Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL33432005M
Compliance #: HL33432006C

Date Concluded: December 10, 2019

Name, Address, and County of Licensee Investigated:
Springbrook Village
1384 County Road 25
La Crescent, MN 55947
Houston County

Facility Type: Home Care Provider

Investigator's Name: Casey DeVries, RN
Special Investigator

Finding: Substantiated, facility responsibility

Nature of Visit:
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: A client was neglected when the client fell and facility staff failed to conduct scheduled services including safety checks, which resulted in the client remaining on the floor for approximately seven hours.

Investigative Findings and Conclusion:
Neglect was substantiated. The facility was responsible for the maltreatment. The client fell during nighttime hours and remained on the floor for approximately eight hours with no assistance from staff, although the client's service plan indicating the client required safety checks every two hours and the facility staff documented these safety checks as completed. Additionally, the facility had failed to follow up on or assess the client after the client had a similar incident two weeks prior.

The investigation included interviews with facility staff, including administrative staff, nursing staff, and unlicensed staff. The investigation included on-site observation of client care, and review of facility documents such as client medical records, incident reports, grievances,

vulnerable adult reports, staffing schedules, personnel records, 24-hour call light response report, and policies and procedures.

The client was admitted to the facility with a diagnosis of Alzheimer's disease. The client's service agreement indicated the client received comprehensive home care services, which included bathing, dressing, grooming, mediation administration, safety checks, toileting, and meal escorts. The client resided in a secured memory care unit.

A facility incident report indicated the client's family member discovered, while monitoring surveillance video from the client's room, that the client had fallen two days prior to the completion of the incident report at approximately 11:00 p.m., and had remained on the floor for over seven hours. A report to the state agency regarding the incident identified alleged perpetrator (AP1) as having been responsible for the client that night.

During an interview, AP1 stated the facility's former director of nursing (DON) originally had disciplined her for the incident. AP1 stated she later pointed out to the DON that the facility scheduled her at 3:00 a.m., so she was not working until after the fall occurred, and her assignment that night did not include the client's unit. AP1 stated that she later learned that the facility identified her as an alleged perpetrator because her initials were on the client's record from when she worked in the client's unit the night prior. AP1 stated the documentation from the night before was incorrect, because all cares documented with her initials took place at exactly 12:00 a.m., despite AP1 not having been in the building until approximately 3:00 a.m. on either night. AP1 was unaware of how that incorrect documentation could have occurred.

Facility records supported AP1's account that the facility scheduled AP1 to begin work at 3:00 a.m. and that AP1 clocked in at 2:45 a.m. Further, the facility assigned AP1 to work in a different unit than where the client resided. The client's record did not identify AP1's initials as the staff member who documented the client's cares for the night of the fall.

A facility internal investigation indicated the name of a different alleged perpetrator (AP2), as the staff member responsible for the client's services during that shift. The facility documented that AP2 reported the client had slept all night and denied the possibility that the client was on the floor. The internal investigation indicated the staff person who worked the following morning said she met the client, seated in her recliner, for morning cares.

During an interview, AP2 denied that the facility had talked to her about an incident with the client. AP2 stated she could not recall that night and it was possible she and another staff member could have traded units, which was a common occurrence at the facility. AP2 stated she no longer works at the facility.

Review of the client's record indicated that a third staff member, also not assigned to the client's unit, had initialed that she provided hourly cares to the client from 1:00 a.m. to 6:00 a.m. on the night of the fall. The facility documented in the internal investigation they had

counseled that staff member for improper documentation. Additionally, that staff member's initials were located within the records of four other clients, also not assigned to her that night, who resided in the client's unit as well.

During an interview, the third staff member stated that she recalled the night of the incident, had not worked on the client's unit, and had not completed any documentation for clients on the unit. The staff member stated management disciplined her for documenting on clients that she did not provide care for, which she questioned because it did not make sense to her that she would have charted for clients in an area where she did not work.

The investigator reviewed client records from the unit where the third staff member stated she did work the night of the incident. The records indicated the staff member initialed the documentation for all of those clients at exactly 12:00 a.m.

After having it brought to their attention that there were multiple client records indicating simultaneous documentation at exactly midnight, the facility explained that upon further inquiry with their electronic records management system and with staff, they discovered those records had been batch filled in, at a later date, by office personnel. The facility stated the office personnel indicated the former DON instructed her to do so, and that she believed it was correct to fill in any missed documentation with the initials of the individuals who the facility had assigned, if those individuals neglected to document at the time of service.

Due to this discrepancy of documentation, in addition to conflicting staff interviews, the investigator was not able to determine what individual staff member was responsible for the client on the night of the incident.

The investigator reviewed a previous report to the state agency, which indicated that a similar incident with the client had occurred two weeks prior when the client fell from her bed, and remained on the floor for three hours. That report identified an alleged perpetrator (AP3) as having been responsible. The facility did not maintain an incident report for that fall, and the client's record did not reflect any information related to the fall.

During an interview, AP3 stated that he had found the client on the floor during a routine safety check, and after ensuring she was ok, assisted her back to bed. AP3 stated although the client had a scheduled safety check at 1:00 a.m., it was his understanding that all clients in the memory care unit received safety checks every two hours, and he was oriented to conduct those safety checks during "rounds", which occurred for all clients in succession of one another despite specific times assigned on service plans. AP3 stated after the fall, the client was able to tell him that she was uninjured and that she had wanted to go back to bed. AP3 stated he assisted the client to bed, but did not fill out an incident report form because he did not receive training to do so. AP3 stated until recently, the facility usually scheduled a nurse on the overnight shift who would respond to incidents and fill out incident reports. AP3 stated the facility later terminated him for failing to fill out the incident report form. AP3's personnel

record reflected that the facility terminated him for failure to follow the care plan, falsifying records, and for putting the client at a safety risk.

During an interview, the client's family member stated the family had installed a video surveillance system in the client's room and that family members took turns monitoring the video daily. A family member stated the video from the first fall showed the client had fallen out of bed at 12:32 a.m., and that the staff member had found and assisted the client back to bed at 3:03 a.m. The video from the second fall showed the client had fallen at approximately 11:00 p.m., and had remained on the floor until at least 7:15 a.m. The family member stated that neither fall resulted in injury to the client, but after the second fall, the client had remained on the floor all night crawling around and was trying to pull herself up on objects such as her dresser, which could have tipped over on top of her. The family member stated there was no video to indicate if anyone eventually found the client and assisted her or if the client was able to get up on her own because the video stopped recording at 7:15 a.m., when the client unplugged the router. The family member stated she had met with facility management following both falls and expressed dissatisfaction related to staff's failure to conduct scheduled safety checks. The family member stated communication and lack of follow-through has been an ongoing concern, in addition to a lack of management's supervision of the direct care staff.

In addition to the falls two weeks apart from one another, the client's record indicated the client had two additional falls during the two preceding months. The client's record did not reflect nursing assessments related to the previous falls or implementation of any new fall prevention strategies in an effort to reduce future falls or risk for injury. Further, staffing and client records reflected discrepancies of who was responsible for the client during the time of the fall when the client had remained on the floor for over eight hours.

In conclusion, neglect did not occur during the fall that involved AP3. Although the staff member was late in conducting the two-hour safety check, there was evidence the client had otherwise received her contracted services during that night. Although the services did not occur at the time the service plan indicated, this incident alone did not constitute neglect.

Neglect was substantiated related to the fall two weeks later, which resulted in the client remaining on the floor for at least eight hours and fifteen minutes. Staff failed to perform contracted services to the client, which included safety checks every two hours at 11:00 p.m., 1:00 a.m., 3:00 a.m., 5:00 a.m., and toileting at 4:00 a.m., and 6:00 a.m. The facility was responsible for the neglect. Although the facility was aware of the similar event two weeks prior, there was no evidence that any re-training had occurred with the remaining direct care staff until after the second fall. Further, the client's record did not reflect any nurse follow up or effort to decrease the risk for future falls or injury in a similar event. As a result, there was a failure to provide the assessments prior, and the services during the night of the incident, that were essential for the client's health, safety, and comfort.

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: No
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility terminate AP2 and AP3's employment.
The facility updated policies and procedures related to falls, safety checks, and when to notify the nurse. The facility conducted staff trainings on vulnerable adults, safety checks, fall protocol, and documentation.

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
Houston County Attorney
La Crescent City Attorney
La Crescent Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H33432	A. BUILDING: _____ B. WING _____	C 11/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGBROOK VILLAGE OF LA CRESCENT L	1384 COUNTY ROAD 25 LA CRESCENT, MN 55947

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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 October 22, 2019, the Minnesota Department of Health initiated an investigation of complaint #HL33432003C/#HL33432004M, #HL33432006C/HL33432005M, and #HL33432008C/HL33432007M. At the time of the survey, there were #72 clients receiving services under the comprehensive license. The following immediate correction order is issued. Correction orders with a period to correct that are not immediate may be issued at a later date during the investigation. The following immediate correction order is issued for #HL33432003C/#HL33432004M, #HL33432006C/HL33432005M, and #HL33432008C/HL33432007M, tag identification 0840.	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).	

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0 840	Continued From page 1	0 840		
0 840 SS=I	144A.4791, Subd. 4 Acceptance of Clients Subd. 4. Acceptance of clients. No home care provider may accept a person as a client unless the home care provider has staff, sufficient in qualifications, competency, and numbers, to adequately provide the services agreed to in the service plan and that are within the provider's scope of practice. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to have staff sufficient in numbers to provide the services and supervision agrred to on the service plans for thirteen of thirteen clients reviewed on memory care unit one, when the unit was without a staff member from 5:00 a.m. to 7:00 a.m. Essential services that were not provided to the clients during that time included scheduled and unscheduled safety checks and scheduled and unscheduled toileting assistance, causing the potential for serious injury. 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 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the clients). The findings include: During an interview on October 31, 2019 at 3:10 p.m., unlicensed personnel (ULP)-A stated she	0 840		

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0 840	Continued From page 2 had recently worked during an overnight shift when one staff member called in as unable to work, leaving two staff for the entire building. ULP-A stated that one staff member was scheduled to work until 3:00 a.m., and another was scheduled to come in at 3:00 a.m., but that person called in as unable to work. ULP-A stated the departing staff member called the registered nurse (RN)-U to inform her of the situation, however RN-U did not assist with staffing support, and as a result, memory care unit one was left unattended from 5:00 a.m. to 7:00 a.m. ULP-A stated she and ULP-K were too busy with assigned tasks on different units to assist the clients on memory care unit one. During an interview on November 1, 2019 at 3:11 p.m., ULP-K stated she worked the overnight shift on October 27, 2019 into October 28, 2019 with ULP-A and ULP-S. ULP-K stated ULP-S was on the schedule until 3:00 a.m., and that another ULP was scheduled to come in at 3:00 a.m., but called in. ULP-K stated that ULP-S called the on-call nurse, RN-U, but RN-U did not assist to provide additional staffing and did not come to the building to provide support. ULP-K stated that she and ULP-A were not able to assist with any client cares in memory care unit one during the hours of 5:00 a.m. to 7:00 a.m. due to scheduled duties in other units. ULP-K stated she only had time to walk through memory care unit one at approximately 5:30 a.m., just to make sure clients were not on the floor. ULP-K stated the nurse who took the original call from staff that night is not a nurse who works in the building, and that she does not know anything about the facility's residents. ULP-K estimated there have been four times in the past three weeks that staffing has been a concern and nursing has not	0 840		

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0 840	Continued From page 3 been of any assistance. During an interview on November 1, 2019 at 3:45 p.m., ULP-S stated she worked the overnight shift on October 27, 2019 into October 28, 2019 with ULP-A and ULP-K. ULP-S stated her work schedule ends at 3:00 a.m. due to her school schedule. ULP-S stated she learned of the call in at approximately 11:00 p.m. on October 27, 2019 and in an attempt to be pro-active, immediately called the on-call nurse to inform her of the situation. ULP-S stated she initially called the nurse listed as on-call, whom she had never met. ULP-S stated that nurse informed her that she was not familiar with the building's policy so to call a different nurse. ULP-S stated she then attempted to call licensed practical nurse (LPN)-H, however, LPN-H did not have an on-call phone since the first nurse had been designated as the on-call. ULP-S stated she then called RN-U whose response was that the ULP who called in should show up. ULP-S stated that she asked RN-U what to do if that ULP did not show up, and RN-U stated that the ULP-A and ULP-K would have to cover all three floors. ULP-S stated that she asked RN-U if she should call back if the ULP who called in did not show up and that RN-U responded no, that ULP-S could leave and the plan would remain for ULP-A and ULP-K to cover the entire building. During an interview on November 4, 2019 at 12:13 p.m., executive director (ED)-V stated she was aware that a staff called in on the overnight shift October 27 into October 28, 2019; however, she was not aware at the time it occurred. ED-V stated the facility has a policy in place that the direct care staff are to attempt to find their own replacement to cover shifts, and if after	0 840		

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0 840	Continued From page 4 contacting five additional staff members, they are unable, management will assist to make calls. ED-V stated if nobody is available to cover the shift, the off-going staff member should be mandated to stay. ED-V stated despite the facility's standard of not having less than three staff in the building for an overnight shift, although not ideal, she considered memory care unit one staffed because there were staff in the building. ED-V stated that in general, the clients in memory care unit one were vulnerable. Email correspondence with ED-V on November 4, 2019 at 1:52 p.m., indicated following the situation that occurred on October 27-28, 2019, ED-V ensured that the new hold over calendar was in place for the following weekend, in addition to ensuring that nurses had the personal numbers for two scheduling/care coordinators, who would come in at the direction of a nurse. Licensee's policy titled, "Call In Procedures-All Staff", dated February 6, 2019 indicated that in the event of an employee call in, staff must allow at least a four hour window to alert the building, and the medication passer would need to assist in replacing the shift. If unable to find a replacement, the lowest seniority direct care staff currently working would stay up to four hours. The policy further indicated if it is decided the shift will run short staffed, direct care staff will be re-assigned in order to cover for the missing staff person. TIME PERIOD FOR CORRECTION: Immediate	0 840		

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0 325	Continued From page 1	0 325		
0 325 SS=G	144A.44, Subd. 1(14) Free From Maltreatment Subdivision 1. Statement of rights. A person who receives home care services has these rights: (14) the right to be free from physical and verbal abuse, neglect, financial exploitation, and all forms 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 one of three clients reviewed (C3) was free from maltreatment (neglect) when the client sustained four falls in three months. The registered nurse failed to re-evaluate the client after the falls to assess for causal factors or implement fall prevention interventionsor other attempts to decrease the risk of further falls and injury. Additionally, the licensee failed to ensure C3 was free from maltreatment (neglect) when unlicensed personnel failed to perform scheduled safety checks or toileting during an overnight shift. The client fell and remained on the floor without staff's assistance for over eight hours. 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 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).	0 325		

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0 325	Continued From page 2 The findings include: C3's medical record was reviewed. C3's diagnosis included Alzheimer's disease. C3's service plan dated September 28, 2019 indicated C3 received services from the comprehensive home care provider for bathing, dressing, grooming, medication administration, toileting assistance ten times daily and as needed, meal escorts, and safety checks every two hours. C3's assessment titled, "Abuse Prevention Plan: Vulnerability and Safety Assessment" dated February 7, 2019, indicated C3 was confused and disoriented and required a locked unit with safety checks every two hours. C3's assessment dated June 19, 2019 indicated the licensee increased C3's services from partial assist to full assist with showering and dressing. The assessment indicated C3 had a previous fall from her recliner while asleep on May 10, 2019. C3 sustained abrasions to her forehead and shoulder and was evaluated in the emergency department. The assessment indicated C3 used a four-wheeled walker but was independent with transfers and ambulation, including getting in and out of bed. The assessment indicated C3 had urinary incontinence and required assistance of one staff for toileting and/or continence care. The assessment indicated C3 had difficulty utilizing the facility's call system and required to have her needs met by her service plan. C3's fall risk portion of assessment dated June 19, 2019 indicated C3 was at high risk for falls related to age, history of falls in past six months resulting in injury, needing assistance with	0 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H33432	A. BUILDING: _____ B. WING _____	C 10/23/2019

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0 325	Continued From page 3 activities of daily living, depressed mood or medications for mood, four or more prescription medications, short term memory impairment, and urinary incontinence. The fall reduction plan was for staff to conduct every two-hour safety checks and assist C3 with activities of daily living, in addition to C3 having a pendant to alert staff if she needed assistance. C3's progress note dated July 10, 2019 indicated staff found C3 on the floor of her bedroom at 7:15 a.m. C3 was sitting up next to her bed. C3 was not wearing shoes or her glasses. The licensee did not maintain an incident report related to the fall. C3's record lacked evidence of a re-evaluation of C3 to assess for causal factors or implementation of fall prevention interventions in an attempt to decrease the risk of further falls and injury. A facility incident report dated August 30, 2019 indicated staff found C3 on the floor of her bedroom at 2:00 a.m. The report indicated C3 told staff that she slid out of bed while getting up to use the restroom. C3 was not wearing socks or shoes and her walker was located behind her. C3 did not page staff for help. The report indicated follow up and prevention included: * General: documentation in the resident service notes, education on safety, medication review, reminders, cues, redirection. * Environmental Modifications: trip hazards removed, walker and bed checked for safety. * Assistive Devices Added: none. * Fall Reduction Interventions Implemented: articles of need within easy reach, bed and furniture assessed for appropriateness, wife educated on surroundings. * Comments: no new injuries noted,	0 325		

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0 325	Continued From page 4 reminded resident to use call pendant for assistance. * Systems Follow-Up: staffing updates at shift huddles, educated tenant, reviewed service schedule, patterns, interventions, falls reviewed. C3's record lacked evidence of a re-evaluation of C3 following the fall to assess for causal factors or implementation of fall prevention interventions in an attempt to decrease the risk of further falls and injury. A report to the Minnesota Adult Abuse Reporting Center (MAARC) dated, September 16, 2019 at 1:05 p.m., indicated C3 fell in her apartment at 12:30 a.m. on September 15, 2019 and was not found until 3:30 a.m. C3's progress notes lacked an entry related to a fall on September 15, 2019, and C3's record lacked evidence of a re-evaluation of C3 to assess for causal factors or implementation of fall prevention interventions in an attempt to decrease the risk of further falls and injury. A Facility incident report dated September 28, 2019 indicated C3's family member discovered, while monitoring surveillance video from C3's room, that C3 had fallen at 11:00 p.m., and remained on the floor for over seven hours. A report to the Minnesota Adult Abuse Reporting Center (MAARC) dated September 30, 2019 at 5:04 p.m., indicated C3 fell in her apartment on September 28, 2019 and remained on the floor from 12:00 a.m., to 7:00 a.m. The report identified unlicensed personnel (ULP)-W as responsible for C3 that night.	0 325		

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0 325	Continued From page 5 During an interview on November 13, 2019 at 1:01 p.m., ULP-W stated the facility's former director of nursing (DON)-E originally held her responsible for the incident, and had disciplined her for it. ULP-W stated, at the time, the reason for the discipline was unclear to her, and that she later pointed out to DON-E that the facility scheduled her at 3:00 a.m., so she was not working until hours after the fall occurred. Furthermore, ULP-W stated her assignment that night did not include the client; ULP-W did not work on that unit during that shift. ULP-W stated that she later learned that the facility identified her as an alleged perpetrator because her initials were on C3's record from when she worked in C3's unit the night prior, which caused some confusion since the fall occurred on an overnight shift before midnight, but on the following day's overnight shift. ULP-W stated even the documentation from the night before was incorrect, because all cares documented with her initials took place at exactly 12:00 a.m., despite ULP-W not having been in the building until approximately 3:00 a.m. on that night either. ULP-W stated she was unaware of how that incorrect documentation could have occurred. Facility nursing schedule dated September 22, 2019 to September 29, 2019 indicated the facility scheduled ULP-W to work in the assisted living unit of the facility at 3:00 a.m. on September 28, 2019. Facility time card for ULP-W dated September 26, 2019 to September 30, 2019 indicated ULP-W clocked in for work at 2:45 a.m., on September 28, 2019. Facility's untitled internal investigation dated	0 325		

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0 325	Continued From page 6 October 4, 2019 indicated surveillance camera footage in C3's apartment revealed C3 fell at approximately 11:00 p.m. and remained on the floor until approximately 6:30 p.m., at which time, C3 pulled at a cord and disconnected the camera. The internal investigation indicated the name of a different unlicensed personnel (ULP)-G, as the staff member assigned to C3 and responsible for C3's services during that shift. The facility documented that when questioned by management, ULP-G reported C3 had slept all night and denied the possibility that C3 was on the floor. The internal investigation indicated the staff person who worked the following morning said she met C3, seated in her recliner, for morning cares. During an interview on November 8, 2019 at 10:04 a.m., ULP-G denied that the facility ever talked to her about an incident C3. ULP-G stated she could not recall that night and it was possible she and another staff member could have traded units, which was a common occurrence at the facility. ULP-G stated she no longer works at the facility. Document titled, "Service Checkoff List" dated September 2019 indicated areas for ULP's to document C3's "Safety Check: 2 Hour" at 1:00 a.m., 3:00 a.m., 5:00 a.m., 7:00 a.m., 9:00 a.m., 11:00 a.m., 1:00 p.m., 3:00 p.m., 5:00 p.m., 7:00 p.m., 9:00 p.m., and 11:00 p.m. The safety checks were initialed by ULP-A, who was not assigned to C3 at the time of the fall. Additionally, the document instructed staff to assist C3 with toileting at 4:00 a.m., and 6:00 a.m., which ULP-A also initialed as completed.	0 325		

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0 325	Continued From page 7 On October 22, 2019, registered nurse (RN)-U stated the facility's practice was for the nurse to conduct fall assessments upon admission, whenever a full assessment is done, or with a change of condition. RN-U stated otherwise, nurses only conduct an investigatory piece of information as part of the facility's incident reporting process. During an interview on October 31, 2019 at 3:10 p.m., ULP-A stated that she recalled the night of the incident, and that she had not worked on C3's unit. ULP-A denied that she had completed any documentation for C3 or any other clients on the unit. The staff member stated management disciplined her for documenting on clients that she did not provide care for, which she questioned because she had not worked in the unit and that it did not make sense to her that she would have charted for clients in an area where she did not work. During an interview on November 1, 2019, family member (FM)-C stated C3's family reviewed surveillance footage from the camera in C3's apartment, and discovered that on November 28, 2019, C3 fell from her bed at 11:00 p.m. and remained on the floor until at least 7:15 a.m., at which time C3 had unplugged the camera router, disconnecting the camera. FM-C stated C3 spent the night crawling around on the floor despite C3's contracted service with the licensee to conduct safety checks on C3 every two hours. Licensee policy titled, "Abuse and Neglect" dated December 27, 2017 indicated the purpose of the policy was to ensure clients remain free from abuse and neglect. The policy defined neglect as any action or inaction that might place a client in	0 325		

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0 325	Continued From page 8 a position that may cause physical or mental harm, including but not limited to, withholding nourishment, necessary hygiene, medication or other assistance.	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 telecommunication methods based on practice standards that meet the individual client's needs. This MN Requirement is not met as evidenced	0 860		

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0 860	Continued From page 9 by: Based on observation, interview, and record review, the licensee failed to reassess one of one clients (C3) following falls to evaluate for potential causal factors so interventions could be implemented to decrease the client's risk for further falls and potential injury. This practice resulted in a level three 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). The findings include: C3's medical record was reviewed. C3's diagnosis included Alzheimer's disease. C3's service plan dated September 15, 2019 indicated C3 received services from the comprehensive home care provider for bathing, dressing, grooming, medication administration, safety checks, toileting, and meal escorts. C3's assessment dated June 19, 2019 indicated the licensee increased C3's services from partial assist to full assist with showering and dressing. The assessment indicated C3 had a previous fall from her recliner while asleep on May 10, 2019. C3 sustained abrasions to her forehead and shoulder and was evaluated in the emergency department. The assessment indicated C3 used a four-wheeled walker but was independent with transfers and ambulation, including getting in and out of bed. The assessment indicated C3 had	0 860		

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0 860	Continued From page 10 urinary incontinence and required assistance of one staff for toileting and/or continence care. The assessment indicated C3 had difficulty utilizing the facility's call system and required to have her needs met by her service plan. C3's fall risk portion of assessment dated June 19, 2019 indicated C3 was at high risk for falls related to age, history of falls in past six months resulting in injury, needing assistance with activities of daily living, depressed mood or medications for mood, four or more prescription medications, short term memory impairment, and urinary incontinence. The fall reduction plan was for staff to conduct every two-hour safety checks and assist C3 with activities of daily living, in addition to C3 having a pendant to alert staff if she needed assistance. C3's progress note dated July 10, 2019 indicated staff found C3 on the floor of her bedroom at 7:15 a.m. C3 was sitting up next to her bed. C3 was not wearing shoes or her glasses. The licensee did not maintain an incident report related to the fall. C3's record lacked evidence of a re-evaluation of C3 to assess for causal factors or implementation of fall prevention interventions in an attempt to decrease the risk of further falls and injury. A facility incident report dated August 30, 2019 indicated staff found C3 on the floor of her bedroom at 2:00 a.m. The report indicated C3 told staff that she slid out of bed while getting up to use the restroom. C3 was not wearing socks or shoes and her walker was located behind her. C3 did not page staff for help. The report indicated follow up and prevention included: * General: documentation in the resident	0 860		

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0 860	Continued From page 11 service notes, education on safety, medication review, reminders, cues, redirection. * Environmental Modifications: trip hazards removed, walker and bed checked for safety. * Assistive Devices Added: none. * Fall Reduction Interventions Implemented: articles of need within easy reach, bed and furniture assessed for appropriateness, wife educated on surroundings. * Comments: no new injuries noted, reminded resident to use call pendant for assistance. * Systems Follow-Up: staffing updates at shift huddles, educated tenant, reviewed service schedule, patterns, interventions, falls reviewed. C3's record lacked evidence of a re-evaluation of C3 following the fall to assess for causal factors or implementation of fall prevention interventions in an attempt to decrease the risk of further falls and injury. A report to the Minnesota Adult Abuse Reporting Center (MAARC) dated, September 16, 2019 at 1:05 p.m., indicated C3 fell in her apartment at 12:30 a.m. on September 15, 2019 and was not found until 3:30 a.m. C3's progress notes lacked an entry related to a fall on September 15, 2019, and C3's record lacked evidence of a re-evaluation of C3 to assess for causal factors or implementation of fall prevention interventions in an attempt to decrease the risk of further falls and injury. On October 22, 2019, registered nurse (RN)-U stated the facility's practice was for the nurse to conduct fall assessments upon admission, whenever a full assessment is done, or with a	0 860		

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0 860	Continued From page 12 change of condition. RN-U stated otherwise, nurses only conduct an investigatory piece of information as part of the facility's incident reporting process. Licensee's policy titled, "Annual Review Requirements" dated, December 27, 2017 indicated, "Per DHS 89.26 (4), annually, all tenant's capabilities, needs, and preferences identified in the comprehensive/admission assessment will be reviewed to determine whether there have been changes that would necessitate a change in the service or risk agreement. The facility policy referenced is a Wisconsin State, Department of Health Services, Comprehensive Assessment statute. TIME PERIOD FOR CORRECTION: Seven (7) days	0 860		
0 865 SS=H	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	0 865		

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0 865	Continued From page 13 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. (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 observation, interview and record review, the licensee failed to ensure all clients received care according to their service plan for four of four clients reviewed (C1, C2, C3, C4). 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 pattern scope (when more than a limited number of clients are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly but is not found to be pervasive).	0 865		

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0 865	Continued From page 14 The findings include: Client #1 C1's medical record was reviewed. C1's diagnosis included dementia. C1's service plan dated September 25, 2019 indicated C1 received assistance with dressing, grooming, bathing, escorts via wheelchair, assist of two staff for transfers and ambulation, dining assistance, CPAP assistance, medication administration, assist of two staff for toileting, wound cares, and safety checks every two hours including to ensure C1's alarm was in place and working. C1's incident report dated September 25, 2019 indicated C1 had fallen at 2:30 a.m., and that C1's bed alarm was not in place. Facility's untitled internal investigation dated October 3, 2019 indicated the evening staff who put C1 to bed the night she fell thought that the bed alarm was on C1's bed, but could not recall if the alarm was activated or not. The internal investigation indicated C1's family member stated the bed alarm was not working. During an interview on November 8, 2019 at 10:04 a.m., unlicensed personnel (ULP)-G stated C1's alarm was on her bed and underneath the sheet, but was not in the on position and did not sound at the time of C1's fall. ULP-G stated she was aware that C1 used an alarm but that she assumed the evening shift who put C1 to bed would have turned the alarm on. ULP-G stated she was unaware that C1's service plan directed staff to ensure the alarm was on during safety checks and that it was her understanding that the service plan required her to ensure the alarm was in place.	0 865		

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0 865	Continued From page 15 Document titled, "Service Checkoff List" dated September 2019 indicated areas for ULP's to document "Safety Check: 2 Hour" at 12:00 a.m., 3:00 a.m., 5:00 a.m., 7:00 a.m., 9:00 a.m., 11:00 a.m., 1:00 p.m., 3:00 p.m., 5:00 p.m., 7:00 p.m., and 9:00 p.m. The document lacked a prompt or area for ULP's to document related to ensure the alarm was in place or turned on. Client #2 C2's medical record was reviewed. C2's diagnosis included Parkinson's disease. C2's service plan dated September 30, 2019 indicated C2 received services from the comprehensive home care provider for bathing, dressing, grooming, medication administration, transfer and mobility assistance, meal escorts, turning and repositioning every two hours, safety checks every two hours and toileting and/or incontinence care. Hospice progress note dated September 21, 2019 indicated, "Facility staff has been educated regarding every 2 hour repositioning and toileting as well as using chair cushion when in recliner and wheelchair. During observation, theses have not been completed. Writer continued to provide education regarding these interventions repeatedly. Upon transfer to recliner, patient was grossly incontinent of urine." Hospice progress note dated September 27, 2019 indicated, "Hospice aide and writer did completed incontinence care and repositioning for patient. Patient was grossly incontinent of urine."	0 865		

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0 865	Continued From page 16 Hospice progress note dated September 30, 2019 indicated, "Pt (patient) was inc (incontinent) of urine resulting in wet tee shirt laying on L (left) side with pillow placed under buttocks." During an interview on October 30, 2019, hospice staff (HS)-D stated on several occasions, s/he found C2 in bed with a circle of wet and dry urine around him, up his back, and on his clothing. During an interview on December 5, 2019, licensed practical nurse (LPN)-P stated that between hospice staff and the facility's day shift staff, she had been informed on approximately five occasions that they had arrived to the facility to find C2 saturated in urine, and that C2 had required a complete bed change. LPN-P stated because C2 could be resistive to care, she believed that staff would leave him. Client #3 C3's medical record was reviewed. C3's diagnosis included Alzheimer's disease. C3's service plan dated September 28, 2019 indicated C3 received services from the comprehensive home care provider for bathing, dressing, grooming, medication administration, toileting assistance ten times daily and as needed, meal escorts, and safety checks every two hours. C3's incident report dated September 28, 2019 indicated C3 had fallen at 11:00 p.m., and remained on the floor for over seven hours. Facility's untitled internal investigation dated October 4, 2019 indicated surveillance camera footage in C3's apartment revealed C3 fell at	0 865		

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0 865	Continued From page 17 approximately 11:00 p.m. and remained on the floor until approximately 6:30 p.m., at which time, C3 pulled at a cord and disconnected the camera. Document titled, "Service Checkoff List" dated September 2019 indicated areas for ULP's to document "Safety Check: 2 Hour" at 1:00 a.m., 3:00 a.m., 5:00 a.m., 7:00 a.m., 9:00 a.m., 11:00 a.m., 1:00 p.m., 3:00 p.m., 5:00 p.m., 7:00 p.m., 9:00 p.m., and 11:00 p.m. The safety checks were initialed by a ULP who was not assigned to C3 at the time of the fall. Additionally, the document instructed staff to assist C3 with toileting at 4:00 a.m., and 6:00 a.m., which the same ULP initialed as completed. During an interview on November 1, 2019, family member (FM)-C stated C3's family reviewed surveillance footage from the camera in C3's apartment, and discovered that on November 28, 2019, C3 fell from her bed at 11:00 p.m. and remained on the floor until at least 7:15 a.m., at which time C3 had unplugged the camera router, disconnecting the camera. FM-C stated C3 spent the night crawling around on the floor despite C3's contracted service with the licensee to conduct safety checks on C3 every two hours. During observation on October 22, 2019, the surveyor observed C3 in the licensee's memory care unit from 2:30 p.m. to 5:33 p.m. Direct care staff failed to assist C3 with toileting for the duration of the observation, which included a shift change of staff at 2:57 p.m., and before, during and after a musical performance, and dinner. After dinner, at 5:33 p.m., ULP-Y assisted C3 into her recliner in her room and whispered something to C3.	0 865		

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0 865	Continued From page 18 Document titled, "Service Checkoff List" dated October 2019 indicated areas for ULP's to document toileting assistance at 4:00 a.m., 6:00 a.m., 7:00 a.m., 9:00 a.m., 11:00 a.m., 1:00 p.m., 3:00 p.m., 5:00 p.m., 7:00 p.m., and 9:00 p.m. During an interview on October 22, 2019 at 5:33 p.m., ULP-Y stated she had toileted C3 following the musical performance. The surveyor requested an explanation as the surveyor had been monitoring C3 since 2:30 p.m., and had not observed any staff assist C3 with toileting. ULP-Y then stated she had just asked C3 if she needed to use the restroom when ULP-Y escorted C3 to her room, which was at 5:33 p.m. Client #4 C4's medical record was reviewed. C4's diagnosis included type II diabetes and coronary artery disease. C4's service plan dated October 22, 2019 indicated C4 received services from the comprehensive home care provider for bathing, dressing, grooming, medication administration, transfer assistance, toileting assistance eight times daily and as needed, meal monitoring, and safety checks every two hours. Document titled, "Service Checkoff List" dated October 2019 indicated areas for ULP's to document toileting assistance at 7:00 a.m., 9:00 a.m., 11:00 a.m., 1:00 p.m., 3:00 p.m., 5:00 p.m., 7:00 p.m., 9:00 p.m., and 11:00 p.m. During observation on October 22, 2019, the surveyor observed C4 in the licensee's memory care unit from 2:30 p.m. to 5:33 p.m. Direct care staff failed to assist C4 with toileting for the	0 865		

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0 865	Continued From page 19 duration of the observation, which included a shift change of staff at 2:57 p.m., and before, during and after a musical performance, and dinner. During an interview on October 22, 2019 at 5:33 p.m., ULP-Y stated she had toileted C4 following the musical performance. The surveyor requested an explanation as the surveyor had been monitoring C4 since 2:30 p.m., and had not observed any staff assist C4 with toileting. ULP-Y stated the off-going day shift told her during shift change that they had toileted C4. ULP-Y did not offer an explanation as to why she had not toileted C4. Licensee undated policy titled, "Service Plan" indicated home care services will be provided to clients according to a suitable and current written service plan based on client's needs and preferences. The policy indicated staff providing home care services would be informed of services identified in the current written service plan. TIME PERIOD FOR CORRECTION: Seven (7) days	0 865		
01060 SS=F	144A.4794, Subd. 1(a) Client Record Subdivision 1. Client record. (a) The home care provider must maintain records for each client for whom it is providing services. Entries in the client records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry. This MN Requirement is not met as evidenced	01060		

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01060	Continued From page 20 by: Based on interview and record review, the licensee failed to ensure entries in the client records were authenticated with the name and/or title of the person making the entry for 20 of 20 clients (C3, and C6 through C24) with records reviewed. The entries included inaccurate documentation for 5 of 5 unlicensed personnel (ULP-A, ULP-F, ULP-M, ULP-W, ULP-AA) reviewed. Additionally, the licensee failed to record a fall sustained by C3. 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the clients.) The findings include: Record of Incident: C3's medical record was reviewed. C3's diagnosis included Alzheimer's disease. C3's service plan dated September 15, 2019 indicated C3 received services from the comprehensive home care provider for bathing, dressing, grooming, medication administration, safety checks, toileting, and meal escorts. A report to the Minnesota Adult Abuse Reporting Center (MAARC) dated, September 16, 2019 at 1:05 p.m., indicated C3 fell in her apartment at 12:30 a.m. on September 15, 2019 and was not found until 3:30 a.m.	01060		

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01060	Continued From page 21 C3's progress notes lacked an entry related to C3's fall on September 15, 2019. Facility incident reports were reviewed and lacked a report or follow up related to C3's fall on September 15, 2019. On October 22, 2019 at 3:52 p.m., interim director of nursing (IDON)-U verified there was no incident report related to C3's fall on September 15, 2019 and stated that the staff member responsible for conducting safety checks that night had since been terminated. Inaccurate Documentation of Services: Document titled, "Service Checkoff List" dated September 2019 for C3 indicated unlicensed personnel (ULP)-W documented C3's provision of services scheduled for 1:00 a.m., 3:00 a.m., 4:00 a.m., 5:00 a.m., and 6:00 a.m., on September 28, 2019. Document titled, "Service Received Record" dated September 28, 2019 indicated ULP-W signed for C3's provision of services scheduled 1:00 a.m., 3:00 a.m., 4:00 a.m., 5:00 a.m., and 6:00 a.m. for September 28, 2019 at 12:00 a.m. Facility staff schedule dated September 22, 2019 through September 29, 2019 indicated ULP-W was scheduled during an overnight shift beginning September 27, 2019 into September 28, 2019, but that ULP-W was scheduled to begin work on September 28, 2019 at 3:00 a.m. Facility time card dated September 26, 2019 through September 30, 2019 indicated ULP-W clocked in on September 28, 2019 at 2:45 a.m.	01060		

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01060	Continued From page 22 Document titled, "Service Received Record" dated September 28, 2019 through September 29, 2019 for clients in memory care unit two were reviewed and revealed services for clients C6 through C24 between the hours of 7:00 a.m., September 28 through 2:00 p.m., September 29 on pages 36 through page 50 of 60. All documented services reflected a time stamp of 12:00 a.m. The services included the following: ambulation, bathing, catheter care, dressing, grooming, oxygen management, safety checks, medication administration, toileting, transfers, repositioning, meal monitoring, and involved four direct care staff's electronic signatures (ULP-A, ULP-F, ULP-M, and ULP-AA). During an interview on November 7, 2019 at 1:45 p.m., electronic records management system representative (R)-X stated it was possible for facility management to go into a client's record and manually batch confirm services that were not signed off as completed by the direct care staff member responsible for them. R-X stated doing so would result in the record reflecting a time stamp of 12:00 a.m. During an interview on November 8, 2019 at 1:28 p.m., executive director, (ED)-V stated she was confused about the documentation at exactly 12:00 a.m., and stated that staff's signatures should not appear for the provision of services at times when they are not in the building. During email correspondence with ED-V on November 8, 2019 at 12:45 p.m., ED-V indicated the services documented for C3 by ULP-W on September 28, 2019 had been documented via	01060		

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01060	Continued From page 23 manual confirmation. During email correspondence with ED-V on November 8, 2019 at 3:07 p.m., ED-V indicated she had consulted a representative from the facility's electronic record management system and that the representative determined the facility's care coordinator had signed for C3's services on September 28, 2019, not ULP-W. ED-V stated in her email that after learning that information, she questioned the care coordinator about the signed services and that the care coordinator told her the facility's former director of nursing had instructed her to do so. ED-V stated the care coordinator said that she thought she was signing off that the cares not completed by the staff who were supposed to have done them. During an interview on December 6, 2019 at 4:01 p.m., registered nurse (RN)-E stated the facility's coordinator monitored client records for holes in documentation. RN-E stated the coordinator was supposed to find out who worked and if they actually did the service. RN-E stated the coordinator was not supposed to sign for another staff, she was only supposed to find out if the service was completed or not. Licensee policy titled, "Electronic Documentation" dated December 27, 2017 indicated staff are expected to document the following in the client's records: Any scheduled and unscheduled care needs, and falls. The policy also indicated staff should not document for another staff person. TIME PERIOD FOR CORRECTION: Seven (7) days	01060		