Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL241024461M
Compliance #: HL241025218C

Date Concluded: December 13, 2024

Name, Address, and County of Licensee Investigated:
Sterling Park Senior Living
114 North 1st Street
Waite Park, MN 56387
Stearns County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Erin Johnson-Crosby, RN
Special Investigator

Finding: Substantiated, facility responsibility

Nature of Investigation:
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.

Initial Investigation Allegation(s):
The facility neglected a resident when they failed to ensure nursing follow-up after staff reported the resident's skin issues. The resident was hospitalized twice for skin concerns.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. Nursing staff failed to assess, monitor, and notify resident's primary care provider when unlicensed staff reported changes in the resident's skin condition.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record, hospital records, facility incident reports, personnel files, staff schedules, and related facility policies and procedures. Also, the investigator observed care provided by facility staff.

The resident resided in an assisted living facility. The resident's diagnoses included congestive heart failure, coronary artery disease, and chronic obstructive pulmonary disease. The resident's service plan included assistance with medication administration, dressing, bathing, skin monitoring by unlicensed and licensed staff, and weight monitoring. The resident's assessment indicated the resident's had bilateral lower extremity edema (swelling). The assessment did not include wound care.

The resident's medical record indicated unlicensed staff contacted the on-call registered nurse (RN) regarding the resident's complaints of sore and weeping legs. The RN instructed staff to continue to observe and call back if needed. No direction was provided to unlicensed staff on what to observe or when to call the RN back and the RN did not complete a skin assessment.

Three days later, the resident requested a nurse to check her skin. A facility RN noted increased swelling but did not document a description of her observation of the resident's skin. The RN advised the resident to see her primary care physician but did not follow up with the resident about an appointment with the physician. Around 11:30 p.m. that evening, the resident was taken to the hospital by family.

The hospital record indicated the resident was admitted due to possible heart failure exacerbation and lower extremity chronic itching. The resident spent two days in the hospital before discharging back to the facility. The hospital discharge summary indicated the resident had multiple scattered circular wounds in various stages of healing, noting that the left leg was worse than the right, and mild lower extremity edema (swelling). Discharge orders included a treatment for the resident's lower legs and to notify the provider if there were any signs of infection including increasing redness, swelling, tenderness, warmth, change in appearance, or increased drainage.

The facility re-admission assessment indicated the resident had bilateral lower extremity edema but did not identify the multiple circular wounds noted in the hospital record and did not include the orders for wound care.

Documentation completed by licensed staff following the resident's readmission indicated the resident's left lower extremity was warm to the touch, was more swollen than the right, and that the left leg was pink, with redness and bumps. Licensed staff did not complete a comprehensive assessment or update the resident's medical provider of their documented observations of the resident's skin.

Ten days after the first hospitalization, the resident's family member took the resident to the hospital again and the resident was admitted for cellulitis (bacterial infection of the skin) of lower left leg and Methicillin Resistant Staphylococcus Aureus (MRSA) (bacteria resistant to several antibiotic). Hospital records indicated both lower extremities were red from the foot to the legs with multiple small open wounds noted throughout both legs with small amounts of

clear to yellow colored discharge, both legs were swollen, and tender to touch. The resident received intravenous (IV) antibiotics and discharged two days later.

During an interview, a facility licensed nurse stated if an on-call nurse was notified of concerns, the nurse should notify the director of nursing or the facility nurses to review progress notes, however, sometimes there was not time to review progress notes. The licensed nurse did not recall concerns with the resident's skin and did not remember if she checked the resident's legs.

During an interview, nurse management staff stated nursing staff would have to review progress notes of concerns triaged by the on-call nurse or if the concern was egregious, they would contact her or call emergency services. The on-call nurse should have been clearer with staff on what to observe and when to call back. Nursing management acknowledged that upon re-admission, the resident had wounds on both lower legs, but stated that she did not document skin concerns on the change of condition assessment since the information was already documented on the hospital discharge paperwork. Nursing management stated that orders should have been followed and changes in skin condition should have been reported to the resident's provider.

During an interview, the resident and family members stated the resident's legs worsened and both timed the family members took the resident to the hospital since facility staff were not following up or ensuring treatments were completed as ordered.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

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

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means 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.

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:

No action taken.

Action taken by the Minnesota Department of Health:

- If substantiated and facility responsibility only:

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

  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

  If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

  You may also call 651-201-4200 to receive a copy via mail or email

cc:

The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Stearns County Attorney
Waite Park City Attorney
Waite Park Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24102	A. BUILDING: _____ B. WING _____	C 09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING PARK SENIOR LIVING	114 NORTH 1ST STREET WAITE PARK, MN 56387

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL241025218C/#HL241024461M #HL241028641C/#HL241025981M On September 25, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 61 residents receiving services under the Assisted Living license. The following correction orders are issued for ##HL241025218C/#HL241024461M, tag identification 2310, 2360 and #HL241028641C/#HL241025981M, tag identification 0450, 2320, 2360.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. 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 evaluators ' 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	

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0 000	Continued From page 1	0 000	ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 450 SS=D	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall: (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the licensee failed to utilize person-centered planning and service delivery processes for one of one resident (R2) who required weight monitoring. Nursing staff did not address R2's refusals for weight monitoring or make attempts to obtain equipment to accommodate R2's needs or ensure physician's orders were followed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident'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 residents are affected or one or	0 450		

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0 450	Continued From page 2 a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: The licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) dated April 5, 2023, indicated the licensee provided daily weights. R2 admitted to the facility on December 2, 2021, due to diagnoses that included congestive heart failure (CHF), peripheral vascular disease, (PVD) and chronic kidney disease (CKD). R2's undated service plan indicated R2 required assistance with bathing, blood sugar monitoring, medication administration, oxygen management, toileting, and weight monitoring by unlicensed staff and monitored by a floor nurse. R2's assessment dated September 16, 2024, indicated R2 required frequent weight monitoring. The assessment did not include monitoring for CHF symptoms. The document also did not indicate R2 refused daily weights at times. R2 physician's orders included a daily weight and staff were to report to the provider if there was a weight gain of 2 lbs over night or 5 lbs in 1 week. R2's weight record included the following: - July 3, 2024, had a fall and could not stand. - July 20, 2024, had back pain so could not stand. - July 30, 2024, knees were buckling so could not stand. - August 3, 2024, attempted to get weight but knees buckled and R2 almost fell and did not want to try again. - August 19, 2024, refused because of fall.	0 450		

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0 450	Continued From page 3 - September 5, 2024, refused says she will fall over. R2's progress notes dated August 1, 2024, indicated R1 refused to be weighed on July 30, 2024, due to "knees buckling and no ability to stand safely on scale." R2's progress notes dated August 14, 2024, indicated a 90 day assessment was completed and noted R2 fell on July 3, 2024, when she attempted to be weighed on the scale. R2's weight record indicated R2 refused weights on the following dates: - September 19, 2024, refused too tired and dizzy. - September 20, 2024, never called for staff to get weight. - September 24, 2024, refused, did not want to be weighed at that time. - September 25, 2024, refused, did not want to wake up. R2's record did not include documentation staff addressed R2's weight refusals or updated the provider on the refusals. R2's medical record lacked documentation of interventions for the resident ' s weight refusals, notification to the provider of frequent refusals, and failed to address the resident ' s fear of falling while being weighed. The record included no documentation of attempts made to obtain a scale sufficient to meet the resident ' s needs or ensure physician ' s orders were followed. On September 25, 2024, at 4:00 p.m., R2 was interviewed and stated she was hospitalized because she was retaining fluid. R2 stated sometimes staff weigh her and sometimes she	0 450		

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0 450	Continued From page 4 tells staff how much she weighs. R2 stated she had a hard time standing on the scale since her knees buckled and she was afraid of falling. On September 26, 2024, at 8:00 a.m., the investigator observed R2 transfer from the recliner and stand on the scale. R2 had to hang on to the counter to be able to stand on the scale. R2 was unsteady while standing on the scale and while standing on the scale, R2 stated, "my knees are going to buckle." On October 17, 2024, at 3:20 p.m., licensed practical nurse (LPN)-D was interviewed stated R2's weight orders have changed many times. LPN-D stated R2 refused weights at times because she did not want to stand on the scale but LPN-D stated she had not observed R2 being weighed. LPN-D stated weight refusals were not communicated to the provider daily but a list was sent monthly of the refusals. LPN-D stated she was not aware if there was another scale R2 could use since it was difficult for R2 to use the standing scale in her room. LPN-D stated if the weight was off, the nurse should have followed up, contacted the provider and assessed the resident. On October 18, 2024, at 10:10 a.m., registered nurse (RN)-E was interviewed and stated orders should be followed and the provider should have been notified if the resident's weight was outside of the ordered parameters. RN-E stated R2 refused to be weighed often. RN-E stated some resident weights were on the medication administration record and others were just on the service delivery document. RN-E stated the licensee did not provide another scale if a resident could not stand and the residents had to provide their own scales.	0 450		

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0 450	Continued From page 5 The licensee's policy dated August 2021 titled Nursing Assessments, Reviews, and Monitoring indicated resident assessment and monitoring will be conducted as needed based on changes in the needs of the resident. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 450		
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards when facility staff failed to identify a change in condition on two separate occasions resulting in hospitalization for one of one resident (R1). This practice resulted in a level three violation (a violation that harmed a resident'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 residents are affected or one or a limited number of staff are involved or the	02310	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. 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 evaluators' findings is the	

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02310	Continued From page 6 situation has occurred only occasionally). The findings include: R1's medical record indicated R1 admitted on March 17, 2023, with diagnoses that included congestive heart failure, coronary artery disease, and chronic obstructive pulmonary disease. R1's assessment dated June 20, 2024, indicated R1 had bilateral lower extremity edema. The assessment did not indicate R1 received wound care. R1's undated service plan indicated R1 received assistance with medication administration, dressing, bathing, (check skin-notify nurse of bruises, redness, open, areas, edema), skin monitoring by unlicensed personnel and licensed staff and weight monitoring. R1's progress notes dated June 16, 2024, at 6:26 a.m., indicated an unlicensed facility staff notified the on-call registered nurse (RN), regarding R1's bilateral lower externalities were open and weeping and R1 complained of sore legs. The RN instructed the staff to continue to observe and call back if needed. The progress note did not include direction for what unlicensed staff were supposed to observe and when to call back. R1's medical record dated June 16, 17, 18, 2024, did not include an assessment, notification to R1's medical provider, or R1's family member regarding R1's concerns. R1's progress note written June 19, at 7:33 a.m., as a late entry for June 18, 2024, at 2:00 p.m., indicated R1 requested a visit from a RN for increased swelling in her legs. A RN confirmed	02310	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 144G.31 SUBDIVISION 1-3.	

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02310	Continued From page 7 increased swelling and advised her to see her primary care physician. Another progress note written that day indicated the care coordinator was directed to set up an appointment for the resident. R1's medical record did not include an assessment, notification to R1's medical provider, or R1's family member. R1's progress note dated June 18, at 11:33 p.m., indicated unlicensed staff called the RN to report R1's family member took her to the hospital due to concerns for lower extremity cellulitis, increased, edema, weeping, and redness. At 3:23 a.m., unlicensed facility staff called the RN to report R1 was admitted to the hospital with heart failure, leg infection, and care issues. R1's progress notes dated June 19, 2024, at 2:08 p.m., indicated R1's family member contacted the executive director (ED) with concerns regarding follow up on R1's legs. The note indicated on June 18, 2024, R1 contacted the unlicensed personnel (ULP) for the RN to come and assess R1's legs. The ULP had to contact the RN three times before the RN came to check R1's legs. The RN told R1 she would make an appointment but never came back to inform R1 of when the appointment was scheduled. R1's family member was upset and did not understand how R1's legs got this way. R1 called her family member on June 18, 2024, around 11:00 p.m., R1's family member looked at R1's legs and took R1 to the emergency room. Another family member contacted the ED the same day regarding recent care. The FM was concerned about staff not checking R1's skin. The note indicated R1 refused to go to the dining room on June 16, 2024, but this was not communicated to the RN or R1's family. The note also indicated it was unclear whether R1's legs were examined to	02310		

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02310	Continued From page 8 determine the cause of the pain. The on-call nurse was called and did not express concerns but could not visually assess R1's skin condition so staff should have reported the issue to the director. R1's hospital records indicated on June 18, 2024, R1 was admitted with lower extremity pruritus (chronic itchy skin) in the setting of possible heart failure exacerbation. The discharge summary dated June 20, 2024, indicated R1 had multiple scattered circular wounds in various stages of healing with the left leg worse than the right with mild lower extremity edema. Hospital discharge orders included wound care included to clean wounds to bilateral lower legs with soap and water, rinse and dry completed, apply triamcinolone ointment to lower legs daily, cover with cotton long stocking, encourage to elevate legs two to three times daily for at least 30 minutes. The orders also included to contact the provider if there were any sign of infection (increasing redness, swelling, tenderness, warmth change in appearance, or increased drainage). R1's progress notes dated June 20, 2024, indicated a change of condition assessment was completed when R1 returned from the hospital with diagnoses of lower extremity edema but did not include an assessment of R1's skin. R1's treatment and therapy management plan dated June 20, 2024, did not include wound care for R1's legs. R1's medical record indicated on June 24, 2024, a licensed nurse noted R1's left lower extremity was warm to touch with more swelling than the right.	02310		

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02310	Continued From page 9 R1's medical record indicated on June 25, 2024, a licensed nurse noted R1's left leg was pink. R1's medical record did not include an assessment, notification to R1's medical provider or family member. R1's medical record indicated on June 26, and June 27, 2024, there were not issues with R1's legs. R1's progress notes on June 27, 2024, included an order for Telfa pads (wound dressings) changed daily for multiple open wounds of lower extremity. R1's medical record indicated on June 29, 2024, staff noted redness and bumps on lower extremity with no drainage. R1's medical record on June 30, 2024, indicated R1's bilateral legs were still reddened, with small bumps, with slight irritation, and no drainage. R1's medical record did not include an assessment, notification to R1's medical provider or family member. Hospital records dated June 30, 2024, indicated R1 was admitted for cellulitis (bacterial infection of the skin) of the lower extremity, methicillin resistant staphylococcus aureus (MRSA, type of bacteria resistant to several antibiotics, and acute kidney injury). R1's bilateral lower extremities were red from the foot to the top of legs, multiple small open wounds throughout both legs with small amount of clear to yellow colored discharge, both legs were swollen, and tender to touch. R1 received intravenous (IV) antibiotics	02310		

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STERLING PARK SENIOR LIVING	114 NORTH 1ST STREET WAITE PARK, MN 56387

(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
02310	Continued From page 10 during the admission and discharged July 2, 2024. On September 26, 2024, at 9:30 a.m., R1, family member (FM)-A, and FM-B were interviewed and stated R1's legs had looked worse for a few days and R1 called them to look at her legs on June 18, 2024, around 11:00 p.m.,. FM-A looked at R1's legs and took R1 to the emergency room since facility staff were not doing anything. FM-A and FM-B stated facility staff did not follow up and ensure treatments were completed as ordered. FM-A and FM-B stated on June 30, 2024, they took R1 back to the ER after receiving the MRSA diagnosis. On October 17, 2024, at 2:55 p.m., licensed practical nurse (LPN)-D was interviewed stated she thought the on-call nursing staff contacted the director of nursing (DON) with concerns that occurred after hours. LPN-D also stated if the on-call nursing staff did not contact the DON then the licensed staff would have to review the progress notes to check for concerns. LPN-D stated if she did check on R1's legs she would have written a progress note. LPN-D stated she could not recall R1 skin concerns. On October 17, 2024, at 9:00 a.m., registered nurse (RN)-E was interviewed and stated facility staff would have to review progress notes of concerns triaged by on-call nurses or if the concern was egregious, they would contact her or call emergency services. RN-E stated the on-call nurse that was contacted on June 16, 2024, should have been more clear with staff on what to observe and when to call back. RN-E stated when R1 was re-admitted on June 20, 2024, R1 had wounds on bilateral lower legs but did not document skin concerns on the change in	02310		

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02310	Continued From page 11 condition assessment completed since the information was already documented on the hospital discharge paperwork. RN-E stated she should have included a skin assessment in the assessment. RN-E stated changes in condition should be reported to the resident's provider. The licensee's comprehensive assessment schedule dated September 8, 2023, indicated a change in condition assessment should be completed as needed. The licensee's individualized treatment plan policy dated June 1, 2023, indicated for each resident receiving management of ordered or prescribed treatments or therapy services, assisted living service provide must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		
02320 SS=G	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by:	02320		

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02320	Continued From page 12 Based on observation, interview, and record review, the licensee failed to ensure healthcare and assisted living services were provided by people who were properly trained and competent to perform their duties, when licensed staff did not follow physician's orders to notify the medical provider after an increase in weight was observed for one of one resident (R2). This resulted in R2 being hospitalized. This practice resulted in a level three violation (a violation that harmed a resident'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 residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) dated April 5, 2023, indicated the licensee provided daily weights. R2 admitted to the facility on December 2, 2021, due to diagnoses that included congestive heart failure (CHF), peripheral vascular disease, (PVD) and chronic kidney disease (CKD). R2's undated service plan indicated R2 required assistance with bathing, blood sugar monitoring, medication administration, oxygen management, toileting, and weight monitoring by unlicensed staff and monitored by a floor nurse. R2 physician's orders included a daily weight and staff were to report to the provider if there was a	02320		

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02320	Continued From page 13 weight gain of 2 lbs over night or 5 lbs in 1 week. R2's progress notes dated September 5, 2024, indicated torsemide (diuretic) was decreased to 20 milligrams (mg). R2's weight record indicated the following weights: - September 6, 2024- 239.6 lbs. - September 7, 2024- 241.4 lbs. - September 8, 2024 - 222.6 lbs. - September 9, 2024 - 243.8 lbs. - September 10, 2024 - 243.6 lbs. - September 11, 2024 - 224.4 lbs. - September 13, 2024 - 246.6 lbs. R2's record indicated licensed staff documented follow up on R2's weights except on September 7, and September 8, 2024. The licensed staff did not communicate weight fluctuations to the medical provider. R2's progress notes dated September 13, 2023, indicated on September 10, 2023, at 10:10 a.m., indicated R2 fell when was transferring to her electric wheelchair. R2's blood pressure was 80/62 following the fall. The provider was not notified of the resident's fall or low blood pressure for three days. R2's progress notes dated September 13, 2024, indicated facility staff sent a note to R2's provider which indicated R2's weight was up to 246.6 lbs, with a puffy face, hands, and abdomen. R2's weight on September 6, 2024, was 239.9. The provider replied to the facility, "does she need to go to the emergency department? This is an alarming amount of weight with symptoms." R2's progress notes dated September 13, 2024,	02320		

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02320	Continued From page 14 indicated R2 was hospitalized for hypotension (low blood pressure) and fluid overload and discharged back to the facility on September 16, 2024. R2's progress noted dated September 17, 2024, indicated facility staff should continue to weigh R2 daily and update if 2 lbs weight gain overnight or 5 lbs in one week related to CHF. R2's assessment dated September 16, 2024, indicated R2 required frequent weight monitoring. The assessment did not include monitoring for CHF symptoms. The document also did not indicate R2 refused daily weights at times. R2's weight record indicated R2 refused weights on the following dates: - September 19, 2024, refused too tired and dizzy. - September 20, 2024, never called for staff to get weight. - September 24, 2024, refused, did not want to be weighed at that time. - September 25, 2024, refused, did not want to wake up. R2's record did not include documentation staff addressed R2's weight refusals or updated the provider on the refusals. On September 25, 2024, at 4:00 p.m., R2 was interviewed and stated she was hospitalized because she was retaining fluid. R2 stated sometimes staff weigh her and sometimes she tells staff how much she weighs. R2 stated she had a hard time standing on the scale since her knees buckled and she was afraid of falling. On September 26, 2024, at 8:00 a.m., the	02320		

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02320	Continued From page 15 investigator observed R2 transfer from the recliner and stand on the scale. R2 had to hang on to the counter to be able to stand on the scale. While standing on the scale, R2 was unsteady and stated, "my knee are going to buckle." On October 17, 2024, at 3:20 p.m., licensed practical nurse (LPN)-D was interviewed stated R2's weight orders have changed many times. LPN-D stated R2 refused weights at times because she did not want to stand on the scale. LPN-D stated weight refusals were not communicated to the provider daily but a list was sent monthly of the refusals. LPN-D stated she was not aware if there was another scale R2 could use since it was difficult for R2 to use the standing scale in her room. LPN-D stated if the weight was off, the nurse should have followed up, contacted the provider and assessed the resident. LPN-D stated she had not observed R2 being weighed. On October 18, 2024, at 10:10 a.m., registered nurse (RN)-E was interviewed and stated orders should be followed and the provider should have been notified if the resident's weight was outside of the ordered parameters. RN-E stated the licensee did not provide another scale if a resident could not stand and the residents had to provide their own scales. RN-E stated R2 refused to be weighed often. RN-E stated some resident weights were on the medication administration record and others were just on the service delivery document. The licensee's policy dated August 2021 titled Nursing Assessments, Reviews, and Monitoring indicated resident assessment and monitoring will be conducted as needed based on changes in the needs of the resident.	02320		

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02320	Continued From page 16 No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure two of two residents reviewed (R1, R2) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No plan of correction is required for this tag.	