospital, and received staples to close the cut on the back of his head. C2 returned to the facility the same evening. C2's progress note written by a licensed practical nurse dated December 21, 2019 at 4:43 p.m.	0 860		

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0 860	Continued From page 8 indicated staff found C2 on the floor after falls two times during the night shift. The progress note indicated C2 had bleeding from the scalp and heels after the first fall and right shoulder pain after the second fall. C2's progress note written by RN-A dated December 23, 2019 at 1:54 p.m. indicated RN-A reviewed C2's services on December 11, 2019 and made no changes to the service plan. C2's medical record did not reflect a reassessment after repeated falls or hospitalization. During an interview on January 27, 2020 at 1:53 p.m., RN-A stated that she did not assess C2 after his falls and did not add any new interventions for falls prevention. RN-A did not state why. During an interview on January 27, 2020 at 3:56 p.m. DON-B stated that additional interventions should be in the service plan. DON-B stated that after a fall there should be some new interventions for staff to try. The Change in Condition policy dated July 1, 2019 indicated falls with injury constituted a change in condition. The policy indicated a reassessment included a clinical review of the client, a determination if a change in services was required, a determination if care plan or assessment needed, and any clinical interventions that needed to be implemented. The Assessment policy dated July 30, 2019 indicated a registered nurse conducted an assessment when a client had a change in condition.	0 860		

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0 860	Continued From page 9 TIME PERIOD FOR CORRECTION: Seven (7) days	0 860		
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 applicable.	0 865		

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0 865	Continued From page 10 (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 licensee failed to ensure revisions to a service plan were added for one of one clients (C1) reviewed for falls. C1 had falls with injuries requiring an emergency room visit and the nurse assessed C1 as needing the assistance of one staff for ambulation to reduce the risk of falls. C1's service plan was not updated to reflect the need in services. This practice resulted in a level three 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 was issued at a 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 Fall Risk Assessment document dated April 6, 2019 indicated a score of 6 (not a high risk for falls), and indicated that a total score of 10 or above represented a high risk (for falls). C1 moved into the memory care unit on April 13, 2019 due to diagnoses that included Alzheimer's disease, type two diabetes, heart failure, and kidney disease. C1's service plan dated April 26, 2019 indicated C1 received services from the home care	0 865		

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0 865	Continued From page 11 provider that included assistance getting ready for bed, assistance getting up and ready in the morning, pain monitoring, reorientation, redirection, bathing, nursing assessments, housekeeping, laundry, medication administration, blood sugar checks, and hourly safety checks. C1's progress note dated August 5, 2019 indicated C1 had an unwitnessed fall in her bathroom with a large bruise on her head, the licensee sent C1 to the emergency room. C1's hospital records dated August 5, 2019 indicated C1 had a fractured left orbit (the bone under the eye) and a large bruise on her face. C1 received morphine for pain and the hospital admitted her. The hospital discharge documentation indicated C1 required increased level of cares and a consultation to maxillofacial surgery in seven to ten days. C1 discharged from the hospital back to the facility on August 7, 2019. C1's Fall Risk Assessment document dated August 7, 2019 indicated a total score of 14, and indicated that a total score of 10 or above represented a high risk (for falls). The second page of the form indicated, "If a client scored a 10 or above, interventions should be initiated. Document interventions below and on the client's care plan. Client should be informed of the risk/benefit associated with each intervention." The second page was blank. The licensee did not update C1's service agreement with interventions to prevent falls. C1's RN Re-Evaluation/Re-Assessment document by registered nurse (RN)-A dated August 7, 2019 indicated C1 returned from the hospital. The form indicated C1 was a high fall	0 865		

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	H31955	A. BUILDING: _____ B. WING _____	C 01/27/2020

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0 865	Continued From page 12 risk, unsteady on her feet, and required the assistance of one staff for ambulation. C1's service plan was not updated to reflect additional service of one staff assistance for ambulation. C1's hospital record dated August 11, 2019 indicated C1 presented to the hospital after a fall. The record indicated C1 had fallen in the morning, resulting in a cut to C1's head, and then fell again in the afternoon resulting in abrasions to both elbows. C1 had a two centimeter cut on the right side of her scalp. The physician placed staples to close the cut and ordered Tylenol for pain. The record indicated the hospital admitted C1 and she did not return to the facility. During an interview on January 27, 2020 at 10:30 a.m., unlicensed personnel (ULP)-G stated the staff use an i-phone to get the list of services required for each client. ULP-G stated the services information came directly from the service plan. During an interview on January 27, 2020 at 1:53 p.m., RN-A stated that she assessed C1 on August 7, 2019 after she returned from the hospital after a fall. RN-A stated that C1's score of 14 indicated C1's fall risk was high. RN-A stated that she did not add any interventions to C1's service plan for falls prevention because C1 was on the memory care unit and received hourly safety checks. During an interview on January 27, 2020 at 3:56 p.m. director of nursing (DON)-B stated that additional interventions should be in the service plan. DON-B stated that after a fall there should be some new interventions for staff to try.	0 865		

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0 865	Continued From page 13 The Falls Policy and Procedure dated February 26, 2018 indicated the facility reported, assessed, documented, and investigated all fall occurrences. The policy further indicated the nurse was responsible for completing an investigation into the fall, developing a priority corrective action, and revising the client's service plan if required. The Service Plans policy dated July 10, 2017 indicated the service plan must be revised, if needed, based on the results of required client monitoring and/or reassessments. TIME PERIOD FOR CORRECTION: Seven (7) days	0 865		
01080 SS=D	144A.4794, Subd. 3 Contents of Client Record Subd. 3. Contents of client record. Contents of a client record include the following for each client: (1) identifying information, including the client's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of an emergency contact, family members, client's representative, if any, or others as identified; (3) names, addresses, and telephone numbers of the client's health and medical service providers and other home care providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) client's advance directives, if any;	01080		

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01080	Continued From page 14 (6) the home care provider's current and previous assessments and service plans; (7) all records of communications pertinent to the client's home care services; (8) documentation of significant changes in the client's status and actions taken in response to the needs of the client including reporting to the appropriate supervisor or health care professional; (9) documentation of incidents involving the client and actions taken in response to the needs of the client including reporting to the appropriate supervisor or health care professional; (10) documentation that services have been provided as identified in the service plan; (11) documentation that the client has received and reviewed the home care bill of rights; (12) documentation that the client has been provided the statement of disclosure on limitations of services under section 144A.4791, subdivision 3; (13) documentation of complaints received and resolution; (14) discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the client's services or status. This MN Requirement is not met as evidenced by: Based on interview and document review the licensee failed to ensure adequate health information was included in the record for one of one client records (C1) reviewed for contents of the client record. C1's medical record did not include documentation from C1's return from the	01080		

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01080	Continued From page 15 hospital after a fall, documentation of a fall with injury that occurred four days later, or documentation of a second fall with injury that occurred, which resulted in C1's return to the hospital. 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 Fall Risk Assessment document dated April 6, 2019 indicated a score of six (not a high risk for falls), and indicated that a total score of 10 or above represented a high risk (for falls). C1 moved into the memory care unit on April 13, 2019 due to diagnoses that included Alzheimer's disease, type two diabetes, heart failure, and kidney disease. C1's service plan dated April 26, 2019 indicated C1 received services from the home care provider that included assistance getting ready for bed, assistance getting up and ready in the morning, pain monitoring, reorientation, redirection, bathing, nursing assessments, housekeeping, laundry, medication administration, blood sugar checks, and hourly safety checks. C1's progress note dated August 5, 2019 indicated C1 had an unwitnessed fall in her bathroom with a large bruise on her head, the	01080		

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01080	Continued From page 16 licensee sent C1 to the emergency room. C1's hospital records dated August 5, 2019 indicated C1 had a fractured left orbit (the bone under the eye) and a large bruise on the left side of her face. C1 received morphine for pain and the hospital admitted her. The hospital registered nurse discharge documentation indicated C1 required increased level of cares and a consultation to maxillofacial surgery in seven to ten days. C1 discharged from the hospital to the facility on August 7, 2019. C1's record lacked documentation in progress notes of C1's return from the hospital after the fall incident on August 5, 2019, any follow-up for the fractured bone, pain monitoring, or changes in services provided for falls prevention. C1's RN Re-evaluation/Re-assessment form by registered nurse (RN)-A dated August 7, 2019 indicated C1 was a high fall risk, C1 was unsteady on her feet, and C1 required assist of one staff for ambulation. C1's service plan was not changed. Emergency Medical Services (EMS) report dated August 11, 2019, indicated that EMS arrived at the facility at 16:04 (4:04 p.m.) for a report of multiple falls. The report indicated C1 was bleeding from a laceration on her head. The report indicated staff (unnamed) told EMS personnel that C1 had a fall in the morning (unknown time, unknown if witnessed) resulting in a laceration on C1's head above the hairline. The report indicated a second fall (unknown time, unknown if witnessed) resulted in abrasions on both of C1's elbows, which staff had bandaged. C1's record lacked documentation of C1's two	01080		

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01080	Continued From page 17 falls on August 11, 2019 in progress notes or in incident reports. C1's hospital record dated August 11, 2019 indicated C1 presented to the hospital after a fall. The record indicated C1 had fallen in the morning, resulting in a cut to C1's head, and then fell again in the afternoon resulting in abrasions to both elbows. C1 had a 2 centimeter cut on the right side of her scalp. The physician placed staples to close the cut and ordered Tylenol for pain. The record indicated the physician admitted C1 to the hospital for monitoring and that C1 was also dehydrated. During an interview on January 27, 2020 at 3:56 p.m. director of nursing (DON)-B stated the staff did not document in C1's chart when C1 returned and did not document the two subsequent falls. DON-B confirmed that no staff wrote an incident report. DON-B stated if the information was not in the electronic health record it was not documented, and she did not know why staff did not document the incidents involving C1. The Falls policy dated February 26, 2018 indicated when a client fell the staff were responsible for documenting specifics of the fall and to complete an accident report. The policy further directed the nurse to complete an investigation into the fall, develop a corrective action, and revise the client's service plan if required. TIME PERIOD FOR CORRECTION: SEVEN (7) DAYS	01080		