DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL20189031M **Date Concluded:** May 25, 2021
Compliance #: HL20189032C

Name, Address, and County of Licensee Investigated:
Cedars of Austin
700 1st Drive NW
Austin, MN 55912
Mower County

Facility Type: Home Care Provider **Investigator's Name:** Shannan Stoltz, 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 that the client had multiple falls within a three-month time frame, so his primary care provider wrote a physician's order for a bed and chair alarm. The client's facility refused to implement the physician's order for the alarms, even as the client continued to have falls.

Investigative Findings and Conclusion:
Neglect was substantiated. The facility was responsible for the maltreatment. Over the course of three months, the client experienced 15 falls, some of which resulted in serious injury and trips to the emergency room. The facility failed to document assessments after all of the falls and failed to attempt new interventions to address the falls. In addition, the client's primary care provider wrote an order for the client to have a bed alarm and a chair alarm activated at all times, and the facility refused to implement the order, citing that the noise of an alarm would bother other clients. The order was written due to the client's continued falls, and the ineffective interventions the facility had implemented up to that point; the client continued to suffer from falls.

An equal opportunity employer.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation also included interviews with the client’s family members and nurse practitioner. The investigation included an onsite visit for observations, review of medical records, and review of facility policies and procedures.

The client's medical record was reviewed. The client’s diagnoses included dementia, Parkinson’s, and high blood pressure. The client’s signed service plan indicated he received services for medication management, reassurance checks, and assistance of one for activities of daily living.

The client’s medical record did not contain an initial comprehensive assessment that was required to be completed within five days of the client’s move-in to the facility. The client’s medical record did not contain a monitoring and reassessment that was required to be completed within 14-days of the client’s move-in to the facility. There is a section in both these assessments where a registered nurse can assess a client for fall risk. The client’s medical record indicated the facility performed the client’s first comprehensive assessment one month after the client had moved into the facility. The client’s medical record indicated that the client’s 90-day assessment was not completed in the required timeframe. The client’s 90-day assessment was completed by a licensed practical nurse (LPN) even though the client had already suffered 14 falls. The client’s record did not include other assessments regarding the change in condition, until a fall assessment was completed for the client almost four months after he had moved into the facility, and had already suffered 15 falls.

Facility staff schedules indicated that the client lived on a floor that should have been staffed with two aides on the morning and evening shifts; but was consistently staffed with only one aide. Every interview conducted with facility aides shared common themes: the facility was short-staffed, and the floor that the client lived on should always be staffed with two aides due to the acuity level and safety needs of the clients on that floor. These aides also stated that the staff shortage directly contributed to the falls that numerous clients suffered.

The client’s nurse notes indicated that over the course of three months, the client suffered 15 falls, some of which caused serious injury. These notes indicated the facility sometimes transmitted fall reports to the client’s primary care provider, but not always.

During an interview with the client’s nurse practitioner (NP), she stated that she was unaware that the client had suffered so many falls. The NP stated she was aware of some of the client’s falls, so she wrote an order for bed and chair alarms. These alarms would alert staff that the client had gotten up from his chair or bed. The NP stated that facility staff advised that they (facility) do not use alarms as it is the client’s right to fall.

During an interview with the client’s family members, they stated that they had suggested alarms be used for the client, but the facility refused to allow it. The family members stated

that facility staff had advised them that if the client were to use alarms, it would disturb other clients who lived at the facility. The facility suggested the client use a call pendant instead, which family felt was ineffective due to the client's dementia.

During an interview, the director of nursing (DON) stated that the amount of falls the client suffered were excessive, but that they had implemented several different interventions in an attempt to address the falls. The DON stated that when she spoke with family, she did not refuse to use an alarm, but instead explained that due to the lay out of their building, an alarm would be mostly ineffective. The DON stated that family members verbalized understanding of this. DON stated that the facility is currently using a "baby monitor" -type device, which is a handheld device that has audio and visual contact with the client, and when staff hear the client making noise, they immediately respond to his room. The DON stated that as of this date, they plan to immediately implement the client's bed alarm.

In conclusion, neglect was substantiated. After the client had suffered 12 falls, his NP wrote an order for a bed and chair alarm that the facility refused to implement, and the client continued to suffer from falls. The client suffered 15 falls before a registered nurse completed a fall assessment on the client. As a result, the client experienced a diminished quality of life due to the facility's failure to monitor, assess, and create effective fall interventions.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

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; unable to provide information due to cognitive status.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
Facility now plans to implement provider orders for alarms, and has completed a fall assessment.

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 651-201-4201 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.

cc:
The Office of Ombudsman for Long-Term Care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H20189	A. BUILDING: ______ B. WING ______	C 05/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	**700 1ST DRIVE NORTHWEST AUSTIN, MN 55912**

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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 investigation. 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 April 27 & 28, 2021, and May 5, 2021, the Minnesota Department of Health initiated an investigation of complaint #HL20189025M//HL20189026C, #HL20189027M//HL20189028C, #HL20189029M//HL20189030C, and #HL20189031M//HL20189032C. At the time of the investigation, there were 92 clients receiving services under the comprehensive license. An immediate correction order was previously issued, tag identification 1252. The following correction orders are issued that were not issued at the time of immediate correction orders. The following correction orders are issued for #HL20189031M//HL20189032C, tag identification 0265, 0325, 0840, and 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 investigators' 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 licensing order follow-ups. 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=I	144A.44, Subd. 1(a)(2) Up-To-Date Plan/Accepted Standards Practice	0 265		

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0 265	Continued From page 1 Subdivision 1.Statement of rights. (a) A client who receives home care services in the community or in an assisted living facility licensed under chapter 144G 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 failed to provide care in accordance with accepted health care, medical, or nursing standards to ensure client safety, when several clients suffered numerous falls and other unsafe conditions. The falls and other unsafe conditions are attributed to staffing shortages, outdated interventions, and the failure of nursing staff to create new interventions and ensure that unlicensed staff were advised of, and implemented the new interventions. Facility staff also failed to implement and follow written physician's orders for a bed and chair alarm, for one of the facility's clients (C7). These issues had the potential to cause serious injury to multiple clients, and contributed to serious injury for C3 and C7. 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	0 265		

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are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the clients).

Findings Include:

During an onsite interview on April 27, 2021, at 11:20 am, director of nursing (DON)-B stated that when a client falls, an Incident Report is completed by facility staff. DON-B stated that "fall interventions should be documented under number 30 on the Incident Report". On the incident report, number 30 (#30) indicated, "What actions will be taken to mitigate the risk/prevention future falls?", and there is an area for a nurse to document client interventions to prevent a future fall.

Client #3's (C3) medical record was reviewed. C3's medical diagnoses included dementia, chronic obstructive pulmonary disease (COPD), and high blood pressure. C3's signed service plan indicated C3 received services for medication management, reassurance checks, and assistance of one for activities of daily living.

C3's Resident Notes, dated January 1, 2021 to April 27, 2021, indicated C3 fell five times within this time frame. C3's fifth fall resulted in serious injuries, which required hospitalization for several days.

Client #4's (C4) medical record was reviewed. C4's medical diagnoses included dementia and falls. C4's Care Plan indicated C4 received services for medication management, reassurance checks, and assistance of one for activities of daily living.

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C4's Incident Report, dated January 2, 2021, at 10:30 pm, indicated C4 fell in the hallway and staff created an incident report. On this document, #30 has been left blank; there were no client interventions created to circumvent another fall.

C4's Incident Report, dated January 27, 2021, at 5:00 pm, indicated C4 again fell in the hallway and staff created an incident report. On this document, #30 has been left blank; there were no client interventions created to circumvent another fall.

During an onsite visit on April 27, 2021, at 9:45 am, to the third floor of the memory care building, this Investigator observed C4 walking around in non-grip socks (with no shoes on), in the dining-room area. The floor in the area was some type of slippery laminate-wood flooring, and created a fall hazard for C4.

Client #5's (C5) medical record was reviewed. C5's medical diagnoses included dementia, falls, and history of absconding from another assisted living facility. C5's Care Plan indicated C5 received services for medication management, reassurance checks, and assistance of one for activities of daily living.

C5's Incident Report, dated July 24, 2020, at 4:14 pm, indicated C5 fell in the hallway and staff created an incident report. On this document, #28, which inquired as to what interventions were being followed at the time of the fall, indicated staff were to make sure client has proper foot ware on when she is up.

C5's Incident Report, dated December 26, 2020,

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at 8:11 am, indicated C5 fell in her bedroom and staff created an incident report. On this document, #30 has been left blank; there were no client interventions created to circumvent another fall.

C5's Incident Report, dated April 16, 2021, at 4:00 pm, indicated C5 fell in the dining room and staff created an incident report. On this document, #30 has been left blank; there were no client interventions created to circumvent another fall.

During an onsite visit on April 27, 2021, at 9:45 am, to the third floor of the memory care building, this Investigator observed C5 sitting in a wheelchair in non-grip socks (with no shoes on), in the dining-room area. The floor in the area was some type of slippery laminate-wood flooring, which created a fall hazard to C5, were she to stand up from her wheelchair.

Client #7's (C7) medical record was reviewed. C7's medical diagnoses included dementia, Parkinson's, and high blood pressure. C7's signed service plan indicated C7 received services for medication management, reassurance checks, and assistance of one for activities of daily living.

C7's Resident Notes, dated January 1, 2021 to April 30, 2021, indicated C7 had 14 falls during this time, some of which required a trip to the emergency room. This document indicated that physical therapy (PT) was not ordered for C7 until after his 12th fall. This document indicated that a facility registered nurse did not complete a Change of Condition Assessment on C7, related to excessive falls.

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C7's After Visit Summary, dated March 6, 2021, no time notated, indicated C7 visited his primary care provider (PCP), for repeated falls.

C7's Provider Visit, dated March 18, 2021, at 2:45 pm, indicated his PCP wrote and signed a physician's order for C7 to have, "Bed Alarm on every night Chair Alarm every day Physical Therapy to be ordered. Bedside urinal". The facility failed to implement this physician's order.

During an interview on May 5, 2021, at 12:35 pm, with director of nursing (DON)-B, she stated that C7's family did not want C7 to use a bed alarm.

During an interview on May 12, 2021, at 3:20 pm, with C7's family member (FM)-P, she stated no family member ever told facility staff they did not want an alarm for C7, and in fact family had suggested a bed and chair alarm. FM-P stated that the facility had discouraged an alarm, and instead suggested C7 wear a pendant alert around his neck. FM-P stated the pendant was not a viable option for C7, as he would forget he had it on.

During an interview on May 14, 2021, at 9:00am, with FM-P, she stated that the facility had told C7's family members that the facility could not use an alarm for C7 because the alarm would disturb other clients, wake other clients, and "we {facility} won't use them {alarms}". FM-P stated the facility refused to supply alarms for C7.

During an interview on May 19, 2021, at 2:00 pm, with family member (FM)-Q, she stated that facility staff stated they (facility) would not use a bed or chair alarm, as the noise from the alarm would disturb other facility clients.

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0 265	Continued From page 6 During an interview on May 21, 2021, at 6:30 am, with nurse practioner (NP)-R, she stated she is C7's primary care provider. NP-R stated that during a medical visit on March 18, 2020, with C7 and his family, C7's family advised her that they had purchased and supplied the facility with a chair alarm for C7, but that the facility refused to implement it. NP-R stated that she wrote an order for the facility to implement a chair and bed alarm, in an attempt to increase C7's safety and decrease falls. After C7 fell on April 12th, 2021, NP-R's staff reached out to the facility staff for a care conference related to C7's falls; during this call facility staff advised NP-R's staff that the facility does not utilize any type of alarms as it would disturb other clients at their facility. NP-R stated the facility had not advised her that C7 had already experienced 12 falls prior to NP-R and C7's medical visit on March 18, 2021. NP-R stated that the facility did not advise her that C7 had experience a fall on March 25, 2021, which was approximately one week after NP-R wrote C7's order for alarms. NP-R stated no facility staff reached out to her or her staff for a care conference related to C7's falls, a medication reconciliation, nor to ascertain interventions in an attempt to circumvent further falls C7 might have. NP-R was not aware that between the dates of January 9, 2021, to May 14, 2021, C7 had experienced a total of 15 falls. NP-R works at a local clinic, does not have access to C7's facility medical record, and is only privy to C7's facility-occurrences if facility staff contacts her office with updates. C7's medical record indicated that he moved into the facility on December 3, 2020, but that a facility registered nurse (RN) did not perform an Initial Comprehensive Assessment, nor did an RN perform the 14-day Monitor and Reassessment.	0 265		

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Records indicated that the first assessment facility staff performed on C7 was on January 6, 2021, when C7 had already lived at the facility for just over one month. The next assessment completed on C7, dated April 19, 2021, was a 90-day assessment, and was completed by a licensed practical nurse (LPN), even though by this date C7 had experienced 12 falls. Records indicated the next time C7 was assessed was on April 27, 2021, by an RN, and it was a Fall Assessment after C7's 14th fall.

The facility provided 14 Incident Reports for C7's falls, and the great majority of the reports have the same interventions listed repeatedly: toilet schedule, visual checks, transfer assist. These interventions were ineffective in keeping C7 from falls, but the facility did not update or create new interventions for C7. Some of the incident reports supplied by the facility did not even list an intervention.

Facility provided Client Roster, dated April 27, 2021, indicated 16 clients who had had three or more falls within the last three months, with some of the clients experiencing up to eight falls each. One client had 12 falls within this time frame; another client had 13 falls; and another client had 18 falls. The clients with 3 or more falls are:

Client Number	Number of Falls
C3	3*
C4	0**
C5	3
C7	8***
C8	4
C9	4
C10	3

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C11 18
C12 5
C13 3
C14 6
C15 12
C16 4
C17 6
C18 13
C20 6
* Client #3's nurse notes indicated she had 5 falls.
** Client #4's Incident Reports indicated he had 2o falls.
*** Client #7's Incident Reports indicated he had 15 falls.

Facility provided Client Roster, dated May 5, 2021, indicated 14 clients who had had three or more falls within the last three months, with some of the clients experiencing up to nine falls each. One client had 13 falls within this time frame, and two other clients had 18 falls each. In the eight days between my two facility visits, nine clients experienced a fall at the facility. One of these clients fell five times in eight days (C18). The clients with 3 or more falls are:

Client Number of
NumberFalls
C3 3*
C4 0**
C5 3
C7 9***
C8 4
C9 4
C10 3
C11 18
C12 5
C13 4
C14 6

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C15 13
C16 5
C17 No Info
C18 18
C19 3
* Client #3's nurse notes indicated she had 5 falls.
** Client #4's Incident Reports indicated he had 2 falls.
*** Client #7's Incident Reports indicated he had 15 falls.

Due to the discrepancies of all audited client's nurse notes, incident reports and the client roster, the true number of client's who have experienced falls and exactly how many falls each client has had is unknown.

Facility provided policy Monitoring of Clients and their Services, updated august 18, 2020, indicated a registered nurse will monitor clients' needs and services on an ongoing basis to determine if the services are appropriate to the client's needs or if changes in the service plan are needed. This same policy indicated that a reassessment will be conducted whenever a client has a change in condition.

Facility provided policy Admission Process for New Clients, updated August 29, 2020, indicated that, "The determination whether our Agency will accept a person as a home care client will be based upon ...whether our Agency has sufficient current resources within the Agency's chosen scope of practice consistent with its licensure, such as staff sufficient in qualifications, competency, and numbers, to adequately provide the services agreed to in the service plan ...".

Facility provided document for Fall Prevention &

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CEDARS OF AUSTIN	**700 1ST DRIVE NORTHWEST AUSTIN, MN 55912**

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0 265	Continued From page 10 Reduction Program, dated October 2020, indicated that if a client has an increase in falls it should be considered a change in condition and an RN must reassess the resident. This document indicated that after a fall an intervention will be developed by the client's care team, and that if a client falls frequently or chronically a nurse will contact PT for a physical assessment. This document does not indicate an exact number of falls or define a certain timeframe, for what the facility deems "frequent", "chronic", or "an increase in falls". TIME PERIOD FOR CORRECTION: Seven (7) days	0 265		
0 325	144A.44, Subd. 1(a)(14) Free From Maltreatment Subdivision 1.Statement of rights. (a) A client who receives home care services in the community or in an assisted living facility licensed under chapter 144G has these rights: (14) 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 one client reviewed was free from maltreatment. The client was neglected. Findings include:	0 325	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of tag 0325.	

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0 325	Continued From page 11 On May 25, 2021, 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		
0 840 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 observation, interview and record review, the licensee failed to ensure there was adequate staff to respond to client's needs and/or emergencies. The staff shortage affected all 90 clients who reside at the facility, as well as direct care staff responsible to provide assistance to these clients. The facility consists of a memory care building which houses four floors of memory care clients, and a separate building that houses three floors of assisted living clients. The licensee's staff schedule, as well as several staff interviews, indicated there were numerous occasions when the facility worked short-staffed in the assisted living areas, and particularly on the four memory care floors that house dementia clients. This had the potential to cause serious injury to all clients.	0 840		

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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 potential to affect a large portion or all of the clients).

Findings Include:

During an observation on April 27, 2021, at 9:35 am, on the second floor of the memory care building, this investigator spoke with unlicensed personnel (ULP)-D, who stated she was scheduled to work on the fifth floor of the memory care building on this day. ULP-D stated she was on the second floor providing a break for the staff member assigned to work the area, and that there was "no one covering my floor" (fifth floor) while ULP-D was on the second floor. ULP-D stated that the ULP's have to break each other, did not know if there was a floater aide to assist with floor-coverage on this day, and that this practice was not safe.

During an observation on April 27, 2021, at 9:40 am, on the fifth-floor memory care center of the building, there were six apartments occupied by clients. In two apartments, there were single female occupants who received memory care services from the facility. In three apartments, there were female memory care clients who received memory care services from the facility, and whose husbands also lived in the apartments. In one apartment there was a male memory care client who received memory care services from the facility, and whose wife also

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lived in the apartment. During this observation, which lasted several moments, it was confirmed that there was no ULP available on the fifth floor to provide assistance and/or help to the clients who resided on this floor.

During an interview on April 27, 2021, at 9:40 am, with registered nurse (RN)-C, she stated there should be a floater aide to assist with breaks, but she did not know if there was one working on this day. RN-C stated that the facility is extremely short-staffed. RN-C stated that higher-acuity clients reside on memory care floors 2, 3, and 4 of the building. RN-C stated that married couples live on the memory care 5th floor, if one member of the couple has memory care issues.

During an interview on May 5, 2021, at 1:25 pm, with ULP-I, she stated ULP's are not able "to give 100% care" due to the staff shortage. ULP-I stated she "tries my best to give good client care, but it's overwhelming sometimes", and "if we had more staff, there would be less {client} falls here". ULP-I stated that this morning one client had to eat breakfast in her pajamas, in the dining room with all the other clients, because ULP-I did not have enough time to get her ready prior to serving breakfast to the rest of the client's.

During an interview on May 5, 2021, at 1:45 pm, with ULP-J, she stated that "there's a shortage of staff here", and that "floors 2 & 3 need two people {ULP's} for sure". ULP-J stated that "short staff is causing falls because staff can't be everywhere all the time", and "sometimes when someone falls we don't know it because there's not enough staff", and "when we're not fully staffed, we can't provide good care for clients".

During an interview on May 5, 2021, at 2:05 pm,

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with ULP-K, she stated that the third floor is the hardest floor to work, and the second floor is the next hardest because of the behaviors of the memory care clients that reside on these floors. ULP-K stated that both floors need two staff members at all times, but only one staff member is scheduled. ULP-K stated that she did not feel clients on the 2nd and 3rd floor are receiving quality care, due to the staff shortage. ULP-K stated that more client supervision is needed to prevent falls and to provide quality care.

During an interview on May 5, 2021, at 2:40 pm, with ULP-M, she stated it is rare to have two aides scheduled to work the 3rd floor of memory care, although two aides are needed. ULP-M stated that to work "by myself on 3rd floor is too much", "gets overwhelming", and "clients don't get good care when we're not fully staffed".

During an interview on May 5, 2021, at 8:35 am, with director of nursing (DON)-B, she stated the facility has been short-staffed for approximately two months. DON-B stated that she reached out to corporate and reported this, and corporate had reached out to a staff-pool agency. DON-B stated corporate had not heard back from the agency, had not followed up or re-called the staff-pool agency, nor had corporate staff reached out to any other staff-pool agencies. DON-B stated that from January 1, 2021 through May 5, 2021, the facility had accepted 11 new clients, and discharged 23 clients. DON-B stated the facility provides services to the following number of clients, what that facility should be fully staffed at, and what the facility is currently staffed at:

Assisted Living--> Fully Staffed (AM/PM Shift)--> Current Staff (AM/PM Shift)

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1st Floor - 11 clients 1st Floor - 1/1
1st Floor - 1/1
2nd Floor - 25 clients 2nd Floor - 2/2
2nd Floor - 1/1
3rd Floor - 15 clients 3rd Floor - 1/1
3rd Floor - 1/1
Total: 51 clients Total: 4/4
Total: 3/3

Memory Care --> Fully Staffed
(AM/PM Shift)--> Current Staff (AM/PM Shift)
2nd Floor - 11 clients 2nd Floor - 2/2
2nd Floor - 1/1
3rd Floor - 13 clients 3rd Floor - 2/2
3rd Floor - 1/1
4th Floor - 9 clients 4th Floor - 2/2
4th Floor - 1/1
5th Floor - 6 clients 5th Floor - 1/1
5th Floor - 1/1
Total: 39 clients Total: 7/7
Total: 4/4

Facility provided Client Roster, dated April 27, 2021, indicated a total of 16 clients who had had three or more falls within the last three months, with some of these clients experiencing up to eight falls. One client had 12 falls; another client had 13 falls; and another client had 18 falls.

Facility provided Client Roster, dated May 5, 2021, indicated a total of 14 clients who had had three or more falls within the last three months, with some of these clients experiencing up to nine falls. One client had 13 falls, and two other clients had 18 falls each. In the eight days between my two facility visits, nine clients experienced a fall at the facility with one of these clients who had fallen

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0 840	Continued From page 16 five times. Facility provided policy Admission Process for New Clients, updated August 29, 2020, indicated that, "The determination whether our Agency will accept a person as a home care client will be based upon ...whether our Agency has sufficient current resources within the Agency's chosen scope of practice consistent with its licensure, such as staff sufficient in qualifications, competency, and numbers, to adequately provide the services agreed to in the service plan ...". TIME PERIOD TO CORRECT: Seven (7) Days	0 840		
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 the date that home care services are first provided. (b) Client monitoring and reassessment must be conducted in the client's home no more than 14 days after the date that home care services are first provided. (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	0 860		

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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 by:
Based on interview and record review, the licensee failed to conduct a comprehensive assessment of the client's needs for one of eight clients reviewed, when client #7's medical record did not contain an initial nursing assessment within five days of client's move-in date and when services were first provided. The facility also failed to conduct the client's 14-day monitor and reassessment, as well as a 90-day reassessment within the allotted timeframe. The failure to assess C7 contributed to C7's continued falls, which has the potential to cause 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 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:

Client #7's (C7) medical record was reviewed. C7's diagnoses include dementia, Parkinson's, and high blood pressure. C7's service plan, dated February 17, 2021, indicated C7 received services for medication management, reassurance checks, and assistance of one with activities of daily living.

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C7's Resident Profile sheet, undated, indicated C7 moved into the facility on December 3, 2020.

C7's medical record did not contain an Initial Comprehensive Assessment dated between December 3 to December 8, 2021.

C7's medical record did not contain a Monitoring and Reassessment (14-day Assessment) dated on or before December 22, 2020.

C7's medical record did not contain a 90-day Assessment, dated on or before March 22, 2021.

C7's Comprehensive Assessment, dated January 6, 2021, was the first documented assessment completed by the facility's registered nurse. The facility utilized this assessment as both the initial comprehensive assessment and the 14-day monitor and reassessment.

C7's medical record did not contain a 90-day Assessment, dated on or before April 6, 2021.

C7's medical record indicated his 90-day Assessment was completed on April 19, 2021.

C7's medical record indicated a Fall Assessment was completed on April 27, 2021, after C7 suffered his 15th fall.

During an interview on May 5, 2021, at 12:35 pm, with director or nursing (DON)-B, she stated she completed C7's assessment prior to his move-in date, but no longer had that assessment. DON-B stated that she did not complete a comprehensive assessment on C7 within five days of C7's move-in date to the facility. DON-B stated she did not complete a 14-day monitor and reassessment on C7 within 14 days of C7's

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move-in date to the facility. DON-B confirmed that C7 moved into the facility on December 3, 2020, and that C7's first documented Assessment by a registered nurse was performed on January 6, 2021. DON-B stated she was the only registered nurse at the facility for several weeks in November and December of 2020, and that a new registered nurse started the facility on December 11, 2020. DON-B stated that she went on vacation the last week of December 2020.

Facility policy Admission Process for New Clients 01-102.13, updated August 29, 2020, indicated an Individualize Initial Assessment will be completed by a registered nurse within five days of initiation of home care services.

Facility policy Initial and On-going Nursing Assessment of Clients 03-003.13, updated August 17, 2020, indicated, "A registered nurse will reassess the service plan within 14 days and update the service plan and plan of care based on the client's needs on an on-going basis at a frequency not to exceed 90 days from the date of the last (re)assessment."

TIME PERIOD FOR CORRECTION: Seven (7) days

01252 SS=F	144A.4798, Subd. 3 Infection Control Program	01252		

Subd. 3.Infection control program. A home care provider must establish and maintain an effective infection control program that complies with accepted health care, medical, and nursing standards for infection control.

This MN Requirement is not met as evidenced

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by:
Based on observation and interview, the licensee failed to establish and maintain an effective infection control program that complies with accepted health care, medical and nursing standards related to quarantine of a positive COVID-19 client. The facility placed a memory care floor on droplet precautions in accordance with their policy, after a positive COVID-19 test, but failed to inform people going to this floor of these precautions and failed ot have signage or other measures to ensure those entering the floor were aware of those precautions and the associated PPE requirements. In addition, the facility's staff was seen to be inconsistent in following those precautions. This affected 11 other clients, multiple staff members, and at least one family member of a client, and staff of the Minnesota Department of Health. This had the potential to affect 80 other clients who reside at the facility, visitors, families, and essential care givers.

On May 5, 2021, the investigator confirmed tag 1252 was corrected. No further action is required.

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), 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:

On April 27, 2021, at 8:30 am, a Minnesota Department of Health (MDH) surveyor visited the facility. Upon arrival to the facility, she was screened for COVID, met the director of nursing (DON)-B and registered nurse (RN)-C, and was then escorted to a room on the second floor of

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the assisted living area of the building to use.

The surveyor requested information from DON-B, and RN-C took her on a tour of the facility, which is compromised of two attached buildings. One building houses 53 assisted living (AL) clients on floors 1 through 3, in which the rooms are laid out with long hallways. The other building houses 39 memory care (MC) clients on floors 2 through 5, and this building is laid out with the rooms are in a large circle around an enclosed space (elevator, housekeeping, other rooms, etc.).

During the tour of the facility, RN-C took the surveyor to the MC third floor where RN-C explained that higher acuity clients resided there and on the fourth floor. While on the third-floor tour, the RN-C and the surveyor discussed why an elderly client would be walking around in stocking feet on a slippery, non-carpeted floor. RN-C never mentioned that the entire third floor was under a droplet-precaution quarantine due to a hospitalized client who had tested positive for COVID-19. There was no quarantine information posted anywhere in the area. The facility staff wore surgical masks and eye protection, but not N-95 masks, gowns, or gloves.

On April 28, 2021, at 9:00 am, the same MDH staff member again visited the facility. Upon arrival, the surveyor was screened for COVID-19, and then advised she could return to the second-floor room she had worked from the day prior. The surveyor wore eye protection over glasses, and had on a surgical mask. The surveyor stopped in DON-B's office to advise of her return, and DON-B stated she had an upcoming meeting, and the surveyor responded that she would show herself around. The surveyor called family member FM-A, who stated

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she was in the facility, and the surveyor decided to speak with FM-A in person. The surveyor took the elevator to the ground floor, walked to the memory care (MC) building (through hallways, past dining room, chapel, etc.), and then had two employees assist her with another elevator code that would take her to the MC third floor. Neither of these employees advised her that the third floor was under quarantine. Exiting the elevator on the third floor, there were no signs posted for quarantine, the staff was only wearing eye protection and surgical masks, and the surveyor still did not know the third floor was under a droplet-precaution quarantine. The surveyor went to FM-A's location, and spoke with her for approximately 45-minutes. FM-A pointed out bowel movement (BM) several places in the client's bathroom, so the surveyor had FM-A press the client's call light, to which an unlicensed personnel (ULP)-D responded. ULP-D came into the client's room with only her eye protection and facemask on, and advised that ULP-F had toileted the client. ULP-F was outside the client's room, and the surveyor and staff had a short discussion about BM smeared in several places in the client's bathroom. ULP-F stated she would clean up the bathroom and then get the client's chart. ULP-F started to put on a gown, and the surveyor asked her why she was putting on a gown to go into the client's room. ULP-F stated "everyone on this floor is on quarantine." The surveyor asked her what she was talking about and ULP-F again stated that the entire floor is on droplet-based quarantine because "a client had tested positive for COVID-19 on Monday {April 26, 2021}." The surveyor decided to immediately leave the floor due not having on the PPE for a droplet precaution quarantine. The surveyor went to DON-B's office, and DON-B she confirmed the entire third floor is under a droplet quarantine

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H20189	A. BUILDING: ______ B. WING ______	C 05/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NORTHWEST AUSTIN, MN 55912

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01252	Continued From page 23 because of a positive COVID-19 client. During an interview on April 28, 2021, at 11:22 am, DON-B did not respond to questions about why she had not informed the surveyor that the third floor was under droplet precautions. DON-B stated that on Monday, April 26, 2021, a client was sent to the hospital for an issue not related to COVID-19. While at the hospital the client tested positive for COVID-19, but was asymptomatic. DON-B stated that due to the difficulty of contact-tracing in a memory care unit, her corporate office advised her to put the entire floor under droplet precautions. The quarantine was implemented on Monday evening, April 26, 2021. DON-B stated that this client had had COVID-19 in December 2020, and was vaccinated in January or February of 2021. DON-B stated that on Tuesday, April 27, 2021, COVID-19 testing was performed on all third-floor client's and staff, and DON-B is awaiting results from the lab. DON-B stated that the physician for the COVID-19 client had advised her that he did not know if the client's positive test was caused by a new variant of COVID-19 or the client's persistent viral shedding. During a phone interview on April 28, 2021, at 2:31 pm, with FM-A, she stated that she is an essential care giver (ECG) and power of attorney (POA) for a family member, and visits the family member every morning for several hours. FM-A stated a ULP told her yesterday (Tuesday, April 27, 2021) that "they" were on droplet precautions due to a client who tested positive for COVID-19. FM-A stated she did not know who "they" were that the ULP referred to, did not know what droplet precautions meant, and did not know the proper PPE to wear for droplet precautions (she wore a cloth mask and no eye protection while in	01252		

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CEDARS OF AUSTIN	**700 1ST DRIVE NORTHWEST AUSTIN, MN 55912**

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01252	Continued From page 24	01252		

the facility). FM-A stated that no facility management advised her that her family member was under quarantine, that the entire floor the family member lived on was under quarantine, or the proper PPE to wear under those circumstances.

Facility provided "COVID-19 P&P", updated November 3, 2020, indicated "In memory care, due to the difficulty of contact tracing, if a resident on a unit/floor tests positive, all other residents will be placed on droplet precautions." This document also indicated that, "All residents on droplet precautions will have notices posted outside their doors", "All residents on droplet precautions will be notified they are on droplet precautions. As applicable, their designated representative(s) will be informed as well", and "Essential Caregivers and compassionate care visits are permitted to continue to visit those on droplet precautions but are advised against doing so."

TIME PERIOD TO CORRECT: IMMEDIATE