*Protecting, Maintaining and Improving the Health of All Minnesotans*

# Office of Health Facility Complaints Investigative Public Report

**Maltreatment Report #:** HL26604006M
**Compliance #:** HL26604007C

**Date Concluded:** July 1, 2020

**Name, Address, and County of Licensee Investigated:**
Traditions of Montgomery LLC
399 Lexington Avenue NW
Montgomery, MN 56069
LeSueur County

**Facility Type: Home Care Provider**

**Investigator's Name:** Jane Aandal, RN, Special Investigator

**Finding: Substantiated, individual responsibility**

**Nature of Visit:**
An investigator from 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: A client was neglected when the alleged perpetrator (AP) failed to complete a comprehensive reassessment after the client fell and sustained a fractured elbow. Two days later, the client fell and sustained a fractured nose and a fractured left hip.

**Investigative Findings and Conclusion:**
Neglect was substantiated. The alleged perpetrator (AP) was responsible for the maltreatment. The AP was aware of the client's fall and neglected to complete a comprehensive reassessment.

The investigation included interviews with facility staff, including administrative staff, nursing staff, and unlicensed staff. The investigation included a review of the client's medical, hospital record, and policies and procedures.

The client received comprehensive home care services for a diagnosis of Alzheimer's dementia. The service plan indicated the client received assistance with medication management,

assistance with dressing, grooming, bathing, eating, toileting, safety checks every two hours, and escorts to meals. The client was admitted to the facility with a pressure pad on her bed to alert staff of her movement. The client was to ambulate with a walker and staff assistance. The client experienced three falls prior to the fall with a fracture. In addition, the client fell again two days later, and was diagnosed with a fractured left hip and nose.

One evening, the client was seated in a chair for the evening meal. The food had not been served yet. Another client came over to the client and told her she did not need staff assistance to walk. At this time, the client stood up from her chair when both staff members were not in the dining room. The one staff member was assisting a client in the bathroom, and the other staff member went to bring another client to the table. The client's pressure pad on the chair beeped three times and the staff members were unable to reach her in time. The client was unsteady, crossed her feet, and fell on the floor landing on her left side. The client reported her elbow hurt and she received a skin tear to the left elbow. A staff member notified the on call nurse and the client's family member about the fall.

After the fall, a staff member documented on a skin observation form. It indicated a potential for bruises on the left hip, shoulder, and elbow.

During an interview, the alleged perpetrator (AP) stated when a client falls, the staff members check the client over, get vital signs, notify the family member, and the on call nurse. The AP stated if the staff member report sounds okay, they are given direction to get the client off the floor. The AP stated the staff would let her know later if they noticed anything with the client. The AP stated, "I rely on their eyes." The AP stated her assessment after a fall would include a fall risk assessment (a document that identifies a client's risk for falls), and her intervention on the incident report. The AP stated the next day, she went to see the client, and staff members were assisting the client in the bathroom. The AP stated later in the afternoon, she went back to check on the client and she was asleep. The AP stated, "I never got back down there to see her."

Two days after the fall, the client's bed alarm sounded in the early morning. A staff member found her on the floor face down with blood gushing out of her nose. The staff member applied pressure to the client's nose to try to stop the bleeding. The staff member requested assistance from another staff member. The staff member called for an ambulance and the on call nurse was notified.

The hospital documentation indicated the client was hospitalized for two days. The client was diagnosed with a fractured nose and fractured left hip. The client was placed on hospice care with no surgical intervention. The physician documented the left elbow fracture appeared to have happened several days ago.

An interview was conducted with a family member. She stated when the hospital staff attempted to assist the client to the bathroom; she stated her left foot hurt. The family

member stated if they had attempted to walk the client, they would have noticed she was unable to walk. The family member also stated she had spoken to the medical examiner. The family member was told if the client had not fractured her left hip she would not have died as soon as she did.

The documentation of death record indicated the client died 17 days after the first fall with injury. The cause of death listed complications of decreased mobility, and left hip/elbow fractures related to a fall.

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
**Family/Responsible Party interviewed**: Yes
**Alleged Perpetrator interviewed**: Yes

**Action taken by facility:**
No action taken

**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. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the

Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc: Health Regulation Division – Home Care and Assisted Living Program
The Office of Ombudsman for Long-Term Care
LeSueur County Attorney
Montgomery City Attorney
Minnesota Board of Nursing

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | H26604 | A. BUILDING: _____ B. WING _____ | C 07/01/2020 |

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| 0 000 | Initial Comments<br><br>******ATTENTION******<br><br>HOME CARE PROVIDER LICENSING CORRECTION ORDER<br><br>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.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>On June 4, 2020, the Minnesota Department of Health initiated an investigation of complaint #HL26604007C/#HL26604006M. At the time of the survey, there were 37 clients receiving services under the comprehensive license.<br><br>The following correction orders are issued for #HL26604007C/#HL26604006M, tag identification 0325, 0805, 0860, 1045, 1060, 2015. | 0 000 | The Minnesota Department of Health documents the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. Per Minnesota Statute § 144A.474, Subd. 8(c), the home care provider must document any action taken to comply with the correction order. A copy of the provider's records documenting those actions may be requested for follow-up surveys. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider's Plan of Correction."<br>The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144A.474, Subd. 11 (b). | |
| 0 325 | 144A.44, Subd. 1(a)(14) Free From Maltreatment<br><br>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: | 0 325 | | |

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| 0 325 | Continued From page 1<br>(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;<br><br>This MN Requirement is not met as evidenced by:<br>Based on interviews and document review, the facility failed to ensure one of one client (C1) reviewed was free from maltreatment. C1 was neglected.<br><br>Findings include:<br><br>On July 1, 2020, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred. | 0 325 | No Plan of Correction (PoC) required. Please refer to the maltreatment public report for details. | |
| 0 805 SS=D | 144A.479, Subd. 6(a) Reporting Maltrx of Vulnerable Adults/Minors<br><br>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.<br><br>This MN Requirement is not met as evidenced | 0 805 | | |

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| 0 805 | Continued From page 2<br>by:<br>Based on interview and record review, the licensee failed to report suspected maltreatment when a client had a black eye of unknown origin for one of one client (C1) reviewed.<br><br>This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the clients).<br><br>Findings include:<br><br>The licensee's internal investigation dated February 18, 2020, indicated an outside physical therapy assistant (PTA) provided assistance with ambulation to C1 around 10:00 a.m. The PTA reported C1 had a bruise to registered nurse (RN)-J. RN-J documented the bruise extended down the right side of C1's face and was approximately 3-1/2 inches long and 1-1/2 inches wide. On February 19, 2020, the bruise extended all the way around the orbit of the eye. The licensee did not know how the bruise occurred.<br><br>On February 18, 2020, the PTA documented that reportedly C1 had a fall last week while she was self transferring in the bathroom. C1 fell on her bottom. Today noted a bruise along the right forehead areas. C1 also very tender along the right rib area.<br><br>An interview was conducted with family member (FM)-A on June 2, 2020, at 9:38 a.m. FM-A stated the bruise around C1's eye was purple and green. | 0 805 | | |

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| 0 805 | Continued From page 3<br><br>FM-A stated when two staff members were working in client rooms, there were ten clients unattended in the common area. FM-A stated that was probably when the black eye occurred. FM-A stated staff were unable to tell her how the injury occurred.<br><br>An interview was conducted with resident support staff (RSS)-H on June 23, 2020, at 2:47 p.m. RSS-H stated when she saw C1's eye, it was really bad as it covered her right eye and was pretty dark in color. RSS-H stated she did not think C1 received the bruise from a fall.<br><br>An interview was conducted with registered nurse (RN)-B director of nursing on June 25, at 2:01 p.m. RN-B stated she was made aware of C1's black eye when outside occupational therapist (OT)-G reported it. RN-B stated it was an injury of unknown origin and was not reported to the MN Adult Abuse Reporting Center (MAARC). RN-B stated she was aware the injury should have been reported. RN-B stated it was her assumption that one of the clients tried to straighten C1's glasses into the tender area of her eye.<br><br>The licensee's Vulnerable Adult Reporting and Investigation Policy, dated January 2014, section titled Mandated Reporting to the Common Entry Point (CEP) includes the phone number for MAARC. The section titled unexplained physical injury, indicated when staff observed an unexplained physical injury they would immediately notify the RN, who would conduct an internal investigation to determine whether the injury was unexplained and whether a report to the CEP was required. The section titled immediate report to CEP required, means immediate, but no longer than 24 hours from the | 0 805 | | |

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| 0 805 | Continued From page 4<br>time the RN received initial knowledge that the incident had occurred.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 0 805 | | |
| 0 860 SS=G | 144A.4791, Subd. 8 Comprehensive Assessment and Monitoring<br><br>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.<br><br>(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.<br><br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the licensee failed to ensure client re-assessments | 0 860 | | |

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| 0 860 | Continued From page 5<br><br>for change of condition were completed following fall incidents to determine causal factors, and to implement interventions to minimize the risk for further falls for one of one client (C1) who sustained a fractured left hip, left elbow, and nose with record reviewed.<br><br>This practice resulted in a level three violation (a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).<br><br>Findings include:<br><br>C1's diagnoses included, but were not limited to, Alzheimer's dementia and depression. C1's fall risk assessment dated February 11, 2020, indicated C1 was at high risk for falls.<br><br>The licensee's "Incident Call and Communication Log-Resident" document dated February 9, 2020, at 7:15 p.m., indicated a client caught the attention of resident support staff (RSS)-H and told her C1 was on the floor. RSS-H attended to C1. C1 was walking in her room to her chair without her walker. Her walker was about one foot away from her. C1 was seen 20 minutes prior to the fall. C1 received no injury. The intervention per registered nurse (RN)-J was for staff to try and keep C1 in the common area to monitor better.<br><br>C1's fall risk assessment (a document that identified a client's risk for falls) dated February 11, 2020, indicated C1 was at high risk for falls. | 0 860 | | |

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| 0 860 | Continued From page 6<br><br>C1's 14 day assessment dated February 14, 2020, was the last assessment completed by registered nurse (RN)-J. C1 experienced falls on March 9, 2020, and April 16, 2020.<br><br>C1's service plan dated February 20, 2020, indicated C1 received assistance with medication management, assistance with dressing, grooming, oral care, transfers, feeding, bathing, escorts to meals, and safety checks every two hours.<br><br>C1's care plan dated February 21, 2020, for fall prevention interventions included: every two hour safety checks, remind to use walker as needed, keep walkways clear, and bed alarm while in bed. C1's new intervention identified by RN-J from the fall on February 9, 2020, for staff to try and keep C1 in the common area to monitor better was not added to C1's care plan.<br><br>The licensee's "Incident Call and Communication Log-Resident" document dated March 9, 2020, with no time listed indicated C1 was standing in front of another client in the common area. C1 picked up the client's foot and dropped it back down, and while turning fell on her back and struck her arm on the recliner. Both staff members were in the dining room when C1 fell. C1's walker was next to the recliner she had been seated in. The new intervention per registered nurse (RN)-J was to keep C1's walker next to her at all times, due to C1 getting up without assistance. C1's new intervention identified by RN-J from the fall on March 9, 2020, to keep C1's walker next to her at all time was not added to C1's care plan.<br><br>An interview was conducted with RSS-D on June | 0 860 | | |

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| 0 860 | Continued From page 7<br><br>23, 2020, at 10:04 a.m. RSS-D stated on March 9, 2020, the fall occurred around 5:10 a.m., in the common area. RSS-D stated she had taken C1 to the toilet and she was restless and did not want to lay in her bed. RSS-D stated she placed the chair alarm in the recliner; however, it did not alarm when C1 stood up. In addition, RSS-D stated the footrest was up on the recliner as C1 put her leg over the side of the recliner to stand up. The incident report indicated the alarm did not sound appropriately. RSS-D stated sometimes the alarms worked and other times they did not. RSS-D verified she did not document on the incident report that C1 went out the side of the recliner. RSS-D stated C1's walker was next to the recliner.<br><br>C1's fall risk assessment dated March 9, 2020, indicated C1 was at high risk for falls.<br><br>An interview was conducted with RN-J on June 25, 2020, at 8:37 a.m. RN-J was interviewed regarding C1's fall on March 9, 2020. RN-J stated she thought C1 had just got up out of the recliner and was not aware she had went out the side of the recliner. RN-J verified she had not documented about the alarm not sounding during the fall. RN-J stated, "I just go by what is written on the incident report." RN-J was asked by the investigator if she interviewed RSS-D about the fall. RN-J stated RSS-D worked the night shift and would have gone home before she comes to work. RN-J stated when she spoke to RSS-D on March 9, 2020, at 5:30 a.m., she had not read the incident report yet. RN-J stated it would be a better plan to speak with the staff who wrote the incident report. RN-J stated all she could think of was that the walker should be next to C1. In addition, RN-J stated she knew the staff were using the chair alarm as C1 moved so fast. RN-J | 0 860 | | |

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| 0 860 | Continued From page 8<br><br>stated C1 was on two hour safety checks and verified the chair alarm was not added to the care plan.<br><br>Even though C1's walker was next to the recliner when the fall occurred on March 9, 2020, RN-J identified that as a new intervention on the incident report. In addition, RN-J did not address the fact the chair alarm did not sound.<br><br>The licensee's "Incident Call and Communication Log-Resident" document dated April 16, 2020, at 5:15 p.m., indicated a staff member was in another client's room and heard C1's chair alarm beep in the dining room. RSS-E stated she responded within three beeps and was unable to catch C1. C1 was unsteady, crossed her feet, fell to her right side into a pillar, and then fell left onto the floor. RN-J's intervention was to keep C1 in the common area. This intervention was identified by RN-J after the February 9, 2020 fall. In addition, that intervention was never added to C1's care plan.<br><br>After C1's fall on April 16, 2020, at 5:15 p.m., a fall risk assessment was not completed.<br><br>The licensee's "Incident Call and Communication Log-Resident" document dated April 18, 2020, at 1:20 a.m., indicated C1's alarm went off and she was found face down with blood gushing out of her nose. C1's head was facing the wall by the head of the bed. A staff member applied pressure to C1's nose to try and stop the bleeding. The staff member called for help from another staff member. The staff member called for an ambulance and notified the on call registered nurse (RN)-I.<br><br>C1's hospital discharge summary dated April 20, | 0 860 | | |

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| 0 860 | Continued From page 9<br><br>2020, indicated C1 was hospitalized for two days. C1 was diagnosed with a fractured left hip and elbow. The physician had a discussion with family member (FM)-A and C1 was placed on hospice care with no surgical intervention. The physician documented that the left elbow fracture appeared to have happened several days ago.<br><br>An interview was conducted with occupational therapist (OT)-G on June 25, 2020, at 8:03 a.m. OT-G stated she completed the Saint Louis University Mental Status (SLUMS) assessment which indicated C1 had severe cognitive impairment.<br><br>An interview was conducted with family member (FM)-A on June 2, 2020, at 9:38 a.m. FM-A stated the next morning when C1 was in the hospital, staff attempted to assist C1 to the bathroom and C1 stated her left foot hurt. C1 was diagnosed with a fractured left hip. FM-A stated she spoke with the medical examiner who told her if C1 had not fractured her left hip she would not have died as soon as she did. FM-A stated they did not assess C1 after her fall on April 16, 2020, and C1 would not have been able to walk. Instead they put her in a wheelchair.<br><br>An interview was conducted with resident support staff (RSS)-E on June 23, 2020, at 11:01 a.m. RSS-E stated on April 16, 2020, after C1 fell they called the on call registered nurse (RN)-I and were given to direction to get C1 off the floor. RSS-E stated they were to tell the nurse if there was anything serious that occurred. RSS-F and another staff member lifted C1 off the floor with a gait belt and she was placed in a wheelchair. RSS-E stated she notified family member (FM)-A who asked if C1 had dislocated anything, and RSS-E responded no. RSS-E stated she checked | 0 860 | | |

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| 0 860 | Continued From page 10<br><br>C1's shoulder and hips and C1 stated her hand hurt. RSS-E noted a skin tear on C1's elbow. RSS-E stated she gave C1 a shower on April 17, 2020, and noticed a bruise on C1's left elbow. RSS-E stated she was hard on herself, when she found out C1 had a fractured elbow.<br><br>An interview was conducted with RN-J on June 25, 2020, at 8:37 a.m. RN-J was interviewed regarding C1's fall on April 16, 2020. The investigator asked RN-J to explain the process after a client had a fall. RN-J stated after a client fall, the staff check them over, get vital signs, notify the family, and call the nurse that was on call. RN-J stated the staff would check the client to see if they had a head strike, can they move their extremities, and if the client was having pain. RN-J stated if the report from the staff sounds okay they give the staff direction to get the client up off the floor. RN-J stated the staff would fill out an incident report and put it in her basket. RN-J stated if she was working the following day she would finish out the assessment and notify the physician. RN-J stated the staff would let her know later if they noticed anything with the client. RN-J stated she was the person that would look at the client, and do C1's assessment on the computer. RN-J stated,"I rely on their eyes," based on what the staff would be telling me. RN-J stated if she had concerns, she would speak with registered nurse RN-B the director of nursing/executive director. RN-J stated RN-B did not sign off on the incident reports. RN-J stated now they would have RN-B sign off on the incident reports as RN-J knew that was the requirement. RN-J stated she requested an order for a urinalysis on April 16, 2020, because C1 had urinary urgency and aggressive behaviors. C1 received the first dose of ciprofloxacin (an antibiotic) on April 17, 2020, in the evening. | 0 860 | | |

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| 0 860 | Continued From page 11<br><br>An interview was conducted with RN-J on June 25, 2020, at approximately 12:45 p.m. regarding C1's fall on April 16, 2020. RN-J stated an internal investigation was documented related to the fall. RN-J stated that would be the comprehensive assessment regarding the fall on April 16, 2020. The investigator asked RN-J where her assessment would be documented in the record. RN-J stated what she wrote for interventions on the incident report along with the fall risk assessment completed after each fall would be the assessment. RN-J stated April 17, 2020, she went to see C1 in the morning. RN-J stated staff had C1 in the bathroom so she did not assess C1. RN-J stated later in the afternoon, she went to see C1 and found her asleep. RN-J stated she did not want to wake up C1. RN-J stated, "I never got back down there to see her." RN-J stated she did not know the staff used a wheelchair all day for C1 after the fall occurred. RN-J stated C1 was left handed and no staff reported she could not move her arm. RN-J stated she thought staff helped her with lunch. RN-J stated she assumed C1 was having pain after she took a fall, and after a day or two she would be out of it. C1's record indicated the last fall risk assessment was completed March 9, 2020, and indicated C1 was at high risk for falling.<br><br>An interview was conducted with RN-B director of nursing/executive director (ED) on on June 25, 2020, at 2:01 p.m. RN-B stated the next morning following a fall a baseline assessment should be done. The documentation should indicate what was seen, and make sure there were no injuries. RN-B stated with each one of C1's falls, interventions were written on the incident report to make her safer. RN-B stated RN-J should have had C1 walk instead of going off what the staff | 0 860 | | |

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| 0 860 | Continued From page 12<br><br>were telling her. RN-B stated we should have gone back to visualize C1. RN-B stated whatever was written on the incident report would be the assessment. RN-B stated every morning she and RN-J would discuss any incidents that had occurred; however, she stated she did not document her review of the incident report.<br><br>C1's documentation of death record indicated C1 died on May 3, 2020. The cause of death was listed as complications of decreased mobility, left hip and elbow fractures due to falls.<br><br>The licensee's Reporting, Documenting and Reviewing Incidents Involving Clients policy, dated February 19, 2015, indicated the incident report would be reviewed with the ED.<br><br>The licensee's Initial and On-Going Nursing Assessment of Clients policy, dated January 1, 2019, indicated the RN would review the nursing assessment and service plan, and if necessary update the assessment and service plan, whenever the client had a change in condition or experienced an incident such as a fall.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 860 | | |
| 01045 SS=F | 144A.4793, Subd. 5 Documentation of Treatment/Therapy<br><br>Subd. 5.Documentation of administration of treatments and therapies. Each treatment or therapy administered by a comprehensive home care provider must be documented in the client's record. The documentation must include the signature and title of the person who administered the treatment or therapy and must | 01045 | | |

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| 01045 | Continued From page 13<br><br>include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the client's needs.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the licensee failed to ensure the occupational therapist's (OT) plan was implemented and documented for one of one client (C1) with record reviewed.<br><br>This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the clients).<br><br>Findings include:<br><br>C1's diagnoses included, but were not limited to, Alzheimer's dementia and depression. C1's fall risk assessment dated February 11, 2020, indicated C1 was at high risk for falls.<br><br>C1's care plan dated February 21, 2020, indicated C1 required reminders to use her walker, assist of one to walk with the client, stand by assist for transfers.<br><br>C1's OT evaluation dated March 5, 2020, indicated to provide assist of one for C1 due to | 01045 | | |

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| 01045 | Continued From page 14<br><br>safety concerns. A list of activities to try that help prevent restlessness and trying to get up on her own. Some activities may need verbal cues initially to know what to do. Recommendations from the OT evaluation dated March 5, 2020, indicated the following.<br>-folding towels<br>-holding the cat that is in her room<br>-balloon toss, and especially encourage using her right arm with this activity<br>-looking through magazines and photos<br>-listening to music<br>-help with completing activities of daily living (ADL) such as hair brushing and washing her face<br><br>Recommendations from the OT evaluation dated March 5, 2020, indicated the following.<br>-seated in a chair, have her hold her hands together and raise them all the way up 10 times<br>-when reclined in lift chair, raise her right arm up and back times 10 repetitions or to her tolerance<br><br>An interview was conducted with resident staff support (RSS)-C on June 23, 2020, at 9:01 a.m. RSS-C stated the arm exercises were not documented. RSS-C stated they would tell C1 that she should do her exercises. RSS-C stated she felt the arm exercises should be documented, and indicated registered nurse (RN)-J would be responsible to put that on C1's activities of daily living (ADL) form.<br><br>An interview was conducted with OT-G on June 25, 2020, at 8:01 a.m. OT-G stated C1 was hospitalized for seven days prior to her admission. OT-G stated there were discharge orders for C1 to receive physical therapy and OT. OT-G stated C1 had decreased range of motion (ROM) in her right shoulder and decreased | 01045 | | |

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| 01045 | Continued From page 15<br><br>balance. C1 required contact guard assist for all standing and required assistance with toileting. OT-G stated C1 had decreased safety awareness and was a fall risk. OT-G stated she recommended the sensory activities to keep C1 from getting up out of her chair. OT-G stated she reviewed the arm exercises with the direct care staff; however, she did not communicate with the RN. OT-G stated she wanted the arm exercises done daily. OT-G stated she had never been asked to review her documentation with the provider.<br><br>An interview was conducted on June 25, 2020, at 8:33 a.m., with registered nurse (RN)-J. RN-J stated she had no documentation that she reviewed the OT evaluation from March 5, 2020. RN-J stated the activity staff could not perform the sensory activities since they did not know about them. RN-J stated the staff could have C1 help with dressing herself; however, RN-J verified there was no documentation on the March 2020, ADL sheet to indicate C1 participated. In addition, RN-J verified there was no documentation of the arm exercises being performed. RN-J stated staff do not have time to do 1:1 exercises.<br><br>An interview was conducted on June 25, 2020, at 2:01 p.m., with registered nurse RN-B director of nursing/executive director. RN-B stated when OT made a recommendation staff should follow it. RN-B stated typically an OT would leave them case notes so they could change the care plan and the ADL forms.<br><br>The licensee's Delegation of Nursing Tasks, Treatments or Therapy Tasks policy, dated February 17, 2015, indicated the RN could delegate nursing tasks to unlicensed personnel (ULP) consistent with the home care | 01045 | | |

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| 01045 | Continued From page 16<br><br>requirements. In addition, other licensed health professional could delegate treatments or assign therapy tasks to ULPs consistent with applicable standards that apply to their license for example an OT. The policy does not include documentation of the the treatment or therapy.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days. | 01045 | | |
| 01060 SS=C | 144A.4794, Subd. 1(a) Client Record<br><br>Subdivision 1.Client record. (a) The home care provider must maintain records for each client for whom it is providing services. Entries in the client records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to maintain records for one of one client (C1) for whom it provided services, which included authentication of documentation with the name and title of the person making the entry with record reviewed.<br><br>This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the client and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the clients).<br><br>Findings include: | 01060 | | |

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| 01060 | Continued From page 17<br><br>C1's diagnoses included, but were not limited to, Alzheimer's dementia and depression.<br><br>C1's February 2020, activities of daily living (ADL) documentation was signed only with staff initials. There was no legend to identify the staff members names or title.<br><br>C1's February 2020, medication administration record (MAR) was signed with staff initials and included a legend with their name. However, there was no title listed.<br><br>C1's March 2020, ADL documentation was signed only with staff initials. There was no legend to identify the staff members names or title.<br><br>C1's March 2020, MAR was signed with staff initials and included a legend with their name. However, there was no title listed.<br><br>C1's progress note dated March 7, 2020, was signed by resident support staff (RSS)-C with no title.<br><br>C1's progress note dated March 12, 2020, was signed by a registered nurse (RN), with no title.<br><br>C1's April 2020, ADL documentation was signed only with staff initials. There was no legend to identify the staff members names or title.<br><br>C1's April 2020, MAR was signed with staff initials and included a legend with their name. However, there was no title listed.<br><br>C1's progress note dated April 16, 2020, was signed by resident support staff (RSS)-E and | 01060 | | |

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| 01060 | Continued From page 18<br>RSS-F with no titles listed.<br><br>C1's progress note dated April 17, 2020, was signed by registered nurse (RN)-I with no title.<br><br>C1's progress note dated April 17,2020, was signed by RN-J with no title.<br><br>An interview was conducted with RSS-C on June 23, 2020, at 9:01 a.m. RSS-C stated she was never told to put her title after signing her name on documentation.<br><br>An interview was conducted with RN-B director of nursing/executive director on June 25, at 2:01 p.m. RN-B verified the RN lacked a title on his March 12, 2020, documentation. RN-B stated she would have the staff put their title in their documentation.<br><br>The licensee's Documentation of Medication Management Services policy, dated March 11, 2015, indicated documentation would follow professional standards for documentation. This included the requirement that entries must be authenticated with the name and title of the person making the entry.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 01060 | | |
| 02015 SS=D | 626.557, Subd. 3 Timing of Report<br><br>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 | 02015 | | |

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| 02015 | Continued From page 19<br><br>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:<br><br>(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<br><br>(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).<br><br>(b) A person not required to report under the provisions of this section may voluntarily report as described above.<br><br>(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.<br><br>(d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.<br><br>(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, | 02015 | | |

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| 02015 | Continued From page 20<br><br>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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to report suspected maltreatment when a client had a black eye of unknown origin for one of one client (C1) reviewed.<br><br>This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the clients).<br><br>Findings include:<br><br>The licensee's internal investigation dated February 18, 2020, indicated an outside physical therapy assistant (PTA) provided assistance with ambulation to C1 around 10:00 a.m. The PTA reported C1 had a bruise to registered nurse (RN)-J. RN-J documented the bruise extended down the right side of C1's face and was approximately 3-1/2 inches long and 1-1/2 inches wide. On February 19, 2020, the bruise extended all the way around the orbit of the eye. The licensee did not know how the bruise occurred. | 02015 | | |

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| 02015 | Continued From page 21<br><br>On February 18, 2020, the PTA documented that reportedly C1 had a fall last week while she was self transferring in the bathroom. C1 fell on her bottom. Today noted a bruise along the right forehead areas. C1 also very tender along the right rib area.<br><br>An interview was conducted with family member (FM)-A on June 2, 2020, at 9:38 a.m. FM-A stated the bruise around C1's eye was purple and green. FM-A stated when two staff members were working in client rooms, there were ten clients unattended in the common area. FM-A stated that was probably when the black eye occurred. FM-A stated staff were unable to tell her how the injury occurred.<br><br>An interview was conducted with resident support staff (RSS)-H on June 23, 2020, at 2:47 p.m. RSS-H stated when she saw C1's eye, it was really bad as it covered her right eye and was pretty dark in color. RSS-H stated she did not think C1 received the bruise from a fall.<br><br>An interview was conducted with registered nurse (RN)-B director of nursing on June 25, at 2:01 p.m. RN-B stated she was made aware of C1's black eye when outside occupational therapist (OT)-G reported it. RN-B stated it was an injury of unknown origin and was not reported to the MN Adult Abuse Reporting Center (MAARC). RN-B stated she was aware the injury should have been reported. RN-B stated it was her assumption that one of the clients tried to straighten C1's glasses into the tender area of her eye.<br><br>The licensee's Vulnerable Adult Reporting and Investigation Policy, dated January 2014, section | 02015 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H26604 | A. BUILDING: _____ B. WING _____ | C 07/01/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TRADITIONS OF MONTGOMERY LLC | 399 LEXINGTON AVENUE NORTHWEST MONTGOMERY, MN 56069 |

| (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 22<br><br>titled Mandated Reporting to the Common Entry Point (CEP) includes the phone number for MAARC. The section titled unexplained physical injury, indicated when staff observed an unexplained physical injury they would immediately notify the RN, who would conduct an internal investigation to determine whether the injury was unexplained and whether a report to the CEP was required. The section titled immediate report to CEP required, means immediate, but no longer than 24 hours from the time the RN received initial knowledge that the incident had occurred.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 02015 | | |