

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL291896923M
Compliance #: HL291891567C

Date Concluded: January 15, 2025

Name, Address, and County of Licensee

Investigated:

The Legacy of Delano
1350 Saint Peter Ave E.
Delano, MN 55328
Wright County

Facility Type: Assisted Living Facility with
Dementia Care (ALFDC)

Evaluator's Name:

Jana Wegener, 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 resident was neglected when she was observed walking unassisted, fell backwards, and sustained a head strike. The resident died.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to ensure staff were aware of the residents assessed needs. The resident had reoccurring falls and the facility failed to implement interventions to prevent further falls. The resident fell while walking without staff assistance and sustained a head strike. The resident's death record indicated the resident died from complications of a subdural and subarachnoid hemorrhage as a result of the fall.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member. The investigation included review of the resident record(s), death record, outside medical

records, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator toured the facility and observed resident's and staff.

The resident resided in an assisted living facility memory care unit with diagnoses including atrial fibrillation, congestive heart failure, coronary artery disease, type 2 diabetes mellitus, and stroke.

The resident's admission assessment indicated the resident was severely cognitively impaired and required staff assistance with dressing and grooming twice daily. The assessment indicated the resident was incontinent of bowel and bladder and needed 1 assist with transfers, ambulation, and toileting using a wheelchair and 4 wheeled walker for mobility. The assessment indicated the resident needed staff assistance to get to and from meals and activities.

An assessment dated 14 days after admission, indicated the resident had 1-2 falls since admission related to balance problems, but was ambulatory and continent of bowel and bladder. The assessment indicated the resident was independent with ambulation dressing, transfers, toileting, and personal hygiene but required stand by assistance (SBA) with ambulation and indicated staff would escort the resident to and from activities and meals using her walker. The assessment did not align with the initial assessment.

The resident's service plan and service delivery of care record from the time of admission indicated the resident was independent and received escort mobility assistance using a 4 wheeled walker to and from all destinations and meals, scheduled 3 times daily. The service plan failed to include any assistance with transfers, ambulation, toileting, dressing, or grooming as assessed on admission and prior to the resident's 14-day assessment.

A review of the resident record indicated although the resident's admission orders included orders for physical therapy (PT) and occupational therapy (OT), the resident record failed to indicate the orders were implemented until 19 days after admission, and after the resident had fallen 3 times. A review of the resident's progress notes and facility communication to the resident's provider failed to indicate why the orders were not implemented timely.

A fall incident report and progress note (the day after the resident was admitted to the facility) indicated at 11:35 a.m. the resident had an unwitnessed fall in her room about 1 hour after staff documented the resident had an episode of explosive diarrhea. The incident report identified the resident had impaired balance, and impaired vision. The incident report identified the resident was not wearing her glasses, had no shoes on, and her walker was out of reach at the time the fall occurred. The incident report indicated the resident's service plan and services were reviewed with scheduled services for safety checks, and indicated the resident was independent with transfers using her walker which did not align with the resident's assessed needs at the time the incident occurred. The incident report indicated interventions to reduce

recurring falls were to continue safety checks, ensure items were within reach, proper footwear was donned, and the resident was wearing her glasses.

The facility failed to identify the resident's services at the time the fall occurred failed to include assistance with transfers, toileting, ambulation, and dressing/grooming as assessed. The resident record failed to indicate safety checks were ever implemented or provided and failed to indicate PT/OT services were implemented as ordered at the time the fall occurred.

Another fall incident report 2 days later identified the resident was cognitively impaired, had a balance disorder, impaired mobility, unsteady gait, and poor safety judgement. The incident report failed to identify the resident had previously fallen, and indicated there was no history of falls. The incident report indicated the resident was walking back from the bathroom unassisted with no shoes on and tripped on a blanket and fell. The report indicated the resident was found during safety checks. The incident report indicated staff were educated to tuck blankets in and family provided a nonslip rug for the floor. The incident report interventions to reduce recurring falls indicated they would continue PT/OT, and ensure the resident was wearing her glasses.

The facility failed to identify the resident's services at the time the fall occurred failed to include assistance with transfers, toileting, ambulation, dressing and grooming as assessed. The resident record failed to indicate safety checks were ever implemented or provided and failed to indicate PT/OT services were implemented as indicated and ordered at the time the fall occurred.

Another fall incident report 18 days later indicated the resident had another unwitnessed fall while ambulating independently in the common area when she went to her room unassisted after breakfast, lost her balance, and fell. The resident's plan of care to provide escort stand by assistance was not followed at the time the fall occurred. The incident report identified contributing factors in the resident's fall included generalized weakness, confusion, decline in status, neuropathy, history of falls, and need to use the bathroom (with bowel/bladder incontinence at the time of the fall) but failed to identify the resident's plan of care to provide stand by assist with ambulation was not followed at the time the fall occurred. The resident's vital signs at the time of the fall indicated the resident's blood pressure was 87/73 (abnormally low, which could increase dizziness and risk for falls). There was no indication in the resident record the resident's fall or low blood pressure were reported to the resident's provider. The incident report interventions to reduce recurring falls indicated the facility would offer toileting, and a PT/OT evaluation. There was no indication the facility implemented the resident's admission order for PT/OT services prior to this fall incident. The incident report indicated safety checks were performed by staff, however there was no indication safety checks were provided to the resident according to her services provided. Although the facility identified the resident needed assistance with toileting, and indicated toileting services would be offered, there was no indication assistance with toileting was ever added to the resident's services for staff to implement.

The next day another fall incident report indicated the resident was observed ambulating independently in the common area, lost her balance, and fell over backwards onto the ground striking the back of her head. The resident's plan of care to provide escort SBA was not followed at the time the fall occurred. The incident report identified contributing factors included fall history, cognitive impairment, generalized weakness, bowel/bladder incontinence, needing to use the bathroom, and indicated the resident was incontinent of stool at the time the incident occurred. The incident report indicated the resident was unresponsive after sustaining a head strike when falling, 911 was called and the resident was transferred to the emergency department via ambulance. There was no indication toileting assistance was provided as indicated for falls prevention noted on the fall incident report the previous day.

The resident's progress notes after the fall with head strike occurred indicated the resident was observed walking independently, stopped, then fell over backwards striking the back of her head. The resident had pale pallor, was not responsive or able to follow commands, and had a fixed blank stare. The resident was transferred to the hospital where she was diagnosed with a brain bleed and died.

A facility adverse event investigation document indicated the resident had a witnessed fall walking independently in the common area utilizing her 4 wheeled walker appropriately, took 3-4 steps and lost her balance resulting in a fall and head strike. Staff called 911, the resident was noted to be in and out of consciousness, unable to respond to questions, and moaning in pain. The facility investigation failed to identify any concerns and indicated services were reviewed and the resident's care plan was followed at the time the incident occurred.

A review of facility provided video surveillance at the time the fall with head strike occurred showed staff escort the resident to a chair in the common area after breakfast at 9:03 a.m. The staff told the resident they would check on her. The resident appeared to be sleeping as numerous staff were observed walk through the common area but did not interact with the resident. At 9:45 a.m. the resident appeared to wake up and was observed moving in the chair (sitting forward then back) then appeared to be trying the rest again. At 9:57 a.m. the resident was observed lean forward and scoot to the edge of the chair as staff walked by the resident. Then, the resident placed her hands on her knees and stood up using her walker. The resident walked toward her room unassisted by staff, suddenly stopped, then took a few more steps and appeared to wobble, then fell backwards to the floor striking her head. Staff immediately responded and called 911. At 10:13 a.m. emergency medical services arrived on scene and the resident was transported to the ED 3 minutes later.

The resident's record of death indicated the resident died from complications of a subdural and subarachnoid hemorrhage as a result of a fall while ambulating at the facility resulting in a head strike.

Interviews with one unlicensed personnel (ULP) staff indicated the resident was confused and unsteady with ambulation. The ULP stated the resident needed staff to escort her to the toilet

and meals. The ULP indicated the resident's plan of care indicated the resident could walk alone and toilet herself, but she seemed weak, unsteady, and needed assistance. The ULP indicated she assisted the resident when she worked and reported her concern with the resident being unsteady and needing assistance to nursing.

Several ULP staff indicated the resident had falls at the facility but had no fall interventions in place other than providing SBA escorts. Some ULP staff stated they provided assistance to the resident with dressing, transfers, and toileting due to the resident being unsteady and indicated they thought the resident's services directed them to do so. Two ULP staff interviewed indicated the last 2 times the resident fell they were short staffed and indicated that was not uncommon. ULP staff indicated they were unable to say if staffing concerns contributed to the resident's fall incidents, but indicated another pair of eyes would be helpful.

A facility nurse indicated the resident's initial assessment which indicated the resident required assistance was not implemented because the resident was able to do more. The nurse verified no reassessment was completed until 14 days later, and indicated the assessment and service plan should match. The nurse stated due to short staffing she was not always able to complete assessments timely. The nurse indicated no fall interventions identified on the incident reports were implemented because it could have changed the cost of services for the family.

Facility leadership stated the resident had 4 falls since admission but indicated the resident was not at a risk for falls, and denied the resident was unsteady, or had balance issues despite those concerns identified repeatedly in the resident's fall incident reports since admission. Leadership stated the resident's care plan was followed and nothing could have prevented the incident. Email communication with facility leadership indicated the resident's admission PT/OT order was not processed timely due to a fax malfunction. Facility leadership indicated staffing was provided based on acuity of care.

A review of the facility contingency staffing plan failed to indicate the staffing plan was based on resident acuity as indicated by facility leadership. The staffing plan and staff schedule failed to indicate adequate staffing was in place at the time the last 2 resident falls occurred.

When interviewed the resident's family member indicated they communicated on admission the resident had a history of falls at the previous facility prior to admission and indicated the resident needed assistance with toileting, dressing, and mobility including transfers and ambulation due to a physical and cognitive decline following a recent hospitalization and surgical procedure. The family member indicated the resident continued to decline after admission to the facility and assumed the facility was providing services and assistance the resident needed to keep her safe including frequent safety checks, cameras in the resident's room to detect falls, and ordered PT/OT services.

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: No, deceased.

Family/Responsible Party interviewed: Yes

Alleged Perpetrator interviewed: N/A

Action taken by facility:

The facility called 911, and transferred the resident to the ED.

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>

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

Wright County Attorney

Delano City Attorney

Delano Police Department

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29189	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/05/2024
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NAME OF PROVIDER OR SUPPLIER THE LEGACY OF DELANO	STREET ADDRESS, CITY, STATE, ZIP CODE 1350 ST. PETER AVENUE EAST DELANO, MN 55328
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0 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p>#HL291896923M/#HL291891567C</p> <p>On December 5, 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 47 residents receiving services under the provider's Asisted Living with Dementia Care license.</p> <p>The following correction orders are issued for #HL291896923M/#HL291891567C, tag identification 0470, 1640, 1650, 1940, 2310, and 2360.</p>	0 000	<p>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.</p> <p>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.</p> <p>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.</p>	
0 470 SS=I	<p>144G.41 Subdivision 1 Minimum requirements</p> <p>(11) develop and implement a staffing plan for determining its staffing level that:</p> <p>(i) includes an evaluation, to be conducted at</p>	0 470		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Minnesota Department of Health

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0 470	<p>Continued From page 1</p> <p>least twice a year, of the appropriateness of staffing levels in the facility;</p> <p>(ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and</p> <p>(iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility;</p> <p>(12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be:</p> <p>(i) awake;</p> <p>(ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time;</p> <p>(iii) capable of communicating with residents;</p> <p>(iv) capable of providing or summoning the appropriate assistance; and</p> <p>(v) capable of following directions;</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the required staffing plan evaluation was conducted and implemented to determine the appropriateness of staffing levels to meet the scheduled and unscheduled needs of each resident as required. One of one resident's (R1) was harmed when she had recurring falls resulting in head strike and death at times when the licensee failed to ensure the minimum number of staffing was available on the memory care unit. This had the potential to affect all current residents, staff, and visitors.</p>	0 470		
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0 470	<p>Continued From page 2</p> <p>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 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 residents).</p> <p>The findings include:</p> <p>R1 was admitted to the licensee memory care unit on October 14, 2024, with diagnoses including atrial fibrillation, congestive heart failure, coronary artery disease, type 2 diabetes mellitus, and stroke.</p> <p>R1's admission assessment dated October 10, 2024, and completed/signed on November 7, 2024, after R1 died, indicated R1 was severely cognitively impaired and required staff assistance with dressing and grooming twice daily. The assessment indicated R1 was incontinent of bowel and bladder and needed 1 assist with transfers, ambulation, and toileting using a wheelchair and 4 wheeled walker for mobility. The assessment indicated R1 needed staff assistance to get to and from meals and activities.</p> <p>R1 assessment dated October 28, 2024, (14 days after admission), signed/completed on November 7, 2024, after R1 died, indicated R1 had 1-2 falls since admission related to balance problems, but was ambulatory and continent of bowel and bladder. The assessment indicated R1 was independent with ambulation dressing, transfers, toileting, and personal hygiene but required stand by assistance (SBA) with ambulation and</p>	0 470		

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0 470	<p>Continued From page 3</p> <p>indicated staff would escort R1 to and from activities and meals using her walker. The assessment did not align with the initial assessment.</p> <p>R1's service plan and service delivery of care record from the time of admission indicated R1 was independent and received escort mobility assistance using a 4 wheeled walker to and from all destinations and meals scheduled 3 times daily. The service plan failed to include any assistance with transfers, ambulation, toileting, dressing, or grooming as assessed on admission and prior to the resident's 14-day assessment.</p> <p>On October 15, 2024, at 11:35 a.m. a fall incident report (the day after the resident was admitted to the facility) indicated R1 had an unwitnessed fall in her room about 1 hour after staff documented in a progress note R1 had an episode of explosive diarrhea. The incident report identified R1 had impaired balance, and impaired vision. The incident report identified R1 was not wearing her glasses, had no shoes on, and her walker was out of reach at the time the fall occurred. The incident report indicated R1's service plan and services were reviewed with scheduled services for safety checks, and indicated R1 was independent with transfers using her walker which did not align with R1's assessed needs at the time the incident occurred. The incident report indicated interventions to reduce recurring falls were to continue safety checks, ensure items were within reach, proper footwear was donned, and ensure R1 was wearing her glasses. The facility failed to identify R1's services at the time the fall occurred did not include assistance with transfers, toileting, ambulation, and dressing/grooming as assessed. R1's record failed to indicate safety checks were ever</p>	0 470		
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0 470	<p>Continued From page 4</p> <p>implemented or provided and failed to indicate PT/OT services were implemented as ordered at the time the fall occurred.</p> <p>On October 17, 2024, at 1:50 a.m. another fall incident report 2 days later identified R1 was cognitively impaired, had a balance disorder, impaired mobility, unsteady gait, and poor safety judgement. The incident report failed to identify R1 had previously fallen, and indicated there was no history of falls. The incident report indicated R1 was walking back from the bathroom unassisted with no shoes on and tripped on a blanket and fell. The report indicated R1 was found during safety checks. The incident report indicated staff were educated to tuck blankets in and family provided a nonslip rug for the floor. The incident report interventions to reduce recurring falls indicated they would continue PT/OT, and ensure R1 was wearing her glasses. The facility failed to identify R1's services at the time the fall occurred failed to include assistance with transfers, toileting, ambulation, dressing and grooming as assessed. R1's record failed to indicate safety checks were ever implemented or provided and failed to indicate PT/OT services were implemented as indicated and ordered at the time the fall occurred.</p> <p>On November 4, 2024, at 11:00 a.m. a fall incident report 18 days later, indicated R1 had another unwitnessed fall while ambulating independently in the common area when she went to her room unassisted after breakfast, lost her balance, and fell. R1's plan of care to provide escort stand by assistance was not followed at the time the fall occurred. The incident report identified contributing factors in the R1's fall included generalized weakness, confusion, decline in status, neuropathy, history of falls, and</p>	0 470		

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0 470	<p>Continued From page 5</p> <p>need to use the bathroom (with bowel/bladder incontinence at the time the fall) but failed to identify R1's plan of care was not followed at the time the fall occurred. R1's vital signs at the time of the fall indicated R1's blood pressure was 87/73 (abnormally low, which could increase dizziness and risk for falls). There was no indication R1's fall or low blood pressure were reported to the provider. The incident report interventions to reduce recurring falls indicated the facility would offer toileting, and a PT/OT evaluation. There was no indication the facility implemented R1's admission orders for PT/OT services prior to this fall incident. The incident report indicated safety checks were performed by staff, however there was no indication safety checks were provided according to R1's services provided. Although the facility identified R1 needed assistance with toileting, and indicated toileting services would be offered, there was no indication assistance with toileting was ever added to R1's services for staff to implement.</p> <p>On November 5, 2024, at 9:56 a.m. a fall incident report the following day indicated R1 was observed ambulating independently in the common area, lost her balance, and fell over backwards onto the ground striking the back of her head. R1's plan of care to provide escort SBA was not followed at the time the fall occurred. The incident report identified contributing factors included fall history, cognitive impairment, generalized weakness, bowel/bladder incontinence, needing to use the bathroom, and indicated R1 was incontinent of stool at the time the incident occurred. The incident report indicated R1 was unresponsive after sustaining the head strike, 911 was called and R1 was transferred to the emergency department via ambulance. There was no indication toileting</p>	0 470		
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0 470	<p>Continued From page 6</p> <p>assistance was provided as indicated for falls prevention noted on the fall incident report the previous day.</p> <p>On November 5, 2024, at 11:35 a.m. a progress notes after the fall with head strike occurred indicated R1 was observed walking independently, stopped, then fell over backwards striking the back of her head. R1 had pale pallor, was not responsive or able to follow commands, and had a fixed blank stare, and was transferred to the hospital. At 3:22 p.m. a progress note indicated the resident was diagnosed with a brain bleed and was intubated, but the breathing tube was removed and comfort care and pain management was provided.</p> <p>On November 6, 2024, at 2:02 p.m. a progress note indicated R1 died on November 5, 2024 around 9:45 p.m.</p> <p>R1's record of death indicated R1 died from complications of a subdural and subarachnoid hemorrhage as a result of a fall while ambulating at the facility resulting in a head strike.</p> <p>On December 5, 2024, at 12:03 p.m. during and entrance conference executive director (ED)-C, and Registered Nurse Director of Health Services (RNDOH)-B stated R1 had 4 falls since admission but indicated R1 was not at a risk for falls, and denied R1 was unsteady, or had balance issues despite those concerns identified repeatedly in the R1's fall incident reports since admission. ED-C and RNDOH-B stated R1's plan of care was followed, nothing could have prevented the incident, and indicated the incident was an accident.</p> <p>On December 10, 2024, at 3:46 p.m. unlicensed</p>	0 470		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29189	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/05/2024
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NAME OF PROVIDER OR SUPPLIER THE LEGACY OF DELANO	STREET ADDRESS, CITY, STATE, ZIP CODE 1350 ST. PETER AVENUE EAST DELANO, MN 55328
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0 470	<p>Continued From page 7</p> <p>personnel (ULP)-K stated the day before R1 fell and sustained a head strike she was the only staff assigned to the unit and another ULP staff (unknown) from the assisted living side had come over to relieve her for a break. ULP-K stated when she returned to the unit R1 was on the floor. ULP-K stated it was not unusual to be short staffed on the memory care unit, but she did not know if staffing concerns contributed to R1's fall that day.</p> <p>On December 10, 2024, at 4:56 p.m. during email communication ED-C indicated indicated staffing was provided based on acuity of care.</p> <p>On December 12, 2024, at 1:49 p.m. ULP-A stated the day R1 fell and sustained a head strike she was the only staff scheduled to work and indicated there was supposed to be 2. The ULP indicated that was not unusual to be sort staffed and indicated she did not know if staffing concerns contributed to R1's fall that day but another pair of eyes was helpful.</p> <p>On December 15, 2024, at 9:30 a.m. registered nurse (RN)-J stated R1's initial assessment which indicated she required assistance was not implemented because R1 was able to do more. RN-J verified no reassessment was completed until 14 days later, and indicated the assessment and service plan should match. RN-J stated due to short staffing she was not always able to complete assessments timely. RN-J indicated no fall interventions identified on the incident reports were implemented because it could have changed the cost of services for R1's family.</p> <p>A facility provided document titled "Contingency Staffing Plan" dated September 2024, failed to indicate the staffing plan was based on resident</p>	0 470		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29189	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/05/2024
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0 470	<p>Continued From page 8</p> <p>acuity as indicated by ED-C. The staffing plan included a staffing table for minimum number of staffing required for to maintain critical functions during normal conditions for each shift. According to the staffing plan provided and staff schedule at the time the last 2 fall incidents occurred, the licensee had inadequate staffing in place at the time the incidents occurred. The staffing plan did not identify how the plan was developed or implemented to ensure sufficient staffing to meet all residents needs. The staffing plan included a table which indicated the number of home health aides and licensed nurses for morning (AM), evening (PM), and night (NOC) shifts required during normal conditions. The plan indicated 4 home health aides and 1 licensed nurse were required for AM and PM shifts, and 3 home health aides for the NOC shift.</p> <p>The facility provided staff schedule from November 3, 2024, to November 9, 2024, indicated only 3 of 4 home health aide staff were scheduled for the AM shift on November 3, 4, 5, 7, and 8th., and only 3 of 4 home health aides were scheduled on November 4th for the PM shift in memory care unit. Indicating the licensee routinely failed to ensure the minimum number of staff were available to meet the needs of the resident's, and at the time R1's last 2 falls occurred.</p> <p>A policy and procedure for staffing assessment/plan was requested, none was provided.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days.</p>	0 470		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29189	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/05/2024
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01640	Continued From page 9	01640		
01640 SS=D	<p>144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to</p> <p>(a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan.</p> <p>(b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities.</p> <p>(c) The facility must implement and provide all services required by the current service plan.</p> <p>(d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable.</p> <p>(e) Staff providing services must be informed of the current written service plan.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure one of one resident's (R1)s assessment and service plan were signed and finalized no later than 14 days after the date services were provided. R1's unsigned admission assessment was not finalized until 25 days after R1 was admitted to the facility, and following R1's death.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or</p>	01640		

Minnesota Department of Health

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01640	<p>Continued From page 10</p> <p>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 a limited number of staff are involved, or the situation has occurred only occasionally).</p> <p>Findings include:</p> <p>R1 was admitted to the licensee memory care unit on October 14, 2024, with diagnoses including atrial fibrillation, congestive heart failure, coronary artery disease, type 2 diabetes mellitus, and stroke.</p> <p>R1's admission assessment dated October 10, 2024, and was completed/signed 25 days later, on November 7, 2024, after R1 died.</p> <p>R1 service plan signed and dated October 22, 2024, included medication administration and management services, escort assistance, and meal set up but failed to include details and instructions for assessed assistance needed for staff to implement.</p> <p>R1 assessment dated October 28, 2024, (14 days after admission), and was not signed/completed until 11 days later on November 7, 2024, after R1 died.</p> <p>On December 15, 2024, at 9:30 a.m. registered nurse (RN)-J stated R1's initial assessment which indicated she required assistance was not implemented because R1 was able to do more. RN-J verified no reassessment was completed until 14 days later, and indicated the assessment and service plan should match. RN-J stated due to short staffing she was not always able to</p>	01640		
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Minnesota Department of Health

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01640	<p>Continued From page 11</p> <p>complete assessments timely.</p> <p>The facility provided a guideline for comprehensive assessment schedule revised on August 2022, indicated the RN/Director of Housing Services would complete a initial individualized assessment prior to admission and initiation of services. The guideline indicated a re-assessment would be completed with in 14 days after initiated services, and as indicated for a change in condition. The table titled assessment guide under change in condition indicated a post fall review would be completed after every fall. The table titled paperwork, preparing services & chart indicated a signed service agreement was required on the day of admission, would be finalized with in 14 days, and indicated any changes to the service agreement required a new signed agreement.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days.</p>	01640		
01650 SS=J	<p>144G.70 Subd. 4 (f) Service plan, implementation and revisions to</p> <p>(f) The service plan must include:</p> <p>(1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences;</p> <p>(2) the identification of staff or categories of staff who will provide the services;</p> <p>(3) the schedule and methods of monitoring assessments of the resident;</p> <p>(4) the schedule and methods of monitoring staff providing services; and</p>	01650		

Minnesota Department of Health

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01650	<p>Continued From page 12</p> <p>(5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters.</p> <p>This MN Requirement is not met as evidenced by: Based on record review and interview the licensee failed to ensure one of one resident's (R1)s service plan included a description of the services to be provided, and the frequency of each service, according to R1's assessed needs for staff to implement. R1 had recurring falls while ambulating independently, and the facility failed to implement identified interventions to help prevent recurring falls. Harm occurred when R1 fell again while ambulating alone, sustained a head strike, and died as a result of her injury.</p> <p>This practice resulted in a level four violation (a violation that results in serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).</p>	01650		

Minnesota Department of Health

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01650	<p>Continued From page 13</p> <p>Findings include:</p> <p>R1 was admitted to the licensee memory care unit on October 14, 2024, with diagnoses including atrial fibrillation, congestive heart failure, coronary artery disease, type 2 diabetes mellitus, and stroke.</p> <p>R1's admission assessment dated October 10, 2024, and completed/signed on November 7, 2024, after R1 died, indicated R1 was severely cognitively impaired and required staff assistance with dressing and grooming twice daily. The assessment indicated R1 was incontinent of bowel and bladder and needed 1 assist with transfers, ambulation, and toileting using a wheelchair and 4 wheeled walker for mobility. The assessment indicated R1 needed staff assistance to get to and from meals and activities.</p> <p>R1 service plan signed and dated October 22, 2024, included medication administration and management services, escort assistance, and meal set up but failed to include details and instructions for assessed assistance needed for staff to implement.</p> <p>R1 assessment dated October 28, 2024, (14 days after admission), signed/completed on November 7, 2024, after R1 died, indicated R1 had 1-2 falls since admission related to balance problems, but was ambulatory and continent of bowel and bladder. The assessment indicated R1 was independent with ambulation dressing, transfers, toileting, and personal hygiene but required stand by assistance (SBA) with ambulation and indicated staff would escort R1 to and from activities and meals using her walker. The assessment did not align with the initial assessment.</p>	01650		

Minnesota Department of Health

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01650	<p>Continued From page 14</p> <p>R1's service plan and service delivery of care record from the time of admission indicated R1 was independent and received escort mobility assistance using a 4 wheeled walker to and from all destinations and meals scheduled 3 times daily. The service plan failed to include any assistance with transfers, ambulation, toileting, dressing, or grooming as assessed on admission and prior to the resident's 14-day assessment.</p> <p>R1's medication administration record (MAR) for October and November 2024, included Aspirin 81 mg, daily and Coumadin (an anticoagulant medication) which can increase the risk for bleeding. The MAR also included several medications that could cause hypotension, dizziness, orthostatic hypotension, abdominal pain, dizziness, and diarrhea which could increase R1's risk for falls.</p> <p>R1's admission orders included orders for physical therapy (PT) and occupational therapy (OT). However, R1's record failed to indicate the orders were implemented until 19 days after admission, and after the resident had fallen 3 times. A review of R1's progress notes and facility communication failed to indicate why the orders were not implemented timely.</p> <p>On October 15, 2024, at 11:35 a.m. a fall incident report (the day after the resident was admitted to the facility) indicated R1 had an unwitnessed fall in her room about 1 hour after staff documented in a progress note R1 had an episode of explosive diarrhea. The incident report identified R1 had impaired balance, and impaired vision. The incident report identified R1 was not wearing her glasses, had no shoes on, and her walker was out of reach at the time the fall occurred. The</p>	01650		

Minnesota Department of Health

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01650	<p>Continued From page 15</p> <p>incident report indicated R1's service plan and services were reviewed with scheduled services for safety checks, and indicated R1 was independent with transfers using her walker which did not align with R1's assessed needs at the time the incident occurred. The incident report indicated interventions to reduce recurring falls were to continue safety checks, ensure items were within reach, proper footwear was donned, and ensure R1 was wearing her glasses. The facility failed to identify R1's services at the time the fall occurred failed to include assistance with transfers, toileting, ambulation, and dressing/grooming as assessed. R1's record failed to indicate safety checks were ever implemented or provided and failed to indicate PT/OT services were implemented as ordered at the time the fall occurred.</p> <p>On October 17, 2024, at 1:50 a.m. another fall incident report 2 days later identified R1 was cognitively impaired, had a balance disorder, impaired mobility, unsteady gait, and poor safety judgement. The incident report failed to identify R1 had previously fallen, and indicated there was no history of falls. The incident report indicated R1 was walking back from the bathroom unassisted with no shoes on and tripped on a blanket and fell. The report indicated R1 was found during safety checks. The incident report indicated staff were educated to tuck blankets in and family provided a nonslip rug for the floor. The incident report interventions to reduce recurring falls indicated they would continue PT/OT, and ensure R1 was wearing her glasses. The facility failed to identify R1's services at the time the fall occurred failed to include assistance with transfers, toileting, ambulation, dressing and grooming as assessed. R1's record failed to indicate safety checks were ever implemented or</p>	01650		

Minnesota Department of Health

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01650	<p>Continued From page 16</p> <p>provided and failed to indicate PT/OT services were implemented as indicated and ordered at the time the fall occurred.</p> <p>On November 4, 2024, at 11:00 a.m. a fall incident report 18 days later, indicated R1 had another unwitnessed fall while ambulating independently in the common area when she went to her room unassisted after breakfast, lost her balance, and fell. R1's plan of care to provide escort SBA was not followed at the time the fall occurred. The incident report identified contributing factors in the R1's fall included generalized weakness, confusion, decline in status, neuropathy, history of falls, and need to use the bathroom (with bowel/bladder incontinence at the time the fall) but failed to identify R1's plan of care was not followed at the time the fall occurred. R1's vital signs at the time of the fall indicated R1's blood pressure was 87/73 (abnormally low, which could increase dizziness and risk for falls). There was no indication R1's fall or low blood pressure were reported to the provider. The incident report interventions to reduce recurring falls indicated the facility would offer toileting, and a PT/OT evaluation. There was no indication the facility implemented R1's admission orders for PT/OT services prior to this fall incident. The incident report indicated safety checks were performed by staff, however there was no indication safety checks were provided according to R1's services provided. Although the facility identified R1 needed assistance with toileting, and indicated toileting services would be offered, there was no indication assistance with toileting was ever added to R1's services for staff to implement.</p> <p>On November 5, 2024, at 9:56 a.m. a fall incident report the following day indicated R1 was</p>	01650		

Minnesota Department of Health

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01650	<p>Continued From page 17</p> <p>observed ambulating independently in the common area, lost her balance, and fell over backwards onto the ground striking the back of her head. R1's plan of care to provide escort SBA was not followed at the time the fall occurred. The incident report identified contributing factors included fall history, cognitive impairment, generalized weakness, bowel/bladder incontinence, needing to use the bathroom, and indicated R1 was incontinent of stool at the time the incident occurred. The incident report indicated R1 was unresponsive after sustaining the head strike, 911 was called and R1 was transferred to the ED via ambulance. There was no indication toileting assistance was provided as indicated for falls prevention noted on the fall incident report the previous day.</p> <p>On November 5, 2024, at 11:35 a.m. a progress notes after the fall with head strike occurred indicated R1 was observed walking independently, stopped, then fell over backwards striking the back of her head. R1 had pale pallor, was not responsive or able to follow commands, and had a fixed blank stare, and was transferred to the hospital. At 3:22 p.m. a progress note indicated the resident was diagnosed with a brain bleed and was intubated, but the breathing tube was removed and comfort care and pain management was provided.</p> <p>On November 6, 2024, at 2:02 p.m. a progress note indicated R1 died on November 5, 2024 around 9:45 p.m.</p> <p>A undated facility adverse event investigation document indicated R1 had a witnessed fall walking independently in the common area utilizing her 4 wheeled walker appropriately, took 3-4 steps and lost her balance resulting in a fall</p>	01650		

Minnesota Department of Health

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01650	<p>Continued From page 18</p> <p>and head strike. Staff called 911, R1 was noted to be in and out of consciousness, unable to respond to questions, and moaning in pain. The facility investigation failed to identify any concerns and indicated services were reviewed and R1's plan of care was followed at the time the incident occurred.</p> <p>A review of facility provided video surveillance for the fall with head strike on November 5, 2024, at 9:03 a.m. showed unlicensed personnel (ULP)-A escort R1 to a chair in the common area after breakfast. ULP-A told R1 she would check on her. R1 appeared to be sleeping as numerous staff (unknown) were observed walk through the common area but did not interact with R1. At 9:45 a.m. R1 appeared to wake up and was observed moving in the chair (sitting forward then back) then appeared to be trying the rest again. At 9:57 a.m. R1 was observed lean forward and scoot to the edge of the chair as staff walked by R1. Then, R1 placed her hands on her knees and stood up using her walker, and walked toward her room unassisted by staff. R1 suddenly stopped, then took a few more steps and appeared to wobble, then fell backwards to the floor striking her head. Staff immediately responded and called 911. At 10:13 a.m. emergency medical services arrived on scene and the resident was transported to the emergency department 3 minutes later.</p> <p>R1's record of death indicated R1 died from complications of a subdural and subarachnoid hemorrhage as a result of a fall while ambulating at the facility resulting in a head strike.</p> <p>On December 5, 2024, at 12:03 p.m. during and entrance conference executive director (ED)-C, and Registered Nurse Director of Health Services</p>	01650		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29189	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/05/2024
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NAME OF PROVIDER OR SUPPLIER THE LEGACY OF DELANO	STREET ADDRESS, CITY, STATE, ZIP CODE 1350 ST. PETER AVENUE EAST DELANO, MN 55328
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01650	<p>Continued From page 19</p> <p>(RNDOH)-B stated R1 had 4 falls since admission but indicated R1 was not at a risk for falls, and denied R1 was unsteady, or had balance issues despite those concerns identified repeatedly in the R1's fall incident reports since admission. ED-C and RNDOH-B stated R1's plan of care was followed, nothing could have prevented the incident, and indicated the incident was an accident.</p> <p>On December 5, 2024, at 2:30 p.m. ULP-H stated R1 was confused and unsteady with ambulation. ULP-H indicated although R1's plan of care indicated R1 was independent and could walk alone and toilet herself, R1 seemed weak, unsteady, and needed assistance with toileting and to get to/from meals. ULP-H indicated she assisted R1 when she worked and reported her concern with R1 being unsteady and needing assistance to nursing.</p> <p>On December 5, 2024, at 1:28 p.m. ULP-D stated R1's plan of care indicated R1 could ambulate independently.</p> <p>On December 5, 2024, at 1:54 p.m. ULP- E stated she provided SBA to R1 with toileting and ambulation, but indicated R1 could do it herself but she needed supervision.</p> <p>On December 5, 2024, at 2:10 p.m. ULP-F stated R1 normally walked independently, and indicated she was unaware R1 had recurring falls and required SBA escort assistance when ambulating. ULP-F stated R1 usually independent with toileting and indicated she usually tried to walk with R1 but denied it was because she was unsteady.</p> <p>On December 5, 2024, at 2:20 p.m. ULP-G stated</p>	01650		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29189	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/05/2024
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01650	<p>Continued From page 20</p> <p>she was unaware R1 was a risk for falls and indicated R1 was independent and she had not provided assistance to R1 other than staying with her when she walked.</p> <p>On December 5, 2024, at 2:39 p.m. licensed practical nurse (LPN)-I stated R1 had no fall interventions in place other than stand by assistance (SBA) with showers, dressing, and ambulation. LPN-I denied being aware R1 had any concerns with weakness, dizziness, or unsteadiness with ambulation. LPN-I stated if a fall occurred interventions identified to help prevent recurring falls should be implemented on the resident's services and communicated to staff during shift to shift report.</p> <p>On December 10, 2024, at 3:46 p.m. ULP-K stated R1 was unsteady with ambulation and needed assistance due to incontinence issues. ULP-K stated R1 had episodes of incontinence and she assisted her because she felt like R1 needed help. ULP-K indicated incontinence was not uncommon for R1, and indicated R1 needed assistance with toileting, but did not recall toileting services for R1's assigned tasks. ULP-K indicated the day before the fall with head strike, R1 fell while trying to get to the bathroom alone after breakfast and was incontinent of stool. ULP-K stated the day R1 fell she was the only staff assigned to the unit and another ULP staff (unknown) from the assisted living side had come over to relieve her for a break. ULP-K stated when she returned to the unit R1 was on the floor. ULP-K indicated she was not involved in a post fall huddle and did not know if any fall interventions were added after the fall occurred. ULP-K stated it was not unusual to be short staffed on the memory care unit, but she did not know if staffing concerns contributed to R1's fall</p>	01650		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29189	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/05/2024
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01650	<p>Continued From page 21</p> <p>that day.</p> <p>On December 12, 2024, at 1:49 p.m. ULP-A stated the day R1 fell and sustained a head strike she was the only staff scheduled to work and indicated there was supposed to be 2. The ULP indicated that was not unusual to be sort staffed and indicated she did not know if staffing concerns contributed to R1's fall that day but another pair of eyes was helpful. ULP-A stated R1 was confused and needed help with dressing, and going to the bathroom. ULP-A stated R1 could do some on her own but needed staff to provide prompts and physical assistance at times, and indicated R1's service task list indicated staff should provide assistance to R1. ULP-A stated R1 was unsteady with ambulation and indicated the day of the incident R1 seemed foggy and off. ULP-A stated she assisted R1 to a chair in the common area after breakfast and went back to help the other residents when she heard a loud crash and saw someone running then pound on the nurses office door for help.</p> <p>On December 15, 2024, at 9:30 a.m. registered nurse (RN)-J stated R1's initial assessment which indicated she required assistance was not implemented because R1 was able to do more. RN-J verified no reassessment was completed until 14 days later, and indicated the assessment and service plan should match. RN-J stated due to short staffing she was not always able to complete assessments timely. RN-J indicated no fall interventions identified on the incident reports were implemented because it could have changed the cost of services for R1's family.</p> <p>On December 10, 2024, at 4:56 p.m. email communication ED-C indicated R1's admission PT/OT order was never processed due to a fax</p>	01650		

Minnesota Department of Health

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01650	<p>Continued From page 22</p> <p>malfunction. ED-C indicated staffing was provided based on acuity of care.</p> <p>On December 10, 2024, at 9:48 a.m. R1's family member indicated they had communicated on admission to RNDOH-B that R1 had a history of falls at the previous facility prior to admission and indicated R1 needed assistance with toileting, dressing, and mobility including transfers and ambulation due to a physical and cognitive decline following a recent hospitalization and surgical procedure. The family member indicated R1 continued to decline after admission to the facility and assumed the facility was providing the services and assistance the R1 needed to keep her safe including frequent safety checks, cameras in R1's room to detect falls, and ordered PT/OT services.</p> <p>The facility provided a guideline for comprehensive assessment schedule revised on August 2022, indicated the RN/Director of Housing Services would complete a initial individualized assessment prior to admission and initiation of services. The guideline indicated a re-assessment would be completed with in 14 days after initiated services, and as indicated for a change in condition. The table titled assessment guide under change in condition indicated a post fall review would be completed after every fall.</p> <p>The facility policy and procedure titled fall risk and prevention revised May 2024, indicated on admission a review of records from the referring institution and family interview would determine history of falls, and fall risk factors, and indicated the plan of care should incorporate fall prevention measures based on information gathered. The post fall procedure indicated the provider and</p>	01650		

Minnesota Department of Health

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01650	Continued From page 23 appropriate notifications would be made, and suggested interventions to manage falls would be implemented and the resident's plan of care and scheduled services would be updated and revised with changes as indicated. No further information was provided. TIME PERIOD FOR CORRECTION: seven (7) days.	01650		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and	01940		

Minnesota Department of Health

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01940	<p>Continued From page 24</p> <p>monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes.</p> <p>This MN Requirement is not met as evidenced by: Based on record review and interview the licensee failed to implement ordered therapy services timely for one of one resident's (R1) reviewed for falls.</p> <p>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 a limited number of staff are involved, or the situation has occurred only occasionally).</p> <p>Findings include:</p> <p>R1 was admitted to the licensee memory care unit on October 14, 2024, with diagnoses including atrial fibrillation, congestive heart failure, coronary artery disease, type 2 diabetes mellitus, and stroke.</p> <p>R1's admission orders included orders for physical therapy (PT) and occupational therapy (OT). However, R1's record failed to indicate the orders were implemented until 19 days after admission, and after the resident had fallen 3 times. A review of R1's progress notes and facility communication failed to indicate why the orders were not implemented timely.</p>	01940		

Minnesota Department of Health

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01940	<p>Continued From page 25</p> <p>On October 15, 2024, at 11:35 a.m. a fall incident report (the day after the resident was admitted to the facility) indicated R1 had an unwitnessed fall in her room about 1 hour after staff documented in a progress note R1 had an episode of explosive diarrhea. The incident report identified R1 had impaired balance, and impaired vision. The incident report identified R1 was not wearing her glasses, had no shoes on, and her walker was out of reach at the time the fall occurred. The incident report indicated R1's service plan and services were reviewed with scheduled services for safety checks, and indicated R1 was independent with transfers using her walker which did not align with R1's assessed needs at the time the incident occurred. The incident report indicated interventions to reduce recurring falls were to continue safety checks, ensure items were within reach, proper footwear was donned, and ensure R1 was wearing her glasses. The facility failed to identify R1's services at the time the fall occurred failed to include assistance with transfers, toileting, ambulation, and dressing/grooming as assessed. R1's record failed to indicate safety checks were ever implemented or provided and failed to indicate PT/OT services were implemented as ordered at the time the fall occurred.</p> <p>On October 17, 2024, at 1:50 a.m. another fall incident report 2 days later identified R1 was cognitively impaired, had a balance disorder, impaired mobility, unsteady gait, and poor safety judgement. The incident report failed to identify R1 had previously fallen, and indicated there was no history of falls. The incident report indicated R1 was walking back from the bathroom unassisted with no shoes on and tripped on a blanket and fell. The report indicated R1 was found during safety checks. The incident report</p>	01940		

Minnesota Department of Health

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01940	<p>Continued From page 26</p> <p>indicated staff were educated to tuck blankets in and family provided a nonslip rug for the floor. The incident report interventions to reduce recurring falls indicated they would continue PT/OT, and ensure R1 was wearing her glasses. The facility failed to identify R1's services at the time the fall occurred failed to include assistance with transfers, toileting, ambulation, dressing and grooming as assessed. R1's record failed to indicate safety checks were ever implemented or provided and failed to indicate PT/OT services were implemented as indicated and ordered at the time the fall occurred.</p> <p>On November 4, 2024, at 11:00 a.m. a fall incident report 18 days later, indicated R1 had another unwitnessed fall while ambulating independently in the common area when she went to her room unassisted after breakfast, lost her balance, and fell. R1's plan of care to provide escort SBA was not followed at the time the fall occurred. The incident report identified contributing factors in the R1's fall included generalized weakness, confusion, decline in status, neuropathy, history of falls, and need to use the bathroom (with bowel/bladder incontinence at the time the fall) but failed to identify R1's plan of care was not followed at the time the fall occurred. R1's vital signs at the time of the fall indicated R1's blood pressure was 87/73 (abnormally low, which could increase dizziness and risk for falls). There was no indication R1's fall or low blood pressure were reported to the provider. The incident report interventions to reduce recurring falls indicated the facility would offer toileting, and a PT/OT evaluation. There was no indication the facility implemented R1's admission orders for PT/OT services prior to this fall incident. The incident report indicated safety checks were performed by</p>	01940		

Minnesota Department of Health

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01940	<p>Continued From page 27</p> <p>staff, however there was no indication safety checks were provided according to R1's services provided. Although the facility identified R1 needed assistance with toileting, and indicated toileting services would be offered, there was no indication assistance with toileting was ever added to R1's services for staff to implement.</p> <p>On November 5, 2024, at 9:56 a.m. a fall incident report the following day indicated R1 was observed ambulating independently in the common area, lost her balance, and fell over backwards onto the ground striking the back of her head. R1's plan of care to provide escort SBA was not followed at the time the fall occurred. The incident report identified contributing factors included fall history, cognitive impairment, generalized weakness, bowel/bladder incontinence, needing to use the bathroom, and indicated R1 was incontinent of stool at the time the incident occurred. The incident report indicated R1 was unresponsive after sustaining the head strike, 911 was called and R1 was transferred to the ED via ambulance. There was no indication toileting assistance was provided as indicated for falls prevention noted on the fall incident report the previous day.</p> <p>On November 5, 2024, at 11:35 a.m. a progress notes after the fall with head strike occurred indicated R1 was observed walking independently, stopped, then fell over backwards striking the back of her head. R1 had pale pallor, was not responsive or able to follow commands, and had a fixed blank stare, and was transferred to the hospital. At 3:22 p.m. a progress note indicated the resident was diagnosed with a brain bleed and was intubated, but the breathing tube was removed and comfort care and pain management was provided.</p>	01940		

Minnesota Department of Health

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01940	<p>Continued From page 28</p> <p>On November 6, 2024, at 2:02 p.m. a progress note indicated R1 died on November 5, 2024 around 9:45 p.m.</p> <p>A undated facility adverse event investigation document indicated R1 had a witnessed fall walking independently in the common area utilizing her 4 wheeled walker appropriately, took 3-4 steps and lost her balance resulting in a fall and head strike. Staff called 911, R1 was noted to be in and out of consciousness, unable to respond to questions, and moaning in pain. The facility investigation failed to identify any concerns and indicated services were reviewed and R1's plan of care was followed at the time the incident occurred.</p> <p>A review of facility provided video surveillance for the fall with head strike on November 5, 2024, at 9:03 a.m. showed unlicensed personnel (ULP)-A escort R1 to a chair in the common area after breakfast. ULP-A told R1 she would check on her. R1 appeared to be sleeping as numerous staff (unknown) were observed walk through the common area but did not interact with R1. At 9:45 a.m. R1 appeared to wake up and was observed moving in the chair (sitting forward then back) then appeared to be trying the rest again. At 9:57 a.m. R1 was observed lean forward and scoot to the edge of the chair as staff walked by R1. Then, R1 placed her hands on her knees and stood up using her walker, and walked toward her room unassisted by staff. R1 suddenly stopped, then took a few more steps and appeared to wobble, then fell backwards to the floor striking her head. Staff immediately responded and called 911. At 10:13 a.m. emergency medical services arrived on scene and the resident was transported to the ED 3 minutes later.</p>	01940		

Minnesota Department of Health

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01940	<p>Continued From page 29</p> <p>R1's record of death indicated R1 died from complications of a subdural and subarachnoid hemorrhage as a result of a fall while ambulating at the facility resulting in a head strike.</p> <p>On December 10, 2024, at 4:56 p.m. email communication with Executive Director (ED)-C indicated R1's admission PT/OT order was never processed due to a fax malfunction.</p> <p>A undated facility provided policy and procedure titled "Order Processing Tool - Guidance for Completion" included guidelines to process referrals for PT/OT services. The order processing tool was used by the nurse to updated the electronic health record and ensure new orders and services were implemented. Step 2 indicated the nurse would update the 24 hour report sheet and list the new order with detailed new order note entered into Eldermark, and indicated the note should include steps taken by the nurse to implement the order and update the residents service plan as needed.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days.</p>	01940		
02310 SS=G	<p>144G.91 Subd. 4 (a) Appropriate care and services</p> <p>(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.</p>	02310		

Minnesota Department of Health

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02310	<p>Continued From page 30</p> <p>This MN Requirement is not met as evidenced by: Based on record review and interview the licensee failed to provide appropriate care and service according to an up to date service plan, and accepted health care standard for one of one resident (R1). R1 was harmed when she was admitted with orders for OT/PT, and assessed to require assistance on admission from 1 staff with mobility, transfers, ambulation, and toileting using a wheel chair and walker. However, the assessed needs were never added to R1's services for staff to implement, and OT/PT orders were not initiated timely. R1 had recurring falls while ambulating independently, and the licensee failed to implement identified interventions to help prevent recurring falls. Then, R1 fell again while ambulating alone, sustained a head strike, and died as a result of her injury.</p> <p>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).</p> <p>Findings include:</p> <p>R1 was admitted to the licensee memory care unit on October 14, 2024, with diagnoses including atrial fibrillation, congestive heart failure, coronary artery disease, type 2 diabetes mellitus, and stroke.</p> <p>R1's admission assessment dated October 10, 2024, and completed/signed on November 7,</p>	02310		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29189	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/05/2024
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NAME OF PROVIDER OR SUPPLIER THE LEGACY OF DELANO	STREET ADDRESS, CITY, STATE, ZIP CODE 1350 ST. PETER AVENUE EAST DELANO, MN 55328
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02310	<p>Continued From page 31</p> <p>2024, after R1 died, indicated R1 was severely cognitively impaired and required staff assistance with dressing and grooming twice daily. The assessment indicated R1 was incontinent of bowel and bladder and needed 1 assist with transfers, ambulation, and toileting using a wheelchair and 4 wheeled walker for mobility. The assessment indicated R1 needed staff assistance to get to and from meals and activities.</p> <p>R1 service plan signed and dated October 22, 2024, included medication administration and management services, escort assistance, and meal set up but failed to include details and instructions for assessed assistance needed for staff to implement.</p> <p>R1 assessment dated October 28, 2024, (14 days after admission), signed/completed on November 7, 2024, after R1 died, indicated R1 had 1-2 falls since admission related to balance problems, but was ambulatory and continent of bowel and bladder. The assessment indicated R1 was independent with ambulation dressing, transfers, toileting, and personal hygiene but required stand by assistance (SBA) with ambulation and indicated staff would escort R1 to and from activities and meals using her walker. The assessment did not align with the initial assessment.</p> <p>R1's medication administration record (MAR) included Aspirin 81 mg, daily and Coumadin (an anticoagulant medication) which can increase the risk for bleeding. The MAR also included several medications that could cause hypotension, dizziness, orthostatic hypotension, abdominal pain, dizziness, and diarrhea which could increase R1's risk for falls.</p>	02310		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29189	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/05/2024
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02310	<p>Continued From page 32</p> <p>R1's service plan and service delivery of care record from the time of admission indicated R1 was independent and received escort mobility assistance using a 4 wheeled walker to and from all destinations and meals scheduled 3 times daily. The service plan failed to include any assistance with transfers, ambulation, toileting, dressing, or grooming as assessed on admission and prior to the resident's 14-day assessment.</p> <p>R1's admission orders included orders for physical therapy (PT) and occupational therapy (OT). However, R1's record failed to indicate the orders were implemented until 19 days after admission, and after the resident had fallen 3 times. A review of R1's progress notes and facility communication failed to indicate why the orders were not implemented timely.</p> <p>On October 15, 2024, at 11:35 a.m. a fall incident report (the day after the resident was admitted to the facility) indicated R1 had an unwitnessed fall in her room about 1 hour after staff documented in a progress note R1 had an episode of explosive diarrhea. The incident report identified R1 had impaired balance, and impaired vision. The incident report identified R1 was not wearing her glasses, had no shoes on, and her walker was out of reach at the time the fall occurred. The incident report indicated R1's service plan and services were reviewed with scheduled services for safety checks, and indicated R1 was independent with transfers using her walker which did not align with R1's assessed needs at the time the incident occurred. The incident report indicated interventions to reduce recurring falls were to continue safety checks, ensure items were within reach, proper footwear was donned, and ensure R1 was wearing her glasses. The facility failed to identify R1's services at the time</p>	02310		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29189	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/05/2024
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02310	<p>Continued From page 33</p> <p>the fall occurred failed to include assistance with transfers, toileting, ambulation, and dressing/grooming as assessed. R1's record failed to indicate safety checks were ever implemented or provided and failed to indicate PT/OT services were implemented as ordered at the time the fall occurred.</p> <p>On October 17, 2024, at 1:50 a.m. another fall incident report 2 days later identified R1 was cognitively impaired, had a balance disorder, impaired mobility, unsteady gait, and poor safety judgement. The incident report failed to identify R1 had previously fallen, and indicated there was no history of falls. The incident report indicated R1 was walking back from the bathroom unassisted with no shoes on and tripped on a blanket and fell. The report indicated R1 was found during safety checks. The incident report indicated staff were educated to tuck blankets in and family provided a nonslip rug for the floor. The incident report interventions to reduce recurring falls indicated they would continue PT/OT, and ensure R1 was wearing her glasses. The facility failed to identify R1's services at the time the fall occurred failed to include assistance with transfers, toileting, ambulation, dressing and grooming as assessed. R1's record failed to indicate safety checks were ever implemented or provided and failed to indicate PT/OT services were implemented as indicated and ordered at the time the fall occurred.</p> <p>On November 4, 2024, at 11:00 a.m. a fall incident report 18 days later, indicated R1 had another unwitnessed fall while ambulating independently in the common area when she went to her room unassisted after breakfast, lost her balance, and fell. R1's plan of care to provide escort SBA was not followed at the time the fall</p>	02310		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29189	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/05/2024
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02310	<p>Continued From page 34</p> <p>occurred. The incident report identified contributing factors in the R1's fall included generalized weakness, confusion, decline in status, neuropathy, history of falls, and need to use the bathroom (with bowel/bladder incontinence at the time the fall) but failed to identify R1's plan of care was not followed at the time the fall occurred. R1's vital signs at the time of the fall indicated R1's blood pressure was 87/73 (abnormally low, which could increase dizziness and risk for falls). There was no indication R1's fall or low blood pressure were reported to the provider. The incident report interventions to reduce recurring falls indicated the facility would offer toileting, and a PT/OT evaluation. There was no indication the facility implemented R1's admission orders for PT/OT services prior to this fall incident. The incident report indicated safety checks were performed by staff, however there was no indication safety checks were provided according to R1's services provided. Although the facility identified R1 needed assistance with toileting, and indicated toileting services would be offered, there was no indication assistance with toileting was ever added to R1's services for staff to implement.</p> <p>On November 5, 2024, at 9:56 a.m. a fall incident report the following day indicated R1 was observed ambulating independently in the common area, lost her balance, and fell over backwards onto the ground striking the back of her head. R1's plan of care to provide escort SBA was not followed at the time the fall occurred. The incident report identified contributing factors included fall history, cognitive impairment, generalized weakness, bowel/bladder incontinence, needing to use the bathroom, and indicated R1 was incontinent of stool at the time the incident occurred. The incident report</p>	02310		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29189	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/05/2024
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02310	<p>Continued From page 35</p> <p>indicated R1 was unresponsive after sustaining the head strike, 911 was called and R1 was transferred to the ED via ambulance. There was no indication toileting assistance was provided as indicated for falls prevention noted on the fall incident report the previous day.</p> <p>On November 5, 2024, at 11:35 a.m. a progress notes after the fall with head strike occurred indicated R1 was observed walking independently, stopped, then fell over backwards striking the back of her head. R1 had pale pallor, was not responsive or able to follow commands, and had a fixed blank stare, and was transferred to the hospital. At 3:22 p.m. a progress note indicated the resident was diagnosed with a brain bleed and was intubated, but the breathing tube was removed and comfort care and pain management was provided.</p> <p>On November 6, 2024, at 2:02 p.m. a progress note indicated R1 died on November 5, 2024 around 9:45 p.m.</p> <p>A undated facility adverse event investigation document indicated R1 had a witnessed fall walking independently in the common area utilizing her 4 wheeled walker appropriately, took 3-4 steps and lost her balance resulting in a fall and head strike. Staff called 911, R1 was noted to be in and out of consciousness, unable to respond to questions, and moaning in pain. The facility investigation failed to identify any concerns and indicated services were reviewed and R1's plan of care was followed at the time the incident occurred.</p> <p>A review of facility provided video surveillance for the fall with head strike on November 5, 2024, at 9:03 a.m. showed unlicensed personnel (ULP)-A</p>	02310		
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Minnesota Department of Health

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02310	<p>Continued From page 36</p> <p>escort R1 to a chair in the common area after breakfast. ULP-A told R1 she would check on her. R1 appeared to be sleeping as numerous staff (unknown) were observed walk through the common area but did not interact with R1. At 9:45 a.m. R1 appeared to wake up and was observed moving in the chair (sitting forward then back) then appeared to be trying the rest again. At 9:57 a.m. R1 was observed lean forward and scoot to the edge of the chair as staff walked by R1. Then, R1 placed her hands on her knees and stood up using her walker, and walked toward her room unassisted by staff. R1 suddenly stopped, then took a few more steps and appeared to wobble, then fell backwards to the floor striking her head. Staff immediately responded and called 911. At 10:13 a.m. emergency medical services arrived on scene and the resident was transported to the ED 3 minutes later.</p> <p>R1's record of death indicated R1 died from complications of a subdural and subarachnoid hemorrhage as a result of a fall while ambulating at the facility resulting in a head strike.</p> <p>On December 5, 2024, at 12:03 p.m. during and entrance conference executive director (ED)-C, and Registered Nurse Director of Health Services (RNDOH)-B stated R1 had 4 falls since admission but indicated R1 was not at a risk for falls, and denied R1 was unsteady, or had balance issues despite those concerns identified repeatedly in the R1's fall incident reports since admission. ED-C and RNDOH-B stated R1's plan of care was followed, nothing could have prevented the incident, and indicated the incident was an accident.</p> <p>On December 5, 2024, at 2:30 p.m. ULP-H stated R1 was confused and unsteady with ambulation.</p>	02310		

Minnesota Department of Health

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02310	<p>Continued From page 37</p> <p>ULP-H indicated although R1's plan of care indicated R1 was independent and could walk alone and toilet herself, R1 seemed weak, unsteady, and needed assistance with toileting and to get to/from meals. ULP-H indicated she assisted R1 when she worked and reported her concern with R1 being unsteady and needing assistance to nursing.</p> <p>On December 5, 2024, at 1:28 p.m. ULP-D stated R1 plan of care indicated R1 could ambulate independently.</p> <p>On December 5, 2024, at 1:54 p.m. ULP- E stated she provided SBA to R1 with toileting and ambulation, but indicated R1 could do it herself but she needed supervision.</p> <p>On December 5, 2024, at 2:10 p.m. ULP-F stated R1 normally walked independently, and indicated she was unaware R1 had recurring falls and required SBA escort assistance when ambulating. ULP-F stated R1 usually independent with toileting and indicated she usually tried to walk with R1 but denied it was because she was unsteady.</p> <p>On December 5, 2024, at 2:20 p.m. ULP-G stated she was unaware R1 was a risk for falls and indicated R1 was independent and she had not provided assistance to R1 other than staying with her when she walked.</p> <p>On December 5, 2024, at 2:39 p.m. licensed practical nurse (LPN)-I stated R1 had no fall interventions in place other than stand by assistance (SBA) with showers, dressing, and ambulation. LPN-I denied being aware R1 had any concerns with weakness, dizziness, or unsteadiness with ambulation. LPN-I stated if a</p>	02310		

Minnesota Department of Health

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02310	<p>Continued From page 38</p> <p>fall occurred interventions identified to help prevent recurring falls should be implemented on the resident's services and communicated to staff during shift to shift report.</p> <p>On December 10, 2024, at 3:46 p.m. ULP-K stated R1 was unsteady with ambulation and needed assistance due to incontinence issues. ULP-K stated R1 had episodes of incontinence and she assisted her because she felt like R1 needed help. ULP-K indicated incontinence was not uncommon for R1, and indicated R1 needed assistance with toileting, but did not recall toileting services for R1's assigned tasks. ULP-K indicated the day before the fall with head strike, R1 fell while trying to get to the bathroom alone after breakfast and was incontinent of stool. ULP-K stated the day R1 fell she was the only staff assigned to the unit and another ULP staff (unknown) from the assisted living side had come over to relieve her for a break. ULP-K stated when she returned to the unit R1 was on the floor. ULP-K indicated she was not involved in a post fall huddle and did not know if any fall interventions were added after the fall occurred. ULP-K stated it was not unusual to be short staffed on the memory care unit, but she did not know if staffing concerns contributed to R1's fall that day.</p> <p>On December 12, 2024, at 1:49 p.m. ULP-A stated the day R1 fell and sustained a head strike she was the only staff scheduled to work and indicated there was supposed to be 2. The ULP indicated that was not unusual to be sort staffed and indicated she did not know if staffing concerns contributed to R1's fall that day but another pair of eyes was helpful. ULP-A stated R1 was confused and needed help with dressing, and going to the bathroom. ULP-A stated R1</p>	02310		

Minnesota Department of Health

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02310	<p>Continued From page 39</p> <p>could do some on her own but staff provided prompts and physical assistance at times, and indicated R1's service task list indicated staff should provide assistance to R1. ULP-A stated R1 was unsteady with ambulation and indicated the day of the incident R1 seemed foggy and off. ULP-A stated she assisted R1 to a chair in the common area after breakfast and went back to help the other residents when she heard a loud crash and saw someone running then pounded on the nurses office door for help.</p> <p>On December 15, 2024, at 9:30 a.m. registered nurse (RN)-J stated R1's initial assessment which indicated she required assistance was not implemented because R1 was able to do more. RN-J verified no reassessment was completed until 14 days later, and indicated the assessment and service plan should match. RN-J stated due to short staffing she was not always able to complete assessments timely. RN-J indicated no fall interventions identified on the incident reports were implemented because it could have changed the cost of services for R1's family.</p> <p>On December 10, 2024, at 9:48 a.m. R1's family member indicated they had communicated on admission to RNDOH-B that R1 had a history of falls at the previous facility prior to admission and indicated R1 needed assistance with toileting, dressing, and mobility including transfers and ambulation due to a physical and cognitive decline following a recent hospitalization and surgical procedure. The family member indicated R1 continued to decline after admission to the facility and assumed the facility was providing the services and assistance the R1 needed to keep her safe including frequent safety checks, cameras in R1's room to detect falls, and ordered PT/OT services.</p>	02310		

Minnesota Department of Health

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02310	<p>Continued From page 40</p> <p>On December 10, 2024, at 4:56 p.m. email communication ED-C indicated R1's admission PT/OT order was never processed due to a fax malfunction. ED-C indicated staffing was provided based on acuity of care.</p> <p>A review of the facility contingency staffing plan dated September 2024, failed to indicate the staffing plan was based on resident acuity as indicated by ED-C. The staffing plan included a staffing table for minimum number of staffing required for to maintain critical functions during normal conditions for each shift. According to the staffing plan provided and staff schedule at the time the last 2 fall incidents occurred, the licensee had inadequate staffing in place at the time the incidents occurred.</p> <p>The facility provided a guideline for comprehensive assessment schedule revised on August 2022, indicated the RN/Director of Housing Services would complete a initial individualized assessment prior to admission and initiation of services. The guideline indicated a re-assessment would be completed with in 14 days after initiated services, and as indicated for a change in condition. The table titled assessment guide under change in condition indicated a post fall review would be completed after every fall. The table titled paperwork, preparing services & chart indicated a signed service agreement was required on the day of admission, would be finalized with in 14 days, and and changes to the service agreement required a new signed agreement.</p> <p>The facility policy and procedure titled fall risk and prevention revised May 2024, indicated on admission a review of records from the referring</p>	02310		

Minnesota Department of Health

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02310	<p>Continued From page 41</p> <p>institution and family interview would determine history of falls, and fall risk factors, and indicated the plan of care should incorporate fall prevention measures based on information gathered. The post fall procedure indicated the provider and appropriate notifications would be made, and suggested interventions to manage falls would be implemented and the resident's plan of care and scheduled services would be updated and revised with changes as indicated.</p> <p>A policy and procedure for staffing assessment/plan was repeatedly requested, none was provided.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days.</p>	02310		
02360	<p>144G.91 Subd. 8 Freedom from maltreatment</p> <p>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.</p> <p>This MN Requirement is not met as evidenced by: Based on interviews and document review, the licensee failed to ensure one of one residents (R1) reviewed was free from maltreatment. R1 was neglected.</p> <p>Findings include:</p> <p>The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the</p>	02360		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29189	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/05/2024
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02360	<p>Continued From page 42</p> <p>maltreatment, in connection with incidents which occurred at the facility.</p> <p>Please refer to the public maltreatment report for details.</p> <p>No plan of correction is required for tag 2360.</p>	02360		