Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL23400013M
Compliance #: HL23400014C

Date Concluded: June 24, 2021

Name, Address, and County of Licensee Investigated:
Cornerstone Residence
115 1st St E
Fosston, MN 56542
Polk County

Facility Type: Home Care Provider

Investigator's Name: Carol Moroney, 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 developed an open area to his buttocks and the facility did not assess, monitor, or provide treatment to the area. The client developed an unstageable pressure ulcer.

Investigative Findings and Conclusion:
Neglect was substantiated. The facility was responsible for the maltreatment. The facility staff failed to assess, monitor, and provide the necessary care to the client when staff discovered an open area on the client's buttocks. The client developed a large, unstageable, pressure ulcer on his buttocks that was discovered by hospital staff.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the client's medical and hospital record, facility record, policy and procedures, and staff training. A tour of the facility was completed, and medication administration was observed.

The client's medical diagnoses included Lewy body's dementia, and Parkinson's disease. The client's signed service plan indicated the client required assistance with medication administration, housekeeping, laundry, bathing assistance, and behavior monitoring.
The facility notes indicated staff documented hourly checks were completed on the client and he had been sleeping in his bed. Staff documented they cleaned "a wound" on the client's buttocks. The facility records lacked documentation of the description of the wound, who was notified, and what treatment and monitoring should be done for the wound. Approximately 12 hours later, a facility staff documented the client would not eat or drink anything, was incontinent of bowel and bladder, and had "sores" on his buttocks. The note indicated the unlicensed facility staff notified the nurse regarding the "concerns." Approximately one hour later another facility staff documented the client was sent to the emergency room. The clients medical record contained no further information of wound measuring, nursing wound assessment, or treatment of the buttock wound and/or the "sore" staff previously mentioned prior to sending the client to the emergency room.

The client's hospital record indicated the client was brought into the emergency room following a fall at the facility and was admitted for failure to thrive, and unstageable (Full thickness tissue thickness loss in which the base of the ulcer is covered by eschar [black] in the wound bed. The hospital took pictures of the wounds and documented the measurements were covering a large area of the client's buttocks measuring approximately 7 inches by 4 inches. The wound was described as "erythema, sloughed skin and bruising" and the wound was foul smelling and part of it was necrotic. A surgical consult was completed for the clients wound which indicated surgery would not be completed due to the clients declining condition, severity of the wound, and the extensive healing time that would be required for the wound to heal.

Three days after the client's admission to the hospital, a facility Licensed Practical nurse documented in the client facility progress notes, "Notified by the hospital that the resident had a black necrotic area of tissue between the resident's upper buttocks." The note indicated one night five days prior to hospital admission the client took off his underwear and was only wearing jeans. The client sat in the chair all night and refused to reposition. The note indicated, "Staff noticed redness started to form across his buttocks with skin peeling and decided to call the ambulance as he was also mentally declining and not eating/taking his pills."

A progress note written in the client's facility medical record three days after the client was admitted to the hospital by a facility Registered nurse indicated the day prior to the client's hospitalization the client continued with weakness and staff reported finding red open wounds on the client's buttocks and the skin was sloughing off. The registered nurse instructed staff to clean up the client and the wound, reposition the client, provide incontinence care, and apply A & D ointment. According to the documentation, the next day staff reported the client was getting worse and had a fever. The client was transferred to the hospital and admitted for a sacral wound.

During interview, unlicensed staff stated at times the client would refuse assistance with cares. The staff stated when they discovered the open area to the client's buttocks prior to hospital admission they notified the facility nurse and put barrier cream on the wound. The staff stated there was no on-going documented cares or treatments they were directed to complete on the clients open area on the buttocks.

During interview the facility nurse stated staff notified her the client had a wound on his buttocks and she instructed them to put barrier cream on it, provide incontinent care to the client, and assist the client with repositioning; however, specific interventions to prevent the wound from increasing were not determined or communicated to staff. The nurse stated she did not assess and/or monitor the clients open area on his buttocks and/or notify the physician to ensure ongoing treatment and monitoring of the clients open areas to prevent them from getting worse.

The client passed away in the hospital due to natural causes.

In conclusion, neglect is substantiated.

"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

"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, deceased
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: N/A

Action taken by facility: None

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
Polk County Attorney
Fosston police department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H23400	A. BUILDING: _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE RESIDENCE	115 1ST STREET EAST FOSSTON, MN 56542

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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: REVISED State form. Specifically, the project numbers detailed on the state form sent to you on March 11, 2021 were incorrection. On January 5, 2021, the Minnesota Department of Health initiated an investigation of complaint #HL23400013M/ HL23400014C. At the time of the survey, there were #27 clients receiving services under the comprehensive license. The following correction order is issued/orders are issued for ##HL23400013M/ HL23400014C, tag identification 0265, 0325, 0805, and 2015.	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	0 265		

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0 265	Continued From page 1 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 observation, interview and record review, the licensee failed to ensure services were provided according to suitable and up-to-date plan and accepted health care medical or nursing standards for one of one client 1 (C1) reviewed. The facility failed to ensure comprehensive assessments/investigation was completed for C1 after a serious medication error (C1); failed to ensure comprehensive assessments/investigations was completed for C1 regarding falls; failed to ensure an assessment and treatment was completed for a severe decubiti wound injury (injuries to the skin and underlying tissue, primarily caused by prolonged pressure on the skin). In addition, the licensee failed to compete comprehensive assessments following C1's change in condition and failed to report potential neglect and/or maltreatment to the Minnesota State of Minnesota reporting system. This resulted in harm to C1 when staff failed to assess and monitor the client pressure ulcer which developed into a unstageable pressure ulcer. 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,	0 265		

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0 265	Continued From page 2 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 indicated the client had diagnoses including Lewy Body's dementia, and Parkinson's disease. C1's service plan dated June 26, 2020, indicated C1's services provided included bathing, 30 minutes per week; behavior potential disruptive (client may exhibit hallucinations-auditory/visual), 30 minutes as needed; behavior, redirection (client may exhibit frustration and resistance to being in the facility), 30 minutes as needed; housekeeping 60 minutes, per week; laundry, linens 90 minutes per week; medication administration passes, five minutes, four times a day; and wellness/safety check two minutes, three times daily. C1's "Monitoring and Reassessment 14/90 day" 90-day assessments dated May 6, 2020, August 3, 2020, and October 30, 2020, lacked a change in condition assessment following a hospitalization on February 5, 2020, and on March 4, 2020. C1's record lacked a medication assessment after the serious medication error, a fall risk assessment after each fall, and a skin assessment after being identified by staff. C1's annual "Medication Assessment and Management Plan", dated October 9, 2020, listed the client had no change for one year. The assessment indicated "Prefers 'while he's here'	0 265		

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0 265	Continued From page 3 for us to administer his meds [medications]". The assessment also indicated, "Unlicensed professional will contact the licensed nurse 24/7 with any questions or concerns with medication administration". C1 was unable to independently store prescribed medications. C1's "Vulnerability Assessment/Abuse Prevention Plan," dated June 29, 2019 indicated C1 received medication management services from the facility. and C1 would receive medication administration after medication set up per service plan. C1's assessment indicated the clients gait was slow and shuffled when walking but required no assistive device when ambulating; the goal was for the client to remain free from falls. C1's Speech can be slow and hard to hear at times related to Parkinson and C1 may have a hard time getting certain words/phrases out due to dementia. SERIOUS MEDICATION ERROR C1's progress note written by licensed practical nurse (LPN)-C dated, March 4, 2020, at 11:11 a.m., indicated C1 had been given another clients medication earlier that morning. LPN-C instructed staff to take the clients vitals and contact the physician. The RN at the clinic instructed LPN-C to call the poison control center who instructed the facility to monitor C1 closely and send him to the emergency room. Emergency services were called and C1 was taken the hospital emergency room at 9:30 a.m. C1 was having symptoms including clamminess, shaking, dizziness, and a pulse of 62. C1 stated he was not feeling well and "felt like there was electricity going though his arms and body". The emergency room monitored the client. C1's progress note dated March 4, 2020, at 11:13	0 265		

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0 265	Continued From page 4 a.m., authored by unlicensed personnel (ULP)-B noted a late entry for 6:40 a.m.. The note indicated during the morning medication pass C1 was given the wrong medications by ULP- B. After administering the wrong medications to C1, ULP-B contacted the facility RN and LPN. The LPN came into the facility and the clients vital signs were taken every 15 minutes times three. C1 was taken by ambulance to the emergency room and was shaking and had a slight blue tint to his lips when leaving. C1's progress note, dated March 4, 2020 at 4:46 p.m., RN-A documented C1 received the following incorrect medications that morning. Potassium 10 milliequivalent (meq), Tylenol 1000 mg, Atenolol 100 mg, Lasix 40 mg (diuretic); klonipin 0.5 mg; and levothyroxine 112 micrograms (mcg). C1's medical record had no documentation a change of condition assessment was completed, no incident report was completed, and the serious medication error was not reported to the State of Minnesota MAARC (Minnesota Adult Abuse Prevention Center) or common entry point. The facility had no follow up investigation of the serious medication error to determine how the client received the incorrect medications and how to prevent medication errors from re-occurring. During interview on January 28th, 2021 at 1:00 p.m. RN-A stated the facility had no further investigation or follow up regarding C1's significant medication error. RN-A stated following the medication error no change of condition assessment had been completed for C1. FALLS C1's record lacked evidence the registered nurse	0 265		

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0 265	Continued From page 5 had assessed the client for and thoroughly investigated each fall for causal factors and interventions to prevent falls. C1's "Resident Incident Report", dated May 15, 2020 at 6:30 p.m., completed by ULP-C indicated the client stated he fell but when staff got to his room he was laying on his bed. The incident report indicated ULP-C took vitals immediately at 6:30 p.m. and a second set at 8:00 p.m.. C1 complained of pain and was given 75 mg of tramadol. The client requested to go to the emergency room but RN-A instructed staff to monitor the client to see if the Tramadol (pain medication) would help with the pain. C1 continued to complain of pain and ULP-C sent the client to the emergency room at 8:00 p.m. and returned back to the facility at 10:30 p.m.. C1's progress notes dated May 18, 2020 at 3:15 p.m., RN-A documented no changes were made to the clients current medications or orders. RN-A documented there was no known evidence of the client "actually falling in apartment" and no injuries were noted. The facility completed no further assessment or investigation of the clients report of a fall resulting in pain and required transfer to the emergency room. C1's progress notes dated November 24, 2020, at 1:46 p.m., ULP-D documented C1 was in his room at 10:00 a.m. when she went to check on him. C1 was sitting on the floor and stated he fell. C1 complained of pain and was sent to the emergency room for evaluation. There were no further progress notes, follow up, or assessment of C1's fall. C1's progress note dated November 25, 2020, at 1:32 p.m., ULP-D documented while cleaning	0 265		

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0 265	Continued From page 6 C1'S room, C1 was in his bathroom. ULP- D heard a loud noise and found C1 laying on the floor. ULP-D checked C1's vitals and notified the facility registered nurse. There were no further progress notes, follow up, or assessment of C1's fall to determine if additional interventions were needed to prevent further falls. During interview on January 28th, 2021, at 1:00 p.m., RN-A stated there was no further investigation or assessment regarding C1's falls to ensure the current interventions were effective in preventing further falls. PRESSURE ULCER C1's record lacked evidence the registered nurse had assessed the client and/or provided any treatment for the development of an unstageable pressure ulcer, which measured 7 inches across both buttocks. C1's progress note dated November 27, 2020, at 10:10 p.m. documented by ULP-E indicated the client was not eating or taking his medications. The note indicated the client would not use the bathroom without help and was "soiling" himself. C1's progress note dated November 29, 2020 at 1:05 a.m., ULP-F documented the client was sleeping in his bed when staff checked on him while doing hourly checks. The progress note indicated the staff cleaned a wound on the clients buttock. There was no further description of the wound on C1's buttocks, nor was there any evidence the clients physician or family was notified of the wound. C1's progress note dated November 29, 2020 at 12:41 p.m. indicated C1 would not eat or drink anything, was soiling himself, and had "sores" on	0 265		

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0 265	Continued From page 7 his buttocks. The facility RN was notified of the staff concerns. C1's facility medical record contained no further information regarding the description or care provided to C1's pressure ulcer(s). C1's progress notes on November 29, 2020, at 1:33 p.m., indicated C1 was sent to the emergency room as his condition worsened (becoming more weak, fever). C1's emergency room note dated November 29, 2020, at 1:32 p.m., indicated the client was brought into the emergency room and became unresponsive. The facility staff stated the client has become increasingly weak over the past few days, and his activity and appetite have decreased. The client had a large wound on the coccyx area. On December 2, 2020 at 1:43 p.m., LPN-C documented in C1's facility medical record, "Writer was notified by the hospital that the resident had a black necrotic area of tissue between the resident's upper buttocks The resident has always been very resistive to assistance with changing and dressing up until he really began to decline and could not change on his own around Friday the 27th of November when two PA's had to help him in the bathroom they did not notice anything redness or dark on his buttocks, it wasn't until Saturday November 28th that when staff had to help him again as the resident had declined further that the resident at one point in the night took his underwear off and was wearing jeans, then sat in his chair and refused to readjust throughout the night. Saturday staff noticed redness started to form across his buttocks with skin peeling and decided to call the ambulance as he was also mentally declining and	0 265		

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0 265	Continued From page 8 not eating/taking his pills". On December 2, 2020, at 10:58 a.m. RN- A documented in C1's facility medical record "Late entry charting for 11/24/20. Writer in house and alerted by staff on duty client had been found on the floor. Writer entered apt. to find client sitting on floor leaning on wall between bathroom and bedroom. Client had obviously fallen and hit his head on the front and had a lump on the back of his head. Client left glasses frame was missing and evident glasses frame had been pushed into his face. Client was not able to specifically state what happened but was found to be incontinent of urine. Writer dialed 911 to have client be evaluated in ER. Blood sugar and blood pressure within normal range. Client to Essentia ER BMP & Hemogram completed as well as CT head & x-ray of hip showing no acute abnormalities. Client did receive 1 liter of normal saline for dehydration. Client returned to facility via city bus with staff by 3 pm. 11/25 - Staff report to writer, while cleaning in client apt. staff heard client fall in bathroom and client stated he lost his balance. Client has no new injuries or pain relating to fall. Client was up and about facility as per self this day. Staff to continue to monitor client and report any further changes or concerns." On December 2, 2020 at 3:16 p.m., RN- A documented she was notified on 11/27/20, the client was more weak and not able to get up alone and use the toilet. Staff report 2 staff assisted client to use toilet and client had BM and staff wiped client at that time and noted no abnormalities in skin condition on buttocks. The following day, 11/2820, staff report client continues with weakness and late in evening on 11/28 staff report finding open wounds on client's buttocks, area red and skin sloughing off. Writer	0 265		

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0 265	Continued From page 9 instructed staff to continue to reposition client and provide incontinence care & use A&D ointment on buttocks. 11/29 staff report client progressively getting worse and report fever. Client then sent to Essentia ER via ambulance for eval & client was admitted. The COVID test returned negative. CT of head, chest & thoracic spine show no acute findings. WBC count at 11.5, lactic acid level within normal range. Client admitted for sacral wound, hypernatremia, AKI on CKD & dementia". On December 2, 2020, at 3:30 p.m. RN- A documented Writer spoke with licensed social worker (LSW)-H who expressed concerns with clients open wounds on buttocks. Writer went through timeline of events surrounding clients physical decline since last week, ER visits and falls. LPN faxed LSW-H progress notes to review. Writer told LSW-H wound not present on client's buttocks on Fri 11/27, but client was incontinent and unable to move self-11/28. LSW-H reports Dr. having concerns this [pressure ulcer] could not appear overnight. Writer notified LSW-H client was planned on moving to secure unit 11/30 to have increase supervision and services but staff reported increased concern 11/29 and that is when client was sent into ER. Client is scheduled to see general surgeon today to discuss treatment plan today for pressure ulcers. Writer also checked with client's daughter, LSW-H did speak with daughter as well today as client continues to decline while in hospital, having increased pain, even upon touch. PRN liquid morphine and Ativan have been initiated in hospital. At this time family has decided to transition client to skilled nursing care due to his increase level of care and will more than likely be admitted to hospice. LSW-H to keep writer up to date on client status".	0 265		

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0 265	Continued From page 10 On December 6, 2020, at 3:47 a.m. C1's hospital note indicated C1 continued on comfort cares due to failure to thrive. Patient was repositioned every 2 hours during night. C1's sacrum wound dressing was changed and described as foul smelling, and necrotic. December 7, 2020, C1's hospital summary indicated the client was admitted from the nursing home with worsening dementia and failure to thrive. Upon admission client was noted to have poor oral intake, was initially combative with cares, and had a large sacral decubiti ulcer with surrounding tissue damage. It was difficult to assess the extent of this wound due to patient's cognitive decline. The wound was evaluated by the wound surgeon who discussed with family that any interventions would be very invasive and would be a very long healing process. During interview on January 12, 2021, at 11:00 a.m. ULP-D stated when she saw the wound on C1's bottom, she sent him to the emergency room. She said C1's wound had a bad smell, looked like a bruise, had some black in it, and had some drainage coming out of it that was bloody and had pus in it. During interview on January 12, 2021, at approximately 3:30 p.m., ULP- E stated when assisting C1 she found a wound on his buttocks. ULP-E could not remember the date, however, she stated she notified the facility RN and was instructed to put barrier cream on the clients open areas on the buttocks. The RN did not come to the facility to assess C1's pressure area. During interview on January 28th, 2021, at 1:00 p.m., RN-A stated when ULP-E notified her about C1's wound on his buttocks she did not observe	0 265		

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0 265	Continued From page 11 the wound, notify the physician, or ensure standing orders for wound care were completed for C1. RN-A instructed ULP-E to apply barrier cream to C1's wound on his buttocks. The licensees "Medication Errors" policy dated July 26, 2016 noted the person who makes the medication error will contact the LPN to explain the situation. The LPN will instruct the staff on next steps. The staff involved with the incident will complete a medication incident report and document this information in the client's medical record of what occurred, date and time. The incident will be followed up by the RN for review. The licensee's "Fall Risk Evaluation" policy, dated July 26, 2016, noted after assessing for risk for falls, a summary will be written in the client's medical record in the notes section with a plan of action to minimize any potential falls. The licensee's "Client Accident/Incident Report" policy dated June 14, 2017, noted client accident/incidents are reported and documented as soon as possible after the accident/incident occurs. This included accident/incidents on and off the premises of cornerstone residence. The staff are to notify the Rn or LPN. All accident's incidents involving cornerstone residence clients are documented on the cornerstone residence client accident/incident report form. The report will be turned into the nurse who will follow up with accident/incident. The investigation sections are to be completed by the LPN and /or RN. The reviews the report for completeness and obtains needed additional information, investigates the accident/incident; implements immediate corrective action as appropriate; documents the investigation and corrective action on the accident/incident report form; informs appropriate	0 265		

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0 265	Continued From page 12 staff of any new physician orders/corrective action to be taken; after full review /assessment, the RN will electronically sign the ED section or signs the final report if not electronically. All accidents/incidents will be documented in the clients record If the client sustains a wound of any kind, the wound identifier information form is to be filled out. If injuries are sustained, document the type and where it is located. The licensee's "Training and Competency Evaluations for Personal Assistants" policy dated October 31, 2014, noted when a registered nurse or licensed health professional delegates tasks, they must make certain that prior to the delegation the Personal Assistant is trained on the proper methods to perform the tasks or procedures for each client and able to demonstrate the ability to competently follow the procedures and perform the tasks. A client assessment policy was requested but not provided. No further information was provided. 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;	0 325		

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0 325	Continued From page 13 This MN Requirement is not met as evidenced by: Based on observations, interviews, and document review, the facility failed to ensure one of one client reviewed (C1) was free from maltreatment. C1 was neglected. Findings include: On February 8, 2021, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility was responsible for the maltreatment, in connection with incidents that occurred at the facility. MDH concluded there was a preponderance of evidence that maltreatment occurred.	0 325	No Plan of Correction (PoC) required. Please refer to the public maltreatment report for details.	
0 805 SS=F	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 observation, interview and record review, the licensee failed to report suspected	0 805		

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0 805	Continued From page 14 maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC) immediately, but no longer than 24 hours for one of one client (C1) reviewed. C1 had a hospitalization following a medication error, which was not reported to MAARC. C1 had a hospital visit following a fall, which was not reported to MAARC. C1 had a hospitalization following the identification of a significant pressure ulcer on November 27, 2020, the licensee did not report the allegation of suspected neglect to MAARC until December 4, 2020. 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 the clients). The findings include: During a maltreatment investigation reported for a severe wound which was not reported timely (seven days late), it was identified the other events of a fall with a hospital visit for pain management was required. In addition, C1 also received the wrong medications in the past which required hospital level monitoring. Neither of these were reported to MAARC. The wound was reported seven days after the identification of the wound. C1 was admitted to the facility on June 20, 2019, with a diagnoses of Lewy Body's dementia, and Parkinson's disease.	0 805		

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0 805	Continued From page 15 C1's Service Plan, dated June 26, 2020. Indicated C1 services listed were behavior monitoring; bathing; medication assistance; and wellness safety checks. C1's "Vulnerability Assessment/Abuse Prevention Plan" dated June 29, 2019 indicated C1 will receive medication management services from the facility and will receive medication administration after medication set up per service plan. C1's gait was slow and shuffled when walking but required no assistive device when ambulating. C1 will remain free from falls while at the facility. The clients speech can be slow and hard to hear at times related to Parkinsonism, and may have a hard time getting certain words/phrases out due to dementia. A MAARC report submitted on December 4, 2020 (not submitted timely as required), indicated C1 was found on the floor on November 24, 2020, and a wound was identified on November 28, 2020. No MAARC report was filed for the severe medication error on March 4, 2020. C1's "Resident Incident Report", dated May 15, 2020 at 6:30 p.m., completed by ULP - C indicated "Resident [client] said he fell but when PA [ULP} got to room he was laying on his bed". The incident report indicated ULP - C took vitals immediately at 6:30 p.m. and a second set at 8:00 p.m., 75 mg of Tramadol was given at 6:50 p.m., to help with pain [C1] continued to complain about the pain. Client wanted to go to the emergency room but [ULP - C] contacted RN [-A] who instructed her to wait to see if the as needed medication helped with the pain. After about 45 minutes the pain was still bad and resident [C1] wanted to still go to the emergency room. [ULP - C] sent resident [C1] to the emergency room at	0 805		

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0 805	Continued From page 16 8:00 p.m. and returned at 10:30 p.m.". No other incident reports were completed and there was no investigation or assessment of C1's reported fall. On January 28th, 2021, at approximately 1:00 p.m., RN- A confirmed no MAARC report was filed following C1's fall requiring an emergency room visit in May. RN- A stated she was not aware she needed to file a MAARC report or do a change of condition assessment. RN-A confirmed no follow up note or plan to reduce falls was completed in C1's record. RN-A stated the MAARC report was filed following the identification of the pressure ulcer on C1's buttock, but not until December 4, 2020, which was seven days after the wound identification instead of the expected immediate submission. RN- A stated she was not aware she needed to do an investigation for causal factors or do a change of condition assessment. The licensee's "Vulnerable Adult" policy, dated January 24, 2017, noted all agency personnel rendering service in the facility are mandated to report any incident. The incident would be reported to the supervisor or MAARC. The supervisor would be responsible to investigate the incident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 805		

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02015	Continued From page 17	02015		
02015 SS=F	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 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	02015		

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02015	Continued From page 18 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 observation, 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 one client (C1) reviewed. C1 had a hospitalization following a medication error, which was not reported to MAARC. C1 had a hospital visit following a fall, which was not reported to MAARC. C1 had a hospitalization following the identification of a significant pressure ulcer on November 27, 2020, the licensee did not report the allegation of suspected neglect to MAARC until December 4, 2020. 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	02015		

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02015	Continued From page 19 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 the clients). The findings include: During a maltreatment investigation reported for a severe wound which was not reported timely (seven days late), it was identified the other events of a fall with a hospital visit for pain management was required. In addition, C1 also received the wrong medications in the past which required hospital level monitoring. Neither of these were reported to MAARC. The wound was reported seven days after the identification of the wound. C1 was admitted to the facility on June 20, 2019, with a diagnoses of Lewy Body's dementia, and Parkinson's disease. C1's Service Plan, dated June 26, 2020. Indicated C1 services listed were behavior monitoring; bathing; medication assistance; and wellness safety checks. C1's "Vulnerability Assessment/Abuse Prevention Plan" dated June 29, 2019 indicated C1 will receive medication management services from the facility and will receive medication administration after medication set up per service plan. C1's gait was slow and shuffled when walking but required no assistive device when ambulating. C1 will remain free from falls while at the facility. The clients speech can be slow and hard to hear at times related to Parkinsonism, and may have a hard time getting certain words/phrases out due to dementia.	02015		

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02015	Continued From page 20 A MAARC report submitted on December 4, 2020 (not submitted timely as required), indicated C1 was found on the floor on November 24, 2020, and a wound was identified on November 28, 2020. No MAARC report was filed for the severe medication error on March 4, 2020. C1's "Resident Incident Report", dated May 15, 2020 at 6:30 p.m., completed by ULP - C indicated "Resident [client] said he fell but when PA [ULP} got to room he was laying on his bed". The incident report indicated ULP - C took vitals immediately at 6:30 p.m. and a second set at 8:00 p.m., 75 mg of Tramadol was given at 6:50 p.m., to help with pain [C1] continued to complain about the pain. Client wanted to go to the emergency room but [ULP - C] contacted RN [-A] who instructed her to wait to see if the as needed medication helped with the pain. After about 45 minutes the pain was still bad and resident [C1] wanted to still go to the emergency room. [ULP - C] sent resident [C1] to the emergency room at 8:00 p.m. and returned at 10:30 p.m.". No other incident reports were completed and there was no investigation or assessment of C1's reported fall. On January 28th, 2021, at approximately 1:00 p.m., RN- A confirmed no MAARC report was filed following C1's fall requiring an emergency room visit in May. RN- A stated she was not aware she needed to file a MAARC report or do a change of condition assessment. RN-A confirmed no follow up note or plan to reduce falls was completed in C1's record. RN-A stated the MAARC report was filed following the identification of the pressure ulcer on C1's buttock, but not until December 4, 2020, which	02015		

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02015	Continued From page 21 was seven days after the wound identification instead of the expected immediate submission. RN- A stated she was not aware she needed to do an investigation for causal factors or do a change of condition assessment. The licensee's "Vulnerable Adult" policy, dated January 24, 2017, noted all agency personnel rendering service in the facility are mandated to report any incident. The incident would be reported to the supervisor or MAARC. The supervisor would be responsible to investigate the incident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02015		