Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL21203011M
Compliance #: H21203012C

Date Concluded: December 10, 2020

Name, Address, and County of Licensee Investigated:
Ecumen of Litchfield Senior Housing
33 South 6th street Suite 3900
Minneapolis, MN 55402
Hennepin County

Name, Address, and County of Housing Services location:
Ecumen of Litchfield Senior Housing
200 North Holcombe Avenue
Litchfield, MN 55355
Meeker County

Facility Type: Home Care Provider

Investigator's Name:
Erin Johnson-Crosby, RN, Special Investigator
Lisa Coil, 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: The facility neglected to provide appropriate assessments and interventions to prevent the client from repeatedly falling.

Investigative Findings and Conclusion:
Neglect was substantiated. The facility was responsible for the maltreatment. The client fell 18 times in approximately three months. The facility failed to assess the client, determine causative factors, and implement interventions after each fall to maintain the client's health and safety. The facility implemented no fall interventions until after the client fell 8 times.

The investigation included observation of staff and client interactions. The investigator conducted interviews with administrative staff, nursing staff, unlicensed staff, the client's medical doctor (MD) and power of attorney (POA). The investigator reviewed facility documentation, including internal investigation notes, incident reports and grievances, policies and procedures, and client records.

Review of the client's record indicated the client had diagnoses that included Alzheimer's disease, autonomic dysfunction and hypotension (low blood pressure). The service plan identified the client needed assistance with all activities of daily living (ADLs) and medication management. The client resided in the memory care unit of the facility.

Review of the initial care plan identified the client was at risk for falls related to confusion and Alzheimer's disease and was not safe with transfers and walking. The care plan interventions included the client not attempt to self-transfer without staff assistance, using the call pendant, encouraging non-skid wear footwear, decreasing clutter, keeping items within reach, and wearing glasses. After the client's twelfth fall, the care plan was updated to include an intervention to place the client in the day room during the morning, afternoon, and evening.

Review of the client's initial comprehensive assessment indicated the client was at risk for falls related to a fall history. In addition, a fall assessment identified the client was a high fall risk related to impaired memory, gait and hypotension. A mini cognition assessment (used to detect cognitive impairment) identified the client was unable to follow the assessment instructions due to poor cognition.

Review of the facility's incident reports identified the client fell 18 times in approximately three months. The incident reports did not note any causative factors of the falls or implementation of interventions to prevent recurring falls.

Review of the client's progress notes identified no fall investigations or interventions following the client's repeated falls.

Review of the client's hospital medical records identified the client was hospitalized for chronic pain after a fall. The client had lumbar fractures; however, the MD could not verify if the fractures were acute (caused by a fall) or chronic.

When interviewed, an unlicensed personnel (ULP) indicated she was not aware where she could find recommended interventions to prevent the client from falling. The ULP stated the client was not able to use her call pendant for assistance due to her memory. The ULP stated no nurse had ever asked for her for input regarding fall interventions to prevent falls for the client.

When interviewed, another ULP also indicated the client was unable to use her call pendant to call for assistance. The ULP stated she does not recall the nurse communicating with her regarding new fall interventions for the client or asking for her input.

When interviewed, the executive director (ED) stated she was not aware the client had fallen 18 times in approximately three months. The ED stated it was her expectation that nursing staff completed an investigation to determine causes of the fall(s) and to implement interventions to prevent further falls.

When interviewed, the registered nurse (RN) indicated she did not believe falls at the facility were tracked and trended to determine the cause of the falls and implement falls prevention. She stated she was unaware of what interventions are initially put in place to prevent client falls. The RN verified nursing staff were responsible for implementing and documenting fall interventions.

When interviewed, the client's MD could not determine if the client's falls contributed to her decline in health or death. The MD stated it would be her expectation that the each fall is investigated for causative factors and interventions implemented to prevent reoccurring falls.

In conclusion, neglect against the facility was substantiated.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means:
(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.
(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Vulnerable Adult interviewed: No. The client is deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility made changes in management staff.

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.

cc:

The Office of Ombudsman for Long-Term Care
County Attorney for Meeker
City Attorney for City of Meeker

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H21203	A. BUILDING: _____ B. WING _____	C 11/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECUMEN OF LITCHFIELD SENIOR HOUSING S	200 NORTH HOLCOMBE AVENUE LITCHFIELD, MN 55355

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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, these correction orders have been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: Project #: HL21203011M/HL21203012C On November 12, 2020, a surveyor of this Department's staff visited the above Comprehensive licensed provider and the following correction orders were issued 0265, 0325, 0790, 0860, 0865, 0935 and 1252. At the time of the survey, there were 65 clients receiving services under the comprehensive license.	0 000		
0 265 SS=G	144A.44, Subd. 1(a)(2) Up-To-Date Plan/Accepted Standards Practice 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	0 265		

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0 265	Continued From page 1 active part in developing, modifying, and evaluating the plan and services; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide services according to accepted standards of medical, nursing, and health care practices for falls for one of three clients (C5) reviewed. C5 fell 18 times during her time at the facility. Nursing staff failed to conduct an assessment to determine causative factors and implement specific interventions to minimize the risk of future falls and potential injury following C5's falls. This practice resulted in a level three violation (a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at 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 American Journal of Nursing article titled "When a Fall Occurs" dated November 2007, volume 107, number 11, indicated fall analysis should be completed to identify to the underlying causes and risk factors of the fall. Immediate follow up will help identify and enable staff to initiate preventative measures. The findings include: C5	0 265		

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0 265	Continued From page 2 C5's diagnoses included, but were not limited to, dementia, autonomic dysfunction (damage to the autonomic nervous system), and chronic pain. C5's Service Plan dated February 1, 2020, noted services provided included medication administration and assistance with dressing, grooming, transfers and toileting daily. C5's initial assessment dated February 12, 2020, identified C5 required hands-on assistance for all activities of daily living (ADLs) and medication management. C5 had memory impairment related to Alzheimer's disease and was at risk for falls related to a fall history. C5's fall risk assessment dated February 12, 2020, indicated C5 was considered a high fall risk, and she received medication for hypotension (low blood pressure). C5's Mini-Cognition Assessment dated, February 12, 2020, indicated a score of zero, which identified C5 was not able to follow commands. C5's change of condition assessment dated May 26, 2020, identified C5 required services, which included the need for one-person assistance with ambulation/transfers, bathing, dressing, grooming and toileting. The assessment also indicated a history of falls, disorientation to time, place and/or person related to Alzheimer's disease. C5's care plan, last reviewed September 19, 2020, identified C5 was not safe with transfers/ambulation with use of the walker, required assistance of one staff member, and did not call for assistance. Interventions included: encourage non-skid footwear, decrease clutter, and keep items within reach. An intervention	0 265		

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0 265	Continued From page 3 added to the care plan on May 4, 2020, identified staff should place C5 in the day room during the day to prevent falls. C5's incident reports identified falls on: -February 16, 2020, at 4:40 p.m., C5 attempted to go into another client's room, and she tripped over the other client. The report indicated staff lowered C5 to the ground, and she had no injury. The report did not include an assessment for causative factors or fall interventions. -February 20, 2020, at 9:20 p.m., staff found C5 lying on the floor by another client's room. The report did not include an assessment for causative factors or fall interventions. -March 2, 2020, at 2:00 p.m., staff found C5 on the floor in another client's bathroom. The report did not include an assessment for causative factors or fall interventions. -April 6, 2020, at 6:10 p.m., staff found C5 lying on the floor in her apartment. The report did not include an assessment for causative factors or fall interventions. -April 17, 2020, at 7:45 p.m., staff observed C5 fall in the doorway. The report did not include an assessment for causative factors or fall interventions. -April 22, 2020, at 4:35 a.m., staff found C5 sitting on the floor in front of her closet. The report did not include an assessment for causative factors or fall interventions. -April 23, 2020, at 10:00 a.m., staff found C5 on the floor in front of the bathroom. The report did	0 265		

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0 265	Continued From page 4 not include an assessment for causative factors or fall interventions. -April 26, 2020, at 8:40 a.m., staff observed C5 walk out of her room, fall, and hit her head. She had cuts on her chin and elbow; her teeth were bleeding. Staff sent C5 to the emergency room, and she was hospitalized from April 26, 2020, to April 29, 2020. -April 29, 2020 at 4:00 p.m., staff found C5 on the floor in the bathroom. The report did not include an assessment for causative factors or fall interventions. -April 29, 2020 at 5:15 p.m., staff found C5 on the floor near the toilet. The report did not include an assessment for causative factors of the fall. -April 30, 2020, time unknown, staff found C5 in the hallway sitting on her bottom. The report did not include an assessment for causative factors or fall interventions. -May 3, 2020, at 11:30 a.m., staff found C5 in her room under a table. The report did not include an assessment for causative factors of the fall. -May 6, 2020, at 5:40 p.m., staff found C5 sitting on her bedroom floor facing the window. The report did not include an assessment for causative factors or fall interventions. -May 9, 2020, at 8:30 p.m., staff found C5 on floor in her bedroom. The report did not include an assessment for causative factors of the fall. -May 13, 2020, at 8:00 a.m., staff C5 was found on the floor in her bedroom. The report did not include an assessment for causative factors or	0 265		

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0 265	Continued From page 5 fall interventions. -May 16, 2020, at 5:15 p.m., staff found C5 on the living room floor of her apartment. The report did not include an assessment for causative factors or fall interventions. -May 17, 2020, at 8:00 a.m., staff found C5 on the floor next to her bed. The report did not include an assessment for causative factors or fall interventions. -May 19, 2020, at 8:30 a.m., staff found C5 lying on the floor on her left side holding the side of her head. The report did not include an assessment for causative factors or fall interventions. C6 C6's diagnoses included, but were not limited to, dementia, congestive heart failure, macular degenerations, osteoporosis, delusions/hallucinations and a history of falling. C6's fall risk assessment, dated January 1, 2019, identified a moderate fall risk related to history or falls and a secondary diagnosis. No other fall assessments were provided for C6. C6's service plan, dated July 20, 2020, identified C6 required assistance with dressing, grooming, and bathing and medication management. The service plan did not identify a risk for falls or interventions to prevent falls. Routine safety checks were not included on the service plan, but were included on the care plan. C6's care plan last reviewed August 16, 2020, identified C6 was at risk for falls, hard of hearing with poor vision, forgetful, an elopement risk, and	0 265		

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0 265	Continued From page 6 had hallucinations. The fall interventions dated January 9, 2020, identified C6 will call for assistance if she if feeling weak or unsteady. Interventions for cognition dated September 10, 2019, included staff would provide routine safety checks to ensure safety in a cognitively impaired client. C6's care plan did not include any new interventions to prevent falls after each incident. C6's 90 day assessment, dated May 21, 2020, identified C6 was at risk for falls related to a history of falls and memory. C6's change of condition assessment dated July 29, 2020, identified C6 was forgetful at times and unable to give accurate information, had a history of falls, vision loss, wanders and hallucinations. C6 recently transitioned from a rehabilitation facility due to a rib fracture. C6's incident reports identified falls on: - April 2, 2020, at 7:00 a.m., C6 fell when she attempted to answer the phone. C6 was able to get herself back up. Staff encouraged C6 to use her call light for assistance. The report did not include an assessment for causative factors or fall interventions. - June 11, 2020, at 6:00 a.m., staff found C6 sitting in her apartment on the couch complaining of severe rib pain. She told staff she fell. C6 was transported to the hospital. The report failed to include an assessment for causative factors or fall interventions, but indicated staff would reassess C6 upon her return to the facility. -August 18, 2020, at 2:00 a.m., staff found C6 crawling on the floor to her couch attempting to stand up. She had hit her head and had a bump	0 265		

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0 265	Continued From page 7 with some blood dripping on her forehead. Staff noted interventions included checking her apartment for easier flow and noted recent therapy. The report did not include further assessment for causative factors or fall interventions. -October 30, 2020, at 1:35 a.m., staff heard C6 calling for help and found her lying on the floor. C6 informed staff she fell forward. She was sent to the emergency room and diagnosed with a fractured left humerous. The report failed to include an assessment for causative factors and fall interventions, but indicated staff would reassess C6 upon return her return to the facility. There was no falls assessment for causative factors or fall interventions noted in C6's progress notes following C6's falls on April 2, June 11, August 18, and October 30, 2020. During an interview on November 24, 2020, at approximately 10:45 a.m., unlicensed personnel (ULP)-I indicated she did not recall being interviewed regarding C5's falls. ULP-I also stated C5 was a high fall risk, and C5 did not know how to use her pendant call light. During interview on November 24, 2020, at 1:15 pm., registered nurse (RN)-K stated it was a team effort to come up with interventions to prevent falls. New interventions were added to the service plan. RN-K stated C5 did not have any safety awareness and did not realize she could not walk. RN-K stated the quality assurance nurse from the corporate office was responsible to track and trend falls. During an interview on November 24, 2020, at 3:15 p.m., ULP- J stated she was not aware of	0 265		

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0 265	Continued From page 8 what interventions were put in place to prevent falls for C5. ULP-J also stated she had never been asked for input regarding fall interventions. During an interview at November 24, 2020, at approximately 11:45 a.m., RN-A stated interventions are entered into the client service plan, which are then transferred to the client care plan. RN-A stated staff are alerted to any new interventions if the service plan is changed. RN-A was unaware of what fall interventions were in place upon C5's admission to prevent falls and could not remember what specific interventions were in place for C5 to prevent falls. During an interview on November 25, 2020, at approximately 10:30 a.m., licensed practical nurse (LPN)-L stated new interventions would be documented on shift report. LPN-L stated the RN added interventions to the care plan it would be put in a communication book for staff to review. During an interview on November 25, 2020, at approximately 1:00 p.m., Executive Director (ED)-B stated she signs the incident reports, but does not review them. ED-B stated the clinical director is responsible to review the incident reports and determine if there is a pattern. ED-B stated she was not aware that C5 fell 18 times from admission to discharge, nor had it ever been brought to her attention that C5 may not be appropriate for assisted living. ED-B stated her expectation was to have interventions in place after every fall. ED-B also verified it is the director of nursing's responsibility to track and trend falls. During an interview on December 9, 2020, at 3:45 p.m., the medical doctor (MD) indicated her expectation would be for staff to investigate each fall for causative factors and implement	0 265		

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0 265	Continued From page 9 interventions. The licensees' policy titled, Falls Prevention and Reduction, dated May 2015, identified the RN will incorporate interventions to prevent or reduce the risk of falls into the client's care plan and will communicate these interventions to staff providing services to the client. The RN clinical director will develop and implement a falls prevention and reduction program in coordination with the Housing Manger. The program will be interdisciplinary and will involve staff. No further information was provided. TIME PERIOD TO 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 interviews, and document review, the facility failed to ensure one of one client reviewed (C5) was free from maltreatment. C5 was neglected.	0 325	No Plan of Correction (PoC) is required. Please refer to the public maltreatment report for details.	

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0 325	Continued From page 10 Findings include: On December 7, 2020, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	0 325		
0 790 SS=F	144A.479, Subd. 3 Quality Management Subd. 3.Quality management. The home care provider shall engage in quality management appropriate to the size of the home care provider and relevant to the type of services the home care provider provides. The quality management activity means evaluating the quality of care by periodically reviewing client services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to clients. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to conduct quality management activities appropriate to the size of the home care provider and relevant to the type of services provided. In addition, the licensee failed to ensure at least two years of quality management	0 790		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 790	Continued From page 11 activity documentation was available to Minnesota Departement of Health (MDH) for review. 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: During an interview on November 25, 2020, at approximately 1:00 p.m., executive director (ED)-B verified the quality management team did not meet on a regular basis, and there were no meeting minutes for the last year. The MDH investigator requested quality management meeting minutes for the past year; no meeting minutes were provided. The MDH investigator requested a policy related to quality management; no policy was provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 790		
0 860 SS=D	144A.4791, Subd. 8 Comprehensive Assessment and Monitoring Subd. 8.Comprehensive assessment, monitoring, and reassessment. (a) When the services being	0 860		

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	H21203	A. BUILDING: _____ B. WING _____	C 11/12/2020

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0 860	Continued From page 12 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 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 14 day assessment, ongoing monitoring and reassessment of clients' individualized needs, not to exceed 90 days from the last date of an assessment, for 1 of 3 clients (C5) reviewed. Licensee staff did not conduct a 14 day, change of condition, and post-hospitalization assessments as indicated for C5 from February to May 2020. As of November 2020, nursing staff reported change of condition assessments did not occur after multiple client falls. This practice resulted in a level two violation (a	0 860		

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0 860	Continued From page 13 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 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: C5's diagnoses included, but were not limited to, Alzheimer's disease, autonomic dysfunction, and chronic pain. C5's medical record included a comprehensive initial assessment completed on February 12, 2020. C5's medical record did not include a 14 day assessment. C5's medical record indicated C5 was hospitalized from April 26, 2020, through April 29, 2020. C5 medical record did not include an assessment after C5's return to the facility after hospitalization. C5's medical record included a change of condition assessment dated May 26, 2020; however, the nurse completed the assessment greater than 90 days from the previous assessment. C5's medical record indicated C5 had 18 falls without reassessment or on-going monitoring. During an interview on November, 24, 2020, at approximately 11:45 a.m., registered nurse (RN)-A stated a change in condition assessment should be completed on anyone who has an overnight hospital stay or enrolls in hospice. She further stated she was not instructed to complete a change of condition assessment after multiple	0 860		

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0 860	Continued From page 14 falls. The licensees' policy was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 860		
0 865 SS=D	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 date that home care services are first provided, a home care provider shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the home care provider and by the client or the client's representative documenting agreement on the services to be provided. The service plan must be revised, if needed, based on client review or reassessment under subdivisions 7 and 8. The provider must provide information to the client about changes to the provider's fee for services and how to contact the Office of the Ombudsman for Long-Term Care. (c) The home care provider must implement and provide all services required by the current service plan. (d) The service plan and revised service plan must be entered into the client's record, including notice of a change in a client's fees when applicable.	0 865		

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0 865	Continued From page 15 (e) Staff providing home care services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to update the service plan after multiple falls and functional decline for 2 of 3 clients (C5, C6) reviewed. C5's service plan was not updated until after C5 fell 12 times. C6's service plan was not updated until after multiple falls. 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 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: C5 C5's diagnoses included, but were not limited to, dementia, autonomic dysfunction (damage to the autonomic nervous system), and chronic pain. C5's service plan, dated February 1, 2020, indicated the client services provided included medication administration and daily assistance with dressing, grooming, transfers and toileting. C5's service plan did not include any services related to assistance with mobility. C5's initial assessment, dated February 12, 2020, identified C5 required hands-on assistance with	0 865		

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0 865	Continued From page 16 all activities of daily living (ADLs) and medication management. It was noted C5 had memory impairment related to Alzheimer's disease and was at-risk for falls related to C5's fall history. C5's fall risk assessment, dated February 12, 2020, indicated C5 was considered a high fall risk and received medication for hypotension (low blood pressure). C5's mini-cognition assessment, dated February 12, 2020, indicated a score of zero, which identified C5 was not able to follow commands. C5's change of condition assessment, dated May 26, 2020, identified C5 required services, including one person assistance with ambulation/transfers, bathing, dressing, grooming and toileting. The assessment also indicated C5 had a history of falls, disorientation to time, place and/or person related to Alzheimer's disease. C5's care plan, last reviewed September 19, 2020, identified C5 was not safe with transfers/ambulation with use of a walker, required the assistance of one staff member, and did not call for assistance. C5's care plan interventions included encouraging non-skid footwear, decreasing clutter, and keeping items within reach. An intervention added to C5's care plan on May 4, 2020, instructed staff to place C5 in the day room during the day to prevent falls. C5's incident reports identified C5 experienced 18 falls within a three month time period. C6 C6's diagnoses included, but were not limited to, dementia, congestive heart failure, macular	0 865		

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0 865	Continued From page 17 degenerations, osteoporosis, delusions/hallucinations, and a history of falling. C6's fall risk assessment, dated January 1, 2019, identified a moderate fall risk related to history of falls and a secondary diagnosis. No other fall assessments were provided for C6. C6's fall interventions dated, January 9, 2020, identified C6 will call for assistance if she if feeling weak or unsteady. C6's incident report noted on April 2, 2020, at 7:00 a.m., C6 fell when she attempted to answer the phone. C6 was able to get herself back up. C6 was encouraged to use her call light for assistance. No assessment or interventions were noted in C6's record after the fall. C6's 90 day assessment, dated May 21, 2020, identified C6 was at-risk for falls related to a history of falls and memory impairment. C6's incident report noted on June 11, 2020, at 6:00 a.m., staff found C6 sitting in her apartment on the couch complaining of severe rib pain. She told staff she fell. C6 was transported to the hospital. The report did not include an assessment for fall causative factors or interventions, but noted C6 would be reassessed upon return from the hospital. No assessment or interventions were noted in C6's record after the fall. C6's service plan, dated July 20, 2020, identified C6 required assistance with dressing, grooming, bathing, and medication management. The service plan did not identify a risk for falls or interventions to prevent falls. Routine safety checks were not included on the service plan, but	0 865		

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0 865	Continued From page 18 were on the care plan. C6's change of condition assessment, dated July 29, 2020, identified C6 was forgetful at times, had a history of falls, unable to give accurate information, had vision loss, wanders and has hallucinations. C6 had recently transitioned from a rehabilitation facility due to a rib fracture. C6's care plan, last reviewed on August 16, 2020, identified C6 was at-risk for falls, hard of hearing, with poor vision, forgetful, an elopement risk, and had hallucinations. C6's incident report noted on August 18, 2020, at 2:00 a.m., staff found C6 crawling on the floor to her couch to try and stand up. She stated she hit her head. C6 had a head bump and some blood dripping on her forehead. No assessment was noted in C6's record after the fall. Fall interventions were updated to include check the apartment for easier flow; recent therapy. C6's interventions for cognition, dated September 10, 2019, instructed staff to provide routine safety checks to ensure safety in cognitively impaired client. C6's incident reported noted on October 30, 2020, at 1:35 a.m., staff heard C6 calling for help and found C6 lying on the floor. C6 informed staff she fell forward. Staff sent C6 to the emergency room for a fractured left humerous. The report did not include an assessment for fall causative factors or interventions, but noted C6 would be reassessed upon return from the hospital. No assessment or interventions were noted in C6's record after the fall. During an interview on November 24, 2020, at	0 865		

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0 865	Continued From page 19 approximately 10:45 a.m., unlicensed personnel (ULP)-I indicated she did not recall being interviewed regarding C5's falls. ULP-I also indicated that C5 was a high fall risk, and C5 did not know how to use her pendant call light. During an interview at November 24, 2020, at approximately 11:45 a.m., RN-A stated interventions are entered into the client service plan, which transfers to the care plan. RN-A stated staff are alerted to any new interventions if a service plan is changed. RN-A was unaware of what fall interventions were in place upon C5's admission and could not remember what specific interventions were currently in place. During interview on November 24, 2020, at 1:15 pm., registered nurse (RN)-K stated it was a team effort to come up with interventions to prevent falls. She stated if interventions were added, they would be added to the client's service plan. Furthermore, RN-K stated C5 did not have any safety awareness and did not realize she could not walk. During an interview on November 24, 2020 at 3:15 p.m., ULP- J stated she was not aware of what interventions were put in place to prevent C5's falls. ULP-J also stated she had never been asked for input regarding interventions for falls. During an interview on November 25, 2020 at approximately 10:30 a.m., licensed practical nurse (LPN)-L stated new interventions would be documented on the shift report. LPN-L stated if the RN added interventions to a client's care plan, the new interventions would be put in the communication book for staff to review. During an interview on November 25, 2020, at	0 865		

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0 865	Continued From page 20 approximately 1:00 p.m., Executive Director (ED)-B stated she signs the incident reports, but does not review them. ED-B stated the clinical director is responsible to review the incident reports and determine if there is a pattern. ED-B stated she was not aware that C5 fell 18 times from admission to discharge, nor had it ever been brought to her attention that C5 may not be appropriate for assisted living. ED-B stated her expectation was to have interventions in place after every fall. During an interview on December 9, 2020, at 3:45 p.m., the medical doctor (MD) indicated her expectation would be for staff to investigate each fall for causative factors and implement interventions. A fall assessment policy was requested, but not provided. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) days	0 865		
0 935 SS=D	144A.4792, Subd. 8 Documentation of Administration of Medication Subd. 8.Documentation of administration of medications. Each medication administered by comprehensive home care provider staff must be documented in the client's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not	0 935		

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0 935	Continued From page 21 completed as prescribed and document any follow-up procedures that were provided to meet the client's needs when medication was not administered as prescribed and in compliance with the client's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff administered medications as ordered for one of one client (C5) reviewed. From February to June 2020, licensee staff administered C5's midodrine 15 times when the medication should have been held due to her elevated systolic BP. Licensee also failed to check C5's BP 24 times prior to midodrine administration during the same timeframe. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: C5's diagnoses included, but were not limited to; dementia, autonomic dysfunction (damage to the autonomic nervous system), hypotension (low blood pressure) and chronic pain. C5's service plan, dated February 1, 2020, noted services provided included medication administration and daily assistance with dressing, grooming, transfers and toileting.	0 935		

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0 935	Continued From page 22 C5's initial assessment, dated February 12, 2020, identified C5 required hand-on assistance for all activities of daily living (ADLs) and medication management. C5's initial physician orders on February 7, 2020, included midodrine 5 milligrams (mg) two times a day and to hold the medication if her systolic blood pressure (BP) was above 150 mmHg (millimeters of mercury). C5's February 2020 medication administration record (MAR) identified staff administered midodrine to C5 on February 19, 20, and 27, 2020, even though her systolic BP was above 150 mmHg. C5's March 2020 MAR identified staff administered midodrine to C5 on March 1, 3, 10, 20, 25, and 30, 2020, even though her systolic BP was over 150 mmHg. C5's April 2020 MAR identified 26 total medication errors. Staff administered midodrine on 13 separate occasions without checking C5's BP. Staff administered midodrine 2 times with a BP greater than 150 mmHg. C5's May 2020 MAR identified staff administered midodrine 11 times without checking C5's BP. C5's June 2020 MAR identified staff administered midodrine 4 times when C5's BP was above 150 mmHg. During interview and record review on November 25, 2020 at approximately 10:30 a.m., licensed practical nurse (LPN)-L stated only one medication error for C5 during her stay, which	0 935		

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0 935	Continued From page 23 was in April 2020. During review of February and March 2020 MARs, LPN-L verified staff administered midodrine in error when C5's systolic BP was greater than 150 mmHG on nine separate occasions. LPN-L stated medication error reports should have been completed on those nine errors. LPN-L also stated that no one at the facility routinely conducted medication administration audits or checked the MARs to verify client medications were administered correctly. During an interview on December 9, 2020, at 3:45 p.m., the medical doctor (MD) identified if staff administer midodrine when a systolic BP is above 150 mmHG, it could cause an abnormally elevated BP. The licensee's policy titled, "Administration of Oral Medications," dated May 2015 identified staff will follow the instructions for that client for medication administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 935		
01252 SS=F	144A.4798, Subd. 3 Infection Control Program 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 by:	01252		

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01252	Continued From page 24 Based on observation, interview and record review, the licensee failed to establish and maintain an effective COVID-19 (coronavirus disease-2019) infection control program that complies with accepted health care, medical and nursing standards. The licensee failed to ensure appropriate infection precautions were in place to reduce the risk of disease. The deficient practices had the potential to affect all 65 out of 65 clients, facility staff, and visitors. 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). Eye protection The licensee failed to ensure staff were wearing appropriate personal protective equipment (PPE) The MDH document titled, "COVID-19 Toolkit: Information for Long-Term Care Facilities," dated August 14, 2020, indicated on page 7 facilities should institute use of eye protection (e.g., face shield, goggles, safety glasses with side shields) during all resident care encounters. During an observation on November 12, 2020, at 10:20 a.m., the facility screener did not wear eye protection at the main entrance. During an observation on November 12, 2020, at 10:26 a.m., unlicensed personnel (ULP)-E did not wear eye protection in the hallway with clients present.	01252		

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(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 25 During an observation on November 12, 2020 at approximately 10:45 p.m., while in the dining room with clients, ULP-E did not wear eye protection. Executive director (ED)-B directed ULP- E to wear eye protection during the observation. During an observation and interview on November 12, 2020, ULP-E wore plastic side shields on her regular eye glasses. During an interview on November 12, 2020, at 3:19 p.m., ED-B indicated her expectation was staff wear eye protection at all times. Licensee's policy was requested, but not provided. Visitation/screening The facility failed to ensure completion of COVID-19 visitor screening. The MDH document titled, "COVID-19 Toolkit: Information for Long-Term Care Facilities," dated August 14, 2020, indicates on pages 8 and 47 that facilities should "actively screen all employees and visitors before they enter the building." "If a resident leaves the facility to stay with a family member, exposures to persons with COVID-19 cannot be ruled out. Upon the resident's return, the resident must be quarantined in a private room with a private (not shared) bathroom. With coronavirus, the recommended period to self-quarantine is 14 days." During the initial facility tour on November 12, 2020, at approximately 10:45 a.m., ED-B stated	01252		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H21203	A. BUILDING: _____ B. WING _____	C 11/12/2020

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01252	Continued From page 26 there were three sections to the building; one section included 61 apartments for independent living with the option to utilize housing with services. Clients who received services under the comprehensive home care license also resided in this section of the building. ED-B stated this section of the building allowed clients to come and go and have visitors. Review of the client roster revealed 22 clients resided in the independent living section. The facility has an east entrance open from 8:00 a.m. to 5:00 p.m. with no COVID-19 restrictions or screenings in place for people coming and going from the building. Licensee's policy was requested, but not provided. Hand hygiene The facility failed to ensure staff completed hand hygiene before and after client encounters. The MDH document titled, "COVID-19 Toolkit: Information for Long-Term Care Facilities," dated August 14, 2020, indicates on page 22 that "staff should perform hand hygiene before and after all resident contact." During an observation on November 12, 2020, at 1:50 p.m., ULP- F delivered mail to C1, C2, and C3's room and did not perform hand hygiene before or after entering/exiting the clients' rooms. During an interview at November 12, 2020, at 1:55 p.m., ULP-F verified she did not use hand sanitizer between entering/exiting the clients' rooms.	01252		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01252	Continued From page 27 During observation on November 12, 2020, at 1:55 p.m., ULP-H entered and exited C4's room, then entered C3's room and provided hands on assistance transferring C3 from the recliner to wheelchair. ULP-H did not perform hand hygiene before or after entering or exiting C3 or C4's rooms. During interview on November 12, 2020, at 3:25 p.m., ED-B stated staff should perform hand hygiene in and out of every room. Licensee's Handwashing/Hand Hygiene policy, dated August 2019, identified hand hygiene should be completed before and after contact with residents. No additional information was provided. TIME PERIOD OF CORRECTION: Two (2) days	01252		