DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL23224007M **Date Concluded:** March 23, 2021
Compliance #: HL23224008C

Name, Address, and County of Licensee Investigated:
Minnesota Greenleaf
1006 Greenwood Street East
Thief River Falls, MN 56701
Pennington County

Facility Type: Home Care Provider **Investigator's Name:** Angela Vatalaro, 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 the client when the client was unresponsive for approximately 28 hours before transferring to the hospital. The client diagnosed with a subdural hematoma (brain bleed), hip fracture, and bruising on her right side.

Investigative Findings and Conclusion:
Neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to assess the client's change in needs, implement required assistance with walking and implement fall interventions after repeated falls. The client had five falls within three weeks and sustained a right eye bruise and cut, bleeding lip, bump on head, bruises, and skin tears. Ten days after the last fall, the hospital diagnosed the client's subdual hematoma and right femoral neck (hip) fracture. She died five days later.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, unlicensed staff, and the client's family. The investigation included review of the client's medical record, hospital record, incident reports, internal investigation, death record,

An equal opportunity employer.

policy and procedures related to maltreatment, nursing assessments, service plans, care plans, and falls.

The client's diagnoses included dementia, atrial fibrillation, and macular degeneration. The clients signed service plan indicated she required assistance with medication administration, bathing, cues for dressing and grooming, and safety checks every two-hours. The service plan indicated the client was independent with toileting, transfers/walking, and repositioning.

A nursing assessment indicated the client had disorientation, had history of falls, and used a walker. The assessment indicated the client required assistance of one person for bathing, dressing, grooming, transfers and the client depended on staff for escorts. The client had physical aggression towards staff and would sometimes hit out during cares. The assessment indicated the client had not wandered. The client's service plan was not updated to include the client's required assistance.

Six days after the completed nursing assessment, the client was found on the floor of another client's room after being awake all night. She hit her right check and eye, which resulted in bruising and a six inch long skin tear. The next day, the client's progress note indicated she was "very sleepy" since the fall.

The facility failed to implement any new interventions or monitoring after a fall, change in sleep status and newly documented wandering.

Approximately two weeks later, the client fell twice during the same day. The second fall shehit her head. The facility updated the client's medical provider regarding the client's two falls, refusal to use the walker and indicated concerns over consistency of falls. The facility requested a urine analysis due to increased behaviors and falls. However, the facility failed to implement any new interventions, monitoring or services to address an increase in falls and unidentified behaviors. The client's service plan remained independent with transfers and mobility.

The next day, the medical provider evaluated the client for increased falls, agitation and hypotension (low blood pressure). The client's blood pressure medication was reduced and staff were instructed to hold medication if the blood pressure was below 100/60. The provider noted a left side limp and gait instability. Orders included to check the client's blood pressure twice a day, changed the blood pressure medication to extended release form, started an antipsychotic medication at bedtime and collect a urine analysis. The provider also ordered occupational therapy (OT) and physical therapy (PT) evaluations for safety, strengthening and cognitive assessment.

Three days later, PT and OT completed their evaluations of the client. Both therapies recommended one-staff assist using a gait belt for all transfers, mobility, and activities of daily

living (ADL's). Neither therapy however was able to add to the client to services due to her inability to follow commands due to cognition.

The facility failed to conduct a change in needs assessment related to repetitive falls, change in mental status, increased behaviors and new medications. The facility also failed to update the clients service plan with assistance with transfers as ordered by therapy and found on evaluation. The facility also failed to implement any new safety measures for increased falls and behaviors.

Four days later, the client experienced a fourth fall in her room with no visible injury. The fall documentation indicated, therapy was unable to provide services, but failed to include any new interventions. Early the next morning, the client was found on the floor (fifth fall) and had bruising and a skin tear to her right side. Staff assisted the client back into bed after obtaining vitals. The facility failed to implement any new interventions nor update the service plan with needed assistance with transfers and mobility.

Two days later, staff obtained a straight catheter urine sample for the urine analysis that was ordered nine days prior. The urine analysis results indicated a urinary tract infection and the client started on an antibiotic.

Nine days following the fifth fall, at 1:45 p.m. the client had a change in status with decreased oxygen saturation and lethargy. The next day at about 9:45 a.m., the client's oxygen saturation decreased further below normal with labored breathing. Staff updated the client's family and sent the client to the hospital.

Hospital records indicated the client had a brain bleed and right hip/leg fracture with bruising to the right side of the body. The client discharged the following day back to the facility on hospice services.

The client died four days later. The client's death record indicated cause of death was traumatic subdural hemorrhage (brain bleed), fall, and other significant conditions contributed to death included right femur (hip/leg) fracture.

A review of the client's service flow sheet indicated she was independent with transfers and mobility. In addition, the flow sheet indicated safety checks were provided as needed on each shift, although the service plan indicated every two hours.

During an interview with a family member, she stated the client had falls. She said the facility would notify family of falls and at other times, they would not. She stated the facility did not discuss fall interventions to reduce the risk of falls. She also stated the facility did not discuss adding additional services to the client's care plan. She stated the day the client diagnosed with a subdural hematoma and hip fracture the client had a black eye and a bruised cheek.

During an interview registered nurse (RN)-A stated after the client's falls she conducted an assessment, checked for injury, assessed ambulation, transfers, and checked neuros. She said she did not document her assessment. She said she did not recall the client's functional status or observations after falls. She stated the care plan should have indicated the client's needs to include one-staff assist using a gait belt for transfers, mobility, ADL's, and should have indicated two-hour safety checks.

During an interview, RN-B who identified as the administrator stated a nurse should have conducted and documented an assessment after the client's falls. She stated it is an expectation a nurse conducts a face-to-face assessment within 24 hours. She also said a nurse should have implemented PT/OT recommendations and this should have reflected in the care plan.

During an interview director of nursing (DON)-C stated it is an expectation that the client's care plan accurately reflects assessed needs. She stated it is an expectation that a nurse conducts and documents an assessment after falls. She added the assessment includes the client's range of motion, leg length discrepancies, level of consciousness, neuros, vital signs, full skin assessment, transfers, and mobility. The nursing assessment indicates services necessary to take care of the client. She said the client had a change in status and a nurse should have conducted an assessment. DON-C stated if a nurse would have conducted assessments, implemented PT/OT recommendations, and updated the service plan the client may not have sustained significant injuries that led to her death.

In conclusion, neglect was substantiated.

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

maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Vulnerable Adult interviewed: No, the client was deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility updated the medical provider of the client's falls and implemented orders. The facility sent the client to the hospital for evaluation.

Action taken by the Minnesota Department of Health:

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

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

cc:

The Office of Ombudsman for Long-Term Care
Pennington County Attorney
Thief River Falls City Attorney
Thief River Falls Police Department
The MN Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H23224	A. BUILDING: ______ B. WING ______	C 02/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNESOTA GREENLEAF	**4445 2ND AVE SOUTH FARGO, ND 58103**

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0 000	Initial Comments ******ATTENTION****** HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, the Minnesota Department of Health issued a correction order(s) pursuant to a survey. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: On February 5, 2021, the Minnesota Department of Health initiated an investigation of complaint #HL23224008C/#HL23224007M. At the time of the survey, there were # 40 clients receiving services under the comprehensive license. The following correction orders are issued for #HL23224008C/#HL23224007M, tag identification 0265, 0325, 0805, 0860, 0865 and 2015.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes 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 is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144A.474 SUBDIVISION 11 (b)(1)(2).	
0 265 SS=J	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 implement fall interventions for one of three clients (C1) reviewed. C1 had five falls between August 25, 2020, and September 16, 2020. The last fall resulted in serious injury and as a result, C1 died a short time later. The practice resulted in a level four violation (a violation that results in 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: C1's medical record was reviewed. C1's diagnoses included dementia, atrial fibrillation, and macular degeneration. C1's signed service plan dated April 26, 2019, included assistance with medication administration, bathing, cues for dressing and grooming, and safety checks every two-hours. C1	0 265		

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was independent with toileting, transfers and repositioning.

C1's nursing assessment dated August 19, 2020, indicated C1 was disoriented and a history of falls. The same document indicated C1 required assistance with bathing, dressing, grooming, one-staff assist with transfers, used a walker, and dependent on staff for escorts. C1 had physical aggression and would sometimes hit out at caregivers. C1 had not wandered.

C1's Supervisory Visit dated August 25, 2020, indicated no change to the service plan or care plan.

C1's Post Fall Progress Note and Fall Risk Tool dated August 25, 2020, indicated a score of 10, high risk for falls. C1 was found on the floor of another client's room without her walker after being awake all night. She hit her right cheek and eye. C1 sustained a bruise and cut.

C1's progress notes dated August 26, 2020, at 10:30 a.m., indicated C1 was "very sleepy" since fall and bruising on face had spread.

C1's record lacked any interventions or monitoring after a change in sleep status and newly documented wandering.

C1's progress notes dated August 27, 2020, at 1:40 p.m., indicated C1 had a skin tear that measured six inches long by a half inch wide to her right forearm.

C1's Post Fall Progress Note and Fall Risk Tool dated September 7, 2020, at 3:30 p.m., indicated C1 had fall in her room without injury. Additional actions indicated a urine analysis was requested

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due to increased behaviors and falls.

C1's Post Fall Progress Note and Fall Risk Tool dated September 7, 2020, at 9:00 p.m., C1 had a fall in her room, her lip bled, and she hit her head.

C1's record lacked an new fall interventions implemented or behavior monitoring for increased unidentified behaviors.

C1's update to the medical provider dated September 7, 2020, signed by unlicensed staff indicated C1's falls, C1's refusal to use walker, and indicated concerns over consistency of falls.

C1's medical provider visit dated September 8, 2020, indicated C1 was seen for two falls, increased agitation and hypotension (low blood pressure). C1's blood pressure medication was reduced and staff instructed to hold medication if blood pressure was below 100/60. The provider noted a left sided limp and gait instability. Orders included: check blood pressure twice a day, changed blood pressure medication to extended release form, start antipsychotic medication for two weeks at bedtime and then increase dose. Orders also included consult with Occupational Therapy (OT) for safety evaluation, strengthening and cognitive assessment.

C1's progress note dated September 9, 2020 at 11:00 a.m., indicated C1 had increased behaviors and falls. The nurse requested a urine analysis (UA) lab order. Clinic records, indicated the UA was ordered on September 9, 2020.

C1's progress notes dated September 10, 2020, 3:24 p.m., indicated orders to obtain urine for analysis.

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C1' Occupational Therapy notes dated September 11, 2020, indicated recommendations of one-staff assist using a gait belt for all transfers and during ADL's for safety and verbal and physical cues to use walker. The same document indicated C1 would not receive OT services, due to C1's inability to tolerate therapy.

C1's Physical Therapy notes dated September 11, 2020, indicated C1 required one-staff assist for all mobility and transfers and cues for walker use. The same document indicated C1 would not receive PT services due to cognitive status and decreased ability to follow commands.

C1's record lacked new fall interventions or increased monitoring for safety. C1's plan of care was not updated to reflect the need for staff assistance with ambulation and inability to follow commands with appropriate interventions. C1's record also lacked monitoring for a urinary tract infection symptoms.

C1's progress notes dated September 15, 2020, at 4:24 p.m., indicated the medical provider updated on staff's inability to obtain urine sample due to C1's behaviors and requested an order for straight catheter.

C1's record lacked description of behaviors, monitoring or nursing interventions to attempt to redirect behaviors.

C1's Post Fall Progress Note and Fall Risk Tool dated September 15, 2020, at 5:20 p.m., indicated C1 had a fall in her room without injury. PT evaluated but could not add to services.

C1's post fall assessment dated September 16, 2020, at 3:10 a.m., indicated C1 had a fall in her

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room, and sustained two bruises and a skin tear to right elbow. Unlicensed staff assisted C1 back to bed.

C1's progress notes dated September 18, 2020, at 10:02 a.m., indicated nursing obtained a urine via straight cath. At 4:11 p.m., indicated C1's urine was positive for urinary tract infection and started nitrofurantoin (antibiotic) 100 mg twice daily for five days.

C1's record lacked new fall interventions or increased monitoring for safety. C1's plan of care was not updated to reflect the need for staff assistance with ambulation and inability to follow commands with appropriate interventions. C1's record also lacked monitoring for a urinary tract infection symptoms.

C1's progress notes dated September 25, 2020, at 1:44 p.m., indicated C1 slept all shift. Staff attempted to rouse C1 and she did not wake up. C1's vital signs included blood pressure (B/P) 135/70, temperature 96.8 Fahrenheit, pulse (P) 81, Respirations (R) 18, oxygen saturation (Sp02) 91-94%. At 7:10 p.m., indicated C1 slept all day, was unable to get out of bed and was drowsy. At 8:13 p.m., indicated the nurse spoke to the medical provider and risperdal put on hold until September 29, 2020. At 8:33 p.m., indicated C1 was lethargic, sleepy, had not got out of bed, and had no oral intake. C1's vital signs included BP 150/76, P 81, SpO2 93 %.

C1's progress notes dated September 26, 2020, at 9:43 a.m., indicated nursing received a phone call that C1 was still lethargic, not talking, and not getting out of bed. C1's vital signs included SpO2 low in the 80's and labored breathing. Staff received instruction to call family to see about

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sending C1 to the emergency room.

C1's hospital records dated September 26, 2020, at 2:39 p.m., indicated C1 diagnosed with subdural hematoma, right femoral neck fracture, with poor prognosis. The same records also indicated bruising to the right side of C1's face, shoulder, and buttocks.

C1's progress notes dated September 27, 2020, at 7:52 a.m., indicated C1 diagnosed with a brain bleed and right hip fracture and the medical provider recommended comfort measures. C1 returned to the facility and admitted to hospice services.

C1's progress notes dated October 1, 2020 at 4:27 p.m., indicated C1 passed away at 9:50 a.m.

C1's death record indicated the cause of death was traumatic subdural hemorrhage, fall, and other significant conditions contributed to death included right femur fracture.

During an interview on March 5, 2020, at 11:04 a.m., RN-A stated she followed up on C1's two falls that occurred on September 7, 2020, on September 15, 2020. She said she conducted an assessment, checked for injury, assessed ambulation, transfers, and checked neuro's. RN-A stated she did not document her assessment. She said nursing did not document an assessment of C1's functional status or observations after the two falls that occurred on September 7, 2020. RN-A said she followed up on C1's falls that occurred on September 15, 2020 and September 16, 2020 on September 22, 2020. She said she did not document her assessment. She said she did not recall C1's functional status, or any observations. She said a

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nurse seen C1 on September 18, 2020, and collected a urine sample using a straight catheter. She said nursing did not document an assessment of C1's functional status or observations after falls that occurred on September 7, 15, and 16. She said C1's subdural hematoma and right femur fracture were sustained when C1 fell. RN-A stated assessments should have been conducted and documented.

During an interview on March 9, 2021, at 12:48 p.m., RN-B who identified as the administrator stated a nurse should have conducted and documented an assessment of C1's functional status after falls that occurred on August 25, September 7, September 15, and September 16, 2020. She stated it is an expectation a nurse conducts a face-to-face assessment within 24 hours of a fall that includes any observations, injuries, and functional status. She stated it is an expectation that PT/OT recommendations implement and this should have reflected in C1's care plan.

During an interview on March 10, 2021, at 2:26 p.m., director of nursing (DON)-C stated it is an expectation that a nurse conducts and documents an assessment after falls. She stated the assessment includes range of motion, leg length discrepancies, level of consciousness, neuro's, vital signs, full skin assessment, transfers, and mobility. She stated the nursing assessment indicates the services necessary to take care of the client. She stated with C1's change in status it was an expectation that a nurse conducts an assessment. DON-C stated if the licensee would have conducted assessments, implemented PT/OT recommendations, and updated the service plan, C1 may not have

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0 265	Continued From page 8 sustained significant injury that led to her death. The licensee policy titled "Care Plan" dated May 1, 2015, indicated Care Plans will included activities of daily living needs and preferences, including ambulation and physical needs. The policy indicated "other areas" would be included as necessary or appropriate and updated annually or if the client's condition, needs or preferences change. 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 interviews and document review, the facility failed to ensure one of three clients reviewed (C1) was free from maltreatment. C1 was neglected. Findings include: On March 23, 2021, the Minnesota Department of Health (MDH) issued a determination that neglect	0 325	No plan of correction is required for tag 325. Please refer to public maltreatment report for details.	

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0 325	Continued From page 9 occurred, and that the facility was responsible for the maltreatment, in connection with an incident which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	0 325		
0 805 SS=D	144A.479, Subd. 6(a) Reporting Maltrx of Vulnerable Adults/Minors Subd. 6.Reporting maltreatment of vulnerable adults and minors. (a) All home care providers must comply with requirements for the reporting of maltreatment of minors in section 626.556 and the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. Each home care provider must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to report suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC) immediately, but no longer than 24 hours for one of three clients (C1) reviewed. C1 diagnosed with a subdural hematoma (brain bleed) and a right femoral neck fracture (hip) at the hospital and passed away five days later. The 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	0 805		

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situation has occurred only occasionally)

The findings include:

C1's medical record was reviewed. C1's diagnoses included dementia, atrial fibrillation, and macular degeneration.

C1's signed service plan dated April 26, 2019, included assistance with medication administration, bathing, cues for dressing and grooming, and safety checks every two-hours.

C1's vulnerability assessment dated October 22, 2019, indicated C1 was unable to report abuse, neglect, or concerns.

C1's nursing assessment dated August 19, 2020, indicated C1 was disoriented and a history of falls. The same document indicated C1 required assistance with bathing, dressing, grooming, one-staff assist with transfers, used a walker, and dependent on staff for escorts.

C1's progress notes dated August 25, 2020, indicated C1 walked without her walker, fell face forward onto the floor. She hit her right cheek and eye. C1 sustained a bruise and cut.

C1's nursing assessment dated August 25, 2020, indicated no change to the service plan or care plan.

C1's Post Fall Progress Note and Fall Risk Tool dated August 25, 2020, indicated a score of 10, high risk for falls. The same document did not include an assessment of C1's functional status.

C1's progress notes dated August 26, 2020, at 10:30 a.m., indicated C1, was "very sleepy" since

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fall and bruising on face had spread.

C1's progress notes dated August 27, 2020, at 1:40 p.m., indicated C1 had skin tear that measured six inches long by a half inch wide to her right forearm.

C1's Post Fall Progress Note and Fall Risk Tool dated September 7, 2020, at 3:30 p.m., indicated C1 had fall in her room without injury.

C1's Post Fall Progress Note and Fall Risk Tool dated September 7, 2020, at 9:00 p.m., C1 had a fall in her room, her lip bled, and she hit her head.

C1's update to the medical provider dated September 7, 2020, signed by unlicensed staff indicated C1's falls, C1's refusal to use walker, and indicated concerns over consistency of falls.

C1's medical provider visit dated September 8, 2020, indicated C1 was seen for two falls, increased agitation and hypotension (low blood pressure). C1's blood pressure medication was reduced and staff instructed to hold medication if blood pressure was below 100/60. The provider noted a left sided limp and gait instability. Orders included: check blood pressure twice a day, changed blood pressure medication to extended release form, start antipsychotic medication for two weeks at bedtime and then increase dose. Orders also included consult with Occupational Therapy (OT) for safety evaluation, strengthening and cognitive assessment.

C1's progress notes dated September 10, 2020, 3:24 p.m., indicated orders to obtain urine for analysis.

C1' Occupational Therapy notes dated

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0 805	Continued From page 12 September 11, 2020, indicated recommendations of one-staff assist using a gait belt for all transfers and during ADL's for safety and verbal and physical cues to use walker. The same document indicated C1 would not receive OT services, due to C1's inability to tolerate therapy. C1's Physical Therapy notes dated September 11, 2020, indicated C1 required one-staff assist for all mobility and transfers and cues for walker use. The same document indicated C1 would not receive PT services due to cognitive status and decreased ability to follow commands. C1's progress notes dated September 15, 2020, at 4:24 p.m., indicated the medical provider updated on staff's inability to obtain urine sample due to C1's behaviors and requested an order for straight catheter. C1's progress notes dated September 15, 2020, at 4:33 p.m., indicated C1 did not admit to PT/OT services. C1's Post Fall Progress Note and Fall Risk Tool dated September 15, 2020, at 5:20 p.m., indicated C1 had a fall in her room without injury. C1's Post Fall Progress Note and Fall Risk Tool dated September 16, 2020, at 3:10 a.m., indicated C1 had a fall in her room, and sustained two bruises and a skin tear to right elbow. Unlicensed staff assisted C1 back to bed. C1's progress notes dated September 18, 2020, at 10:02 a.m., indicated nursing obtained a urine via straight cath. The same progress notes did not include C1's functional status after falls or observations made by the nurse.	0 805		

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0 805	Continued From page 13	0 805		

C1's progress notes dated September 18, 2020, at 4:11 p.m., indicated C1's urine was positive for urinary tract infection and started nitrofurantoin (antibiotic) 100 mg twice daily for five days.

C1's medication administration record indicated on September 24, 2020, indicated C1 received risperdal 0.5 mg.

C1's progress notes dated September 25, 2020, at 1:44 p.m., indicated C1 slept all shift. Staff attempted to rouse C1 and she did not wake up. C1's vital signs included blood pressure (B/P) 135/70, temperature 96.8 Fahrenheit, pulse (P) 81, Respirations (R) 18, oxygen saturation (Sp02) 91-94%. At 7:10 p.m., indicated C1 slept all day, was unable to get out of bed and was drowsy. At 8:13 p.m., indicated the nurse spoke to the medical provider and risperdal put on hold until September 29, 2020. At 8:33 p.m., indicated C1 was lethargic, sleepy, had not got out of bed, and had no oral intake. C1's vital signs included BP 150/76, P 81, SpO2 93 %.

C1's progress notes dated September 26, 2020, at 9:43 a.m., indicated nursing received a phone call that C1 was still lethargic, not talking, and not getting out of bed. C1's vital signs included SpO2 low in the 80's and labored breathing. Staff received instruction to call family to see about sending C1 to the emergency room.

C1's hospital records dated September 26, 2020, at 2:39 p.m., indicated C1 diagnosed with subdural hematoma, right femoral neck fracture, with poor prognosis. The same records also indicated bruising to the right side of C1's face, shoulder, and buttocks.

C1's progress notes dated September 27, 2020,

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at 7:52 a.m., indicated C1 diagnosed with a brain bleed and right hip fracture and the medical provider recommended comfort measures. C1 returned to the facility and admitted to hospice services.

C1's progress notes dated October 1, 2020 at 4:27 p.m., indicated C1 passed away at 9:50 a.m.

C1's death record indicated the cause of death was traumatic subdural hemorrhage, fall, and other significant conditions contributed to death included right femur fracture.

During an interview on March 5, 2020, at 11:04 a.m., RN-A stated she followed up on C1's two falls that occurred on September 7, 2020, on September 15, 2020. She said she conducted an assessment, checked for injury, assessed ambulation, transfers, and checked neuro's. RN-A stated she did not document her assessment. She said nursing did not document an assessment of C1's functional status or observations after the two falls that occurred on September 7, 2020. RN-A said she followed up on C1's falls that occurred on September 15, 2020 and September 16, 2020 on September 22, 2020. She said she did not document her assessment. She said she did not recall C1's functional status, or any observations. She said a nurse seen C1 on September 18, 2020, and collected a urine sample using a straight catheter. RN-A stated assessments should have been conducted and documented.

During an interview on March 9, 2021, at 12:48 p.m., RN-B who identified as the administrator stated a nurse should have conducted and documented an assessment of C1's functional status after falls that occurred on August 25,

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September 7, September 15, and September 16, 2020. She stated it is an expectation a nurse conducts a face-to-face assessment within 24 hours of a fall that includes any observations, injuries, and functional status. She stated it is an expectation that PT/OT recommendations implement and this should have reflected in C1's care plan.

During an interview on March 10, 2021, at 2:26 p.m., director of nursing (DON)-C stated it is an expectation that a nurse conducts and documents an assessment after falls. She stated the assessment includes range of motion, leg length discrepancies, level of consciousness, neuro's, vital signs, full skin assessment, transfers, and mobility. She stated the nursing assessment indicates the services necessary to take care of the client. She stated with C1's change in status it was an expectation that a nurse conducts an assessment. DON-C stated if the licensee would have conducted assessments, implemented PT/OT recommendations, and updated the service plan, C1 may not have sustained significant injury that led to her death. She stated once the facility learned of C1's significant injuries this should have reported to MAARC.

The licensee policy titled "Mandated Reporting" dated January 1, 2016, indicated maltreatment would be reported to the Minnesota Adult Abuse Reporting Center (MAARC). The policy did not include timing of report.

TIME PERIOD FOR CORRECTION: Seven (7) days

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0 860	Continued From page 16	0 860		
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 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 document review, the licensee failed to conduct a change in needs assessment for one of three clients (C1) reviewed. C1 had five falls between August 25, 2020, and September 16, 2020, required additional assistance with ambulation and had increased cognitive decline. This practice resulted in a level three violation (a	0 860		

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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:

C1's medical record was reviewed. C1's diagnoses included dementia, atrial fibrillation, and macular degeneration.

C1's signed service plan dated April 26, 2019, included assistance with medication administration, bathing, cues for dressing and grooming, and safety checks every two-hours. C1 was independent with toileting, transfers and repositioning.

C1's nursing assessment dated August 19, 2020, indicated C1 was disoriented and a history of falls. The same document indicated C1 required assistance with bathing, dressing, grooming, one-staff assist with transfers, used a walker, and dependent on staff for escorts. C1 had physical aggression and would sometimes hit out at caregivers. C1 had not wandered.

C1's Supervisory Visit dated August 25, 2020, indicated no change to the service plan or care plan.

C1's Post Fall Progress Note and Fall Risk Tool dated August 25, 2020, indicated a score of 10, high risk for falls. C1 was found on the floor of another client's room without her walker after being awake all night. She hit her right cheek and

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0 860	Continued From page 18 eye. C1 sustained a bruise and cut. C1's progress notes dated August 26, 2020, at 10:30 a.m., indicated C1 was "very sleepy" since fall and bruising on face had spread. C1's progress notes dated August 27, 2020, at 1:40 p.m., indicated C1 had a skin tear that measured six inches long by a half inch wide to her right forearm. C1's Post Fall Progress Note and Fall Risk Tool dated September 7, 2020, at 3:30 p.m., indicated C1 had fall in her room without injury. Additional actions indicated a urine analysis was requested due to increased behaviors and falls. C1's Post Fall Progress Note and Fall Risk Tool dated September 7, 2020, at 9:00 p.m., C1 had a fall in her room, her lip bled, and she hit her head. C1's update to the medical provider dated September 7, 2020, signed by unlicensed staff indicated C1's falls, C1's refusal to use walker, and indicated concerns over consistency of falls. C1's medical provider visit dated September 8, 2020, indicated C1 was seen for two falls, increased agitation and hypotension (low blood pressure). C1's blood pressure medication was reduced and staff instructed to hold medication if blood pressure was below 100/60. The provider noted a left sided limp and gait instability. Orders included: check blood pressure twice a day, changed blood pressure medication to extended release form, start antipsychotic medication for two weeks at bedtime and then increase dose. Orders also included consult with Occupational Therapy (OT) for safety evaluation, strengthening and cognitive assessment.	0 860		

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C1's progress note dated September 9, 2020 at 11:00 a.m., indicated C1 had increased behaviors and falls. The nurse requested a urine analysis (UA) lab order. Clinic records, indicated the UA was ordered on September 9, 2020.

C1's progress notes dated September 10, 2020, 3:24 p.m., indicated orders to obtain urine for analysis.

C1' Occupational Therapy notes dated September 11, 2020, indicated recommendations of one-staff assist using a gait belt for all transfers and during ADL's for safety and verbal and physical cues to use walker. The same document indicated C1 would not receive OT services, due to C1's inability to tolerate therapy.

C1's Physical Therapy notes dated September 11, 2020, indicated C1 required one-staff assist for all mobility and transfers and cues for walker use. The same document indicated C1 would not receive PT services due to cognitive status and decreased ability to follow commands.

C1's record lacked a change in needs assessment completed by a registered nurse (RN) after C1 experienced several repeated falls, wandering, walking without her walker and OT/PT evaluations which indicated she required assistance of one person for walking and was unable to follow commands due to cognition. C1 also had increased behaviors and concerns about a urinary tract infection.

C1's progress notes dated September 15, 2020, at 4:24 p.m., indicated the medical provider updated on staff's inability to obtain urine sample due to C1's behaviors and requested an order for

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straight catheter.

C1's Post Fall Progress Note and Fall Risk Tool dated September 15, 2020, at 5:20 p.m., indicated C1 had a fall in her room without injury. PT evaluated but could not add to services.

C1's post fall assessment dated September 16, 2020, at 3:10 a.m., indicated C1 had a fall in her room, and sustained two bruises and a skin tear to right elbow. Unlicensed staff assisted C1 back to bed.

C1's progress notes dated September 18, 2020, at 10:02 a.m., indicated nursing obtained a urine via straight cath. The same progress notes did not include C1's functional status after falls or observations made by the nurse.

C1's progress notes dated September 18, 2020, at 4:11 p.m., indicated C1's urine was positive for urinary tract infection and started nitrofurantoin (antibiotic) 100 mg twice daily for five days.

C1's record lacked a change in needs assessment completed by a registered nurse (RN) after C1 experienced several repeated falls, wandering, walking without her walker and OT/PT evaluations which indicated she required assistance of one person for walking and was unable to follow commands due to cognition. C1 also had increased behaviors and concerns about a urinary tract infection.

During an interview on March 5, 2020, at 11:04 a.m., RN-A stated she followed up on C1's two falls that occurred on September 7, 2020, on September 15, 2020. She said she conducted an assessment, checked for injury, assessed ambulation, transfers, and checked neuro's.

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RN-A stated she did not document her assessment. She said nursing did not document an assessment of C1's functional status or observations after the two falls that occurred on September 7, 2020. RN-A said she followed up on C1's falls that occurred on September 15, 2020 and September 16, 2020 on September 22, 2020. She said she did not document her assessment. She said she did not recall C1's functional status, or any observations. She said a nurse seen C1 on September 18, 2020, and collected a urine sample using a straight catheter. RN-A stated assessments should have been conducted and documented.

During an interview on March 9, 2021, at 12:48 p.m., RN-B who identified as the administrator stated a nurse should have conducted and documented an assessment of C1's functional status after falls that occurred on August 25, September 7, September 15, and September 16, 2020. She stated it is an expectation a nurse conducts a face-to-face assessment within 24 hours of a fall that includes any observations, injuries, and functional status. She stated it is an expectation that PT/OT recommendations implement and this should have reflected in C1's care plan.

The licensee policy titled "Assessments-Schedules" dated June 3, 2015, indicated the nurse conducts assessments, monitoring and reassessments consistent with comprehensive home care requirements and the individualized needs of each home care resident.

TIME PERIOD FOR CORRECTION: Seven (7) Days

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0 865	Continued From page 22	0 865		
0 865 SS=J	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. (e) Staff providing home care services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed implement fall interventions for one of three clients (C1) reviewed. C1 had five falls between August 25, 2020, and September 16, 2020. The last fall resulted in serious injury	0 865		

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and as a result, C1 died a short time later.

The practice resulted in a level four violation (a violation that results in 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:

C1's medical record was reviewed. C1's diagnoses included dementia, atrial fibrillation, and macular degeneration.

C1's signed service plan dated April 26, 2019, included assistance with medication administration, bathing, cues for dressing and grooming, and safety checks every two-hours. C1 was independent with toileting, transfers and repositioning.

C1's nursing assessment dated August 19, 2020, indicated C1 was disoriented and a history of falls. The same document indicated C1 required assistance with bathing, dressing, grooming, one-staff assist with transfers, used a walker, and dependent on staff for escorts. C1 had physical aggression and would sometimes hit out at caregivers. C1 had not wandered.

The licensee failed to update C1's service plan to include services to assist with dressing, grooming, transfers and escorts.

C1's Supervisory Visit dated August 25, 2020, indicated no change to the service plan or care plan.

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0 865	Continued From page 24	0 865		

C1's Post Fall Progress Note and Fall Risk Tool dated August 25, 2020, indicated a score of 10, high risk for falls. C1 was found on the floor of another client's room without her walker after being awake all night. She hit her right cheek and eye. C1 sustained a bruise and cut.

C1's progress notes dated August 26, 2020, at 10:30 a.m., indicated C1 was "very sleepy" since fall and bruising on face had spread.

C1's progress notes dated August 27, 2020, at 1:40 p.m., indicated C1 had a skin tear that measured six inches long by a half inch wide to her right forearm.

C1's Post Fall Progress Note and Fall Risk Tool dated September 7, 2020, at 3:30 p.m., indicated C1 had fall in her room without injury. Additional actions indicated a urine analysis was requested due to increased behaviors and falls.

C1's Post Fall Progress Note and Fall Risk Tool dated September 7, 2020, at 9:00 p.m., C1 had a fall in her room, her lip bled, and she hit her head.

C1's update to the medical provider dated September 7, 2020, signed by unlicensed staff indicated C1's falls, C1's refusal to use walker, and indicated concerns over consistency of falls.

C1's medical provider visit dated September 8, 2020, indicated C1 was seen for two falls, increased agitation and hypotension (low blood pressure). C1's blood pressure medication was reduced and staff instructed to hold medication if blood pressure was below 100/60. The provider noted a left sided limp and gait instability. Orders included: check blood pressure twice a day, changed blood pressure medication to extended

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0 865	Continued From page 25	0 865		

release form, start antipsychotic medication for two weeks at bedtime and then increase dose. Orders also included consult with Occupational Therapy (OT) for safety evaluation, strengthening and cognitive assessment.

C1's progress note dated September 9, 2020 at 11:00 a.m., indicated C1 had increased behaviors and falls. The nurse requested a urine analysis (UA) lab order. Clinic records, indicated the UA was ordered on September 9, 2020.

C1's progress notes dated September 10, 2020, 3:24 p.m., indicated orders to obtain urine for analysis.

C1' Occupational Therapy notes dated September 11, 2020, indicated recommendations of one-staff assist using a gait belt for all transfers and during ADL's for safety and verbal and physical cues to use walker. The same document indicated C1 would not receive OT services, due to C1's inability to tolerate therapy.

C1's Physical Therapy notes dated September 11, 2020, indicated C1 required one-staff assist for all mobility and transfers and cues for walker use. The same document indicated C1 would not receive PT services due to cognitive status and decreased ability to follow commands.

The licensee failed to update C1's service plan to include orders from therapy indicating C1 required assistance of one person for transfers and ambulation.

C1's progress notes dated September 15, 2020, at 4:24 p.m., indicated the medical provider updated on staff's inability to obtain urine sample due to C1's behaviors and requested an order for

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0 865	Continued From page 26	0 865		

straight catheter.

C1's Post Fall Progress Note and Fall Risk Tool dated September 15, 2020, at 5:20 p.m., indicated C1 had a fall in her room without injury. PT evaluated but could not add to services.

C1's Post Fall Progress Note and Fall Risk Tool dated September 16, 2020, at 3:10 a.m., indicated C1 had a fall in her room, and sustained two bruises and a skin tear to right elbow. Unlicensed staff assisted C1 back to bed.

C1's progress notes dated September 18, 2020, at 10:02 a.m., indicated nursing obtained a urine via straight cath. At 4:11 p.m., indicated C1's urine was positive for urinary tract infection and started nitrofurantoin (antibiotic) 100 mg twice daily for five days.

C1's progress notes dated September 25, 2020, at 1:44 p.m., indicated C1 slept all shift. Staff attempted to rouse C1 and she did not wake up. C1's vital signs included blood pressure (B/P) 135/70, temperature 96.8 Fahrenheit, pulse (P) 81, Respirations (R) 18, oxygen saturation (Sp02) 91-94%. At 7:10 p.m., indicated C1 slept all day, was unable to get out of bed and was drowsy. At 8:13 p.m., indicated the nurse spoke to the medical provider and risperdal put on hold until September 29, 2020. At 8:33 p.m., indicated C1 was lethargic, sleepy, had not got out of bed, and had no oral intake. C1's vital signs included BP 150/76, P 81, SpO2 93 %.

C1's progress notes dated September 26, 2020, at 9:43 a.m., indicated nursing received a phone call that C1 was still lethargic, not talking, and not getting out of bed. C1's vital signs included SpO2 low in the 80's and labored breathing. Staff

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0 865	Continued From page 27 received instruction to call family to see about sending C1 to the emergency room. C1's hospital records dated September 26, 2020, at 2:39 p.m., indicated C1 diagnosed with subdural hematoma, right femoral neck fracture, with poor prognosis. The same records also indicated bruising to the right side of C1's face, shoulder, and buttocks. C1's progress notes dated September 27, 2020, at 7:52 a.m., indicated C1 diagnosed with a brain bleed and right hip fracture and the medical provider recommended comfort measures. C1 returned to the facility and admitted to hospice services. C1's service Flow Sheet dated September 2020, indicated C1 was independent with transfer, repositioning and safety checks were deemed "PRN (as needed)" throughout shift. C1's progress notes dated October 1, 2020 at 4:27 p.m., indicated C1 passed away at 9:50 a.m. C1's death record indicated the cause of death was traumatic subdural hemorrhage, fall, and other significant conditions contributed to death included right femur fracture. During an interview on March 5, 2020, at 11:04 a.m., RN-A stated she followed up on C1's two falls that occurred on September 7, 2020, on September 15, 2020. She said she conducted an assessment, checked for injury, assessed ambulation, transfers, and checked neuro's. RN-A stated she did not document her assessment. She said nursing did not document an assessment of C1's functional status or observations after the two falls that occurred on	0 865		

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0 865	Continued From page 28 September 7, 2020. RN-A said she followed up on C1's falls that occurred on September 15, 2020 and September 16, 2020 on September 22, 2020. She said she did not document her assessment. She said she did not recall C1's functional status, or any observations. She said a nurse seen C1 on September 18, 2020, and collected a urine sample using a straight catheter. She said nursing did not document an assessment of C1's functional status or observations after falls that occurred on September 7, 15, and 16. She said C1's subdural hematoma and right femur fracture were sustained when C1 fell. RN-A stated assessments should have been conducted and documented. During an interview on March 9, 2021, at 12:48 p.m., RN-B who identified as the administrator stated a nurse should have conducted and documented an assessment of C1's functional status after falls that occurred on August 25, September 7, September 15, and September 16, 2020. She stated it is an expectation a nurse conducts a face-to-face assessment within 24 hours of a fall that includes any observations, injuries, and functional status. She stated it is an expectation that PT/OT recommendations implement and this should have reflected in C1's care plan. During an interview on March 10, 2021, at 2:26 p.m., director of nursing (DON)-C stated it is an expectation that a nurse conducts and documents an assessment after falls. She stated the assessment includes range of motion, leg length discrepancies, level of consciousness, neuro's, vital signs, full skin assessment, transfers, and mobility. She stated the nursing assessment indicates the services necessary to	0 865		

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0 865	Continued From page 29 take care of the client. She stated with C1's change in status it was an expectation that a nurse conducts an assessment. DON-C stated if the licensee would have conducted assessments, implemented PT/OT recommendations, and updated the service plan, C1 may not have sustained significant injury that led to her death. The licensee policy titled "Service Plans," dated May 1, 2015, indicated the service plan must be modified due to change in prescriber's orders or a change in the client's needs. The updated service plan would be completed and reviewed with the client or responsibly party. TIME PERIOD FOR CORRECTION: Seven (7) Days	0 865		
02015 SS=D	626.557, Subd. 3 Timing of Report Subd. 3.Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe	02015		

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that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4).

(b) A person not required to report under the provisions of this section may voluntarily report as described above.

(c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point.

(d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.

(e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the

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licensee failed to report suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC) immediately, but no longer than 24 hours for one of three clients (C1) reviewed. C1 diagnosed with a subdural hematoma (brain bleed) and a right femoral neck fracture (hip) at the hospital and passed away five days later.

The 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:

C1's medical record was reviewed. C1's diagnoses included dementia, atrial fibrillation, and macular degeneration.

C1's signed service plan dated April 26, 2019, included assistance with medication administration, bathing, cues for dressing and grooming, and safety checks every two-hours.

C1's vulnerability assessment dated October 22, 2019, indicated C1 was unable to report abuse, neglect, or concerns.

C1's nursing assessment dated August 19, 2020, indicated C1 was disoriented and a history of falls. The same document indicated C1 required assistance with bathing, dressing, grooming, one-staff assist with transfers, used a walker, and dependent on staff for escorts.

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C1's progress notes dated August 25, 2020, indicated C1 walked without her walker, fell face forward onto the floor. She hit her right cheek and eye. C1 sustained a bruise and cut.

C1's nursing assessment dated August 25, 2020, indicated no change to the service plan or care plan.

C1's Post Fall Progress Note and Fall Risk Tool dated August 25, 2020, indicated a score of 10, high risk for falls. The same document did not include an assessment of C1's functional status.

C1's progress notes dated August 26, 2020, at 10:30 a.m., indicated C1, was "very sleepy" since fall and bruising on face had spread.

C1's progress notes dated August 27, 2020, at 1:40 p.m., indicated C1 had skin tear that measured six inches long by a half inch wide to her right forearm.

C1's Post Fall Progress Note and Fall Risk Tool dated September 7, 2020, at 3:30 p.m., indicated C1 had fall in her room without injury.

C1's Post Fall Progress Note and Fall Risk Tool dated September 7, 2020, at 9:00 p.m., C1 had a fall in her room, her lip bled, and she hit her head.

C1's update to the medical provider dated September 7, 2020, signed by unlicensed staff indicated C1's falls, C1's refusal to use walker, and indicated concerns over consistency of falls.

C1's medical provider visit dated September 8, 2020, indicated C1 was seen for two falls, increased agitation and hypotension (low blood pressure). C1's blood pressure medication was

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02015	Continued From page 33 reduced and staff instructed to hold medication if blood pressure was below 100/60. The provider noted a left sided limp and gait instability. Orders included: check blood pressure twice a day, changed blood pressure medication to extended release form, start antipsychotic medication for two weeks at bedtime and then increase dose. Orders also included consult with Occupational Therapy (OT) for safety evaluation, strengthening and cognitive assessment. C1's progress notes dated September 10, 2020, 3:24 p.m., indicated orders to obtain urine for analysis. C1' Occupational Therapy notes dated September 11, 2020, indicated recommendations of one-staff assist using a gait belt for all transfers and during ADL's for safety and verbal and physical cues to use walker. The same document indicated C1 would not receive OT services, due to C1's inability to tolerate therapy. C1's Physical Therapy notes dated September 11, 2020, indicated C1 required one-staff assist for all mobility and transfers and cues for walker use. The same document indicated C1 would not receive PT services due to cognitive status and decreased ability to follow commands. C1's progress notes dated September 15, 2020, at 4:24 p.m., indicated the medical provider updated on staff's inability to obtain urine sample due to C1's behaviors and requested an order for straight catheter. C1's progress notes dated September 15, 2020, at 4:33 p.m., indicated C1 did not admit to PT/OT services.	02015		

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02015	Continued From page 34 C1's Post Fall Progress Note and Fall Risk Tool dated September 15, 2020, at 5:20 p.m., indicated C1 had a fall in her room without injury. C1's Post Fall Progress Note and Fall Risk Tool dated September 16, 2020, at 3:10 a.m., indicated C1 had a fall in her room, and sustained two bruises and a skin tear to right elbow. Unlicensed staff assisted C1 back to bed. C1's progress notes dated September 18, 2020, at 10:02 a.m., indicated nursing obtained a urine via straight cath. The same progress notes did not include C1's functional status after falls or observations made by the nurse. C1's progress notes dated September 18, 2020, at 4:11 p.m., indicated C1's urine was positive for urinary tract infection and started nitrofurantoin (antibiotic) 100 mg twice daily for five days. C1's medication administration record indicated on September 24, 2020, indicated C1 received risperdal 0.5 mg. C1's progress notes dated September 25, 2020, at 1:44 p.m., indicated C1 slept all shift. Staff attempted to rouse C1 and she did not wake up. C1's vital signs included blood pressure (B/P) 135/70, temperature 96.8 Fahrenheit, pulse (P) 81, Respirations (R) 18, oxygen saturation (Sp02) 91-94%. At 7:10 p.m., indicated C1 slept all day, was unable to get out of bed and was drowsy. At 8:13 p.m., indicated the nurse spoke to the medical provider and risperdal put on hold until September 29, 2020. At 8:33 p.m., indicated C1 was lethargic, sleepy, had not got out of bed, and had no oral intake. C1's vital signs included BP 150/76, P 81, SpO2 93 %.	02015		

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02015	Continued From page 35	02015		

C1's progress notes dated September 26, 2020, at 9:43 a.m., indicated nursing received a phone call that C1 was still lethargic, not talking, and not getting out of bed. C1's vital signs included SpO2 low in the 80's and labored breathing. Staff received instruction to call family to see about sending C1 to the emergency room.

C1's hospital records dated September 26, 2020, at 2:39 p.m., indicated C1 diagnosed with subdural hematoma, right femoral neck fracture, with poor prognosis. The same records also indicated bruising to the right side of C1's face, shoulder, and buttocks.

C1's progress notes dated September 27, 2020, at 7:52 a.m., indicated C1 diagnosed with a brain bleed and right hip fracture and the medical provider recommended comfort measures. C1 returned to the facility and admitted to hospice services.

C1's progress notes dated October 1, 2020 at 4:27 p.m., indicated C1 passed away at 9:50 a.m.

C1's death record indicated the cause of death was traumatic subdural hemorrhage, fall, and other significant conditions contributed to death included right femur fracture.

During an interview on March 5, 2020, at 11:04 a.m., RN-A stated she followed up on C1's two falls that occurred on September 7, 2020, on September 15, 2020. She said she conducted an assessment, checked for injury, assessed ambulation, transfers, and checked neuro's. RN-A stated she did not document her assessment. She said nursing did not document an assessment of C1's functional status or observations after the two falls that occurred on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H23224	A. BUILDING: ______ B. WING ______	C 02/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNESOTA GREENLEAF	4445 2ND AVE SOUTH FARGO, ND 58103

(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
02015	Continued From page 36 September 7, 2020. RN-A said she followed up on C1's falls that occurred on September 15, 2020 and September 16, 2020 on September 22, 2020. She said she did not document her assessment. She said she did not recall C1's functional status, or any observations. She said a nurse seen C1 on September 18, 2020, and collected a urine sample using a straight catheter. RN-A stated assessments should have been conducted and documented. During an interview on March 9, 2021, at 12:48 p.m., RN-B who identified as the administrator stated a nurse should have conducted and documented an assessment of C1's functional status after falls that occurred on August 25, September 7, September 15, and September 16, 2020. She stated it is an expectation a nurse conducts a face-to-face assessment within 24 hours of a fall that includes any observations, injuries, and functional status. She stated it is an expectation that PT/OT recommendations implement and this should have reflected in C1's care plan. During an interview on March 10, 2021, at 2:26 p.m., director of nursing (DON)-C stated it is an expectation that a nurse conducts and documents an assessment after falls. She stated the assessment includes range of motion, leg length discrepancies, level of consciousness, neuro's, vital signs, full skin assessment, transfers, and mobility. She stated the nursing assessment indicates the services necessary to take care of the client. She stated with C1's change in status it was an expectation that a nurse conducts an assessment. DON-C stated if the licensee would have conducted assessments, implemented PT/OT recommendations, and updated the service plan, C1 may not have	02015		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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
02015	Continued From page 37 sustained significant injury that led to her death. She stated once the facility learned of C1's significant injuries this should have reported to MAARC. The licensee policy titled "Mandated Reporting" dated January 1, 2016, indicated maltreatment would be reported to the Minnesota Adult Abuse Reporting Center (MAARC). The policy did not include timing of report. TIME PERIOD FOR CORRECTION: Seven (7) days	02015		