Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL304906326M
Compliance #: HL304909561C

Date Concluded: February 24, 2025

Name, Address, and County of Licensee Investigated:
Millstream Commons
210 West 8th Street
Northfield, MN 55057
Rice County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Michele Larson, RN
Special Investigator

Finding: Substantiated, individual 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):
Facility staff neglected the resident when they failed to perform a 2:00 a.m. safety check according to the resident's plan of care. The resident was found on his bedroom floor the next morning by his caregiver. After complaining of back pain for hours, the resident's family transported him to the hospital where he was diagnosed with five fractured ribs.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. Alleged perpetrator (AP#1), and AP#2 were responsible for the maltreatment. Although AP#1 (unlicensed personnel) told the previous shift unlicensed personnel she would complete the resident's evening personal cares, AP #1 failed to assist the resident according to his care plan needs. In addition, AP#2 a facility licensed staff, failed to monitor and assess the resident after he received injuries to his back and left elbow after his fall. The resident complained of back pain the entire day into the evening until family arranged for the resident to be evaluated at a hospital. The resident was diagnosed with five rib fractures and admitted to the hospital.

The investigator conducted interviews with facility staff members, including facility leadership, nursing staff, and unlicensed staff. The investigator contacted the resident's family members. The investigation included review of the resident's facility record, hospital record, facility internal investigation, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed staff and resident interactions during the onsite investigation.

The resident resided in an assisted living facility. The resident's diagnoses included dementia and abnormalities of gait and mobility. The resident's service plan included assistance with personal cares, medication management and administration. In addition, at 2:00 a.m., staff were to enter the resident's bedroom and ensure the resident's dirty clothes and underwear were placed in appropriate containers and lay out clean clothes and underwear for the morning. The resident's assessment indicated the resident experienced syncope (dizziness), had cognitive impairment, was able to make his needs known, was hard of hearing, and wore hearing aids in both ears. The resident used a four-wheeled walker for mobility. Staff were to monitor and ensure the resident's safety. The resident had a history of falls and staff were to promptly report any falls to a nurse.

The resident's incident report completed by AP#2, indicated at 7:47 a.m., the resident's personal caregiver found the resident lying on the floor sleeping with a blanket covering his body. The resident had a laceration (cut) and abrasion (scrape) to his left elbow and an abrasion to the left side of his mid-back region. The resident's left elbow was open and bleeding. The resident was assisted to his knees to a standing position then transferred to bed. The resident complained of back pain. AP#2 documented, "The resident did not have pendant with him when he fell. Discussed with family increased safety checks and bracelet pendant."

The resident's record lacked documentation AP#2 assessed the resident after his complaints of back pain.

The ambulance report indicated twelve hours after the resident's fall, emergency medical services (EMS) was dispatched to the facility per request of the resident's family. The resident's chief complaint was "My back hurts." Throughout the day, after the resident's fall, the resident's family member noticed a decline in the resident's mental status, and observed the resident was not eating or responding normally. The resident was brought to a hospital for an evaluation.

The resident's hospital record indicated the resident arrived at the hospital for evaluation of altered mental status and weakness. The resident complained of pain in his ribs and elbow. Intravenous (IV) pain medication, anti-nausea, and fluids were administered. The resident's family member reported after the resident fell, he became weaker throughout the day, refusing to eat, drink, and showed signs of increased confusion. The resident's family member was unsure how long he laid on his floor. Computed tomography (CT) scan showed resident sustained five rib fractures (5th, 6th, 7th) on the front and two rib fractures (11th, 12th) on the

back. The resident was admitted to the hospital and four days later discharged to a rehabilitation facility for a higher level of care.

Review of an email from facility leadership to the resident's family member dated one day after the resident's fall, indicated leadership reviewed recorded camera footage from the facility lobby and outside the resident's apartment and noted the following: At 7:00 p.m. on the evening before the resident was found on the floor, the resident was seated in lobby chair. At 8:04 p.m. the resident used the lobby restroom until 8:15 p.m. Between 8:31 p.m. and 8:45 p.m., the resident rummaged through a lobby desk drawer. At 8:51 p.m. the resident took the elevator up to his floor. At 8:54 p.m., the resident entered his apartment, and at 8:07 a.m. the following morning, the resident's personal caregiver entered the resident's apartment followed by staff at 8:10 a.m. Leadership confirmed no staff entered the resident's apartment between 8:54 p.m. and 8:07 a.m. The email indicated AP#1 walked past the resident's apartment at 11:54 p.m., 2:44 a.m., and 4:16 a.m. but did not enter the resident's apartment.

Review of the facility' investigation indicated the facility was unsure how long the resident laid on the floor. Evening unlicensed personnel reported to AP#1 at 10:00 p.m. shift change the resident was still awake. During an internal investigation interview, the evening unlicensed personnel stated she made multiple attempts to get the resident to comply with evening cares, stating she laid out the resident's clean clothes and care supplies but stated the resident was up and down facility stairs multiple times and was unable to comply with his evening cares. The evening unlicensed personnel stated at shift change, she asked AP#1 to return to the resident's apartment for a night check and finish up with his evening cares she was unable to complete. The evening unlicensed personnel indicated she last saw the resident at 9:00 p.m. in the lobby. The recorded camera footage confirmed AP#1 did not complete the resident's 2:00 a.m. scheduled service even though AP#1 documented the service was completed.

During an interview, the resident's personal caregiver stated at 7:45 a.m. she arrived at the facility to get the resident ready for the day. The personal caregiver stated she heard "moaning and groaning" coming from the resident's bedroom. The personal caregiver stated she found the resident lying naked on his bedroom floor with a bedspread pulled over him. The personal caregiver stated she observed the resident's bed was still made stating, "I said something like it doesn't look like he was in bed." The personal caregiver stated she saw blood on his bedspread, blood on the floor, and noticed the resident's arm was bleeding. The personal caregiver stated staff had difficulty getting the resident off the floor, stating it took 15 minutes to get the resident off the floor using a mechanical lift due to the resident's complaints of pain, stating the resident wanted to lie down because his back hurt. The caregiver stated the resident continued to moan and groan whenever staff tried to reposition him, stating the resident cried "Oh, my back hurts!" The caregiver stated she left the facility around 3:00 p.m. to purchase unfrozen gel ice packs for staff to apply to the resident's back since the facility did not have icepacks.

During an interview, the evening shift unlicensed personnel stated another unlicensed personnel scheduled the evening shift called off, stating she was the only staff who worked the

evening shift and was responsible for providing services for 25 residents that night stating the shift was extremely busy. The evening unlicensed personnel stated she administered the resident's medications around 7:00 p.m. in the resident's apartment then set up the resident's nightly routine but was unable to provide his cares even after multiple attempts to try and get the resident upstairs and ready for bed but was unable to persuade the resident. During shift change at 10:00 p.m. she told AP#1 she did not perform the resident's 9:00 p.m. services and asked AP#1 if she could complete the resident's cares she was unable to do stating AP#1 agreed she would complete the tasks. The evening unlicensed personnel stated she fully expected AP#1 to perform the tasks because AP#1 said she would.

During an interview, AP#1 stated she normally worked the overnight shift stating most of the residents slept during her shift. AP#1 stated, "All in all it is pretty laid back. I am not overworked by any means." AP#1 insisted the resident's 2:00 a.m. scheduled service was not a safety check but only a service to pick his dirty clothes off the floor and put them in his hamper located in his bedroom. AP#1 stated she did not perform the resident's 2:00 a.m. service even though she initially told AP#2 she completed the scheduled service but then changed her story stating she "accidentally" confirmed she performed the resident's 2:00 a.m. service instead of canceling it.

When interviewed, AP#2 stated she took the resident's vital signs after he fell but was unable to complete a full assessment because the resident wanted to lie down and sleep. AP#2 stated after the resident woke up, she "assessed" the resident by taking his vital signs. AP#2 had no explanation why there was no documentation she completed assessments and vital signs. In addition, AP#2 stated she periodically checked the resident's oxygen saturation levels throughout the day because she was "worried about his ribs." AP#2 stated, "when an individual had that kind of pain and had a fall like that; I was concerned about rib fractures." AP#2 stated she asked a family member to come to the facility to make the decision to have the resident evaluated at a hospital.

When interviewed, the resident's family member stated one morning they received a call from the resident's personal caregiver stating the resident fell, was not doing well and complained of pain. The family member stated the caregiver observed the resident's bed was still made and not slept in. The family member stated that afternoon, at 4:45 p.m. they got an "icky feeling" after talking to an unlicensed staff member who stated the resident was "doing great," and ate all of his supper. Early evening when family had not heard an update on the resident, the family member went to the facility. The family member stated when they entered the resident's room, he was up against his recliner which was positioned in a nearly standing position. The resident's body barely touched the recliner's back cushion with the resident's walker was positioned in front of him with his untouched dinner placed on his walker in a teetering position. The resident's lunch was on the table untouched. The resident appeared confused, calling out, "What is going on? Help me, help me." The family member arranged for the resident to be evaluated at a hospital.

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 unable to interview due to cognition.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrators interviewed: Yes, both AP#1 and AP#2 were interviewed.

Action taken by facility:
AP#1 received a written warning from facility.

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

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

Rice County Attorney
Northfield City Attorney
Northfield Police Department
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30490	A. BUILDING: _____ B. WING _____	C 12/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLSTREAM COMMONS	210 WEST 8TH STREET NORTHFIELD, MN 55057

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL304909561C/#HL304906326M On December 31, 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 23 residents receiving services under the provider's Assisted Living license. The following correction order orders are issued for #HL304909561C/#HL304906326M, tag identification 2310 and 2360.	0 000	Assisted Living Provider 144G. Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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02310	Continued From page 1	02310		
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure unlicensed personnel (ULP)-F and ULP-I performed scheduled services for one of two residents (R1) with records reviewed. On October 6, 2024, at 9:00 p.m. and October 7, 2024 at 2:00 a.m., ULP-I and ULP-F were to assist R1 with his personal cares and ensure R1's dirty clothes were picked up and clean clothes laid out for the morning both falsely documented the services were performed. On October 7, 2024, at 8:07 a.m., 11 hours after he was last seen, R1's personal caregiver (PC)-G found R1 injured and lying on his bedroom floor with his bed still made from the previous day. floor. In addition, the licensee failed to ensure registered nurse (RN)-C, monitored and assessed R1 after his fall. For several hours R1 complained of back pain, yet RN-C never assessed R1. R1 was transported to the hospital where he was diagnosed with five fractured ribs. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the	02310		

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02310	Continued From page 2 situation has occurred only occasionally). The findings Include: R1's facility record was reviewed. R1 was admitted to the licensee's facility on October 11, 2021. R1's diagnoses included but were not limited to dementia and abnormalities of gait and mobility. R1's service plan dated July 24, 2024, indicated R1 received assistance with personal cares, medication management and administration. In addition, at 2:00 a.m., staff were to enter R1's bedroom and ensure R1's dirty clothes were in his hamper and place clean clothes and underwear out for the morning. R1's assessment dated July 26, 2024, indicated R1 experienced syncope (dizziness). Although assessed as having a cognitive impairment, R1 was able to make his needs known. R1 was hard of hearing and wore hearing aids in both ears. R1 used a four-wheeled walker for mobility. R1's individual abuse prevention plan (IAPP), dated July 26, 2024, indicated R1 was not oriented to person, place, time, was forgetful, and required cues and reminders from staff. Staff were to monitor and ensure R1's safety. R1 had a history of falls. Staff were to promptly report any falls to a nurse. R1's service check-off record dated October 2024, indicated at 9:00 p.m. each evening, an ULP was to prepare R1 for bed and assist with personal cares. The ULP's were to encourage R1 to be in bed by 9:00 p.m. per family's request. In addition, the ULP's were to place R1's dirty clothes inside his hamper and place clean clothes	02310		

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02310	Continued From page 3 out for the morning. If R1 refused his 9:00 p.m. cares, the ULP's were instructed to go back into R1's bedroom and put his hearing aides on the charger. R1's incident report dated October 7, 2024, at 7:47 a.m., completed by RN-C, indicated R1's caregiver found R1 lying on the floor sleeping with a blanket covering his body. R1 had a laceration/abrasion to his left elbow and an abrasion to the left side of his mid-back region. R1's left elbow was open and bleeding. R1 was assisted to his knees to a standing position then transferred to bed. R1 complained of back pain. At 9:00 a.m., R1's family member (FM)-E was notified, and at 11:30 a.m., R1's healthcare provider was notified, 3.5 hours after R1 was found on the floor. Review of R1's vital sign record dated October 7, 2024, at 7:47 a.m., indicated the only time R1's vital signs were obtained. R1's progress note dated October 7, 2024, at 12:27 p.m., completed by RN-C, indicated at 7:47 a.m., R1 was found on the floor of his bedroom lying on his left side and bleeding from an abrasion on his left elbow that measured 8 centimeters (cm) x 4 cm. R1 was unsure why he was on the floor but believed he fell. RN-C documented R1 was able to move all extremities and ambulated using his four wheeled walker. R1 requested to lie down and sleep. After resting for an hour, wound care was performed. At 10:00 a.m., 1,000 milligrams (mg) of as needed (prn) Tylenol was administered after R1 complained of pain in his back. R1's family member (FM)-E was called and arrived at 11:00 a.m. RN-C documented, "R1 did not have pendant with him when he fell. Discussed with family increased	02310		

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02310	Continued From page 4 safety checks and bracelet pendant." R1's record lacked documentation RN-C reassessed R1 after he continued to complain of back pain. R1's progress note dated October 7, 2024, at 4:15 p.m., indicated orders from R1's provider included scheduled Tylenol, 1000 milligrams (mg) three times per day, not to exceed 3,00 mg in 24 hours. Physical therapy (PT) to evaluate and treat due to fall. Orders faxed to pharmacy. Ice applied to back with relief. R1's ambulance run report dated October 7, 2024, at 7:33 p.m.,indicated emergency medical services (EMS) was dispatched to the facility and arrived at 7:45 p.m. after R1's family requested 911 be called. R1's chief complaint was "My back hurts." R1's family noticed a change in R1's mental status and observed R1 was not eating or responding normally. EMS documented R1 presented with an altered mental status. At 8:01 p.m., R1 was transported to the hospital. R1's hospital record dated October 7, 2024, at 8:14 p.m., R1 arrived at the hospital for evaluation of altered mental status and weakness. R1 complained of pain in his ribs and elbow. Strong intravenous (IV) pain medication, anti-nausea, and fluids were administered. R1's family reported after his unwitnessed fall, R1 became weaker throughout the day, refusing to eat, drink, and showing signs of increased confusion. R1's family was unsure how long he laid on his floor. Computed tomography (CT) scan showed five rib fractures (5th, 6th, 7th) on the front (anterior), and two rib fractures (14th, 20th) on the back (posterior). R1 was admitted to the hospital. On October 11, 2024, R1 was	02310		

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02310	Continued From page 5 discharged to a rehabilitation facility. R1 did not return to the facility. A progress note dated October 8, 2024, at 9:18 a.m., licensed practical nurse (LPN)-J documented, "R1 was taken to the emergency room (ER) around 8:00 p.m. by family for a post-fall evaluation related to pain. RN-C aware." In an email dated October 8, 2024, at 11:27 a.m., from the licensed assisted living director (LALD)-H to family member (FM)-D, LALD-H indicated she reviewed recorded camera footage from the facility lobby and outside of R1's apartment between October 6, 2024, at 7:00 p.m. and October 7, 2024, at 8:10 a.m. LALD-H indicated the following: On October 6, 2024, at 7:00 p.m., R1 was seated downstairs in the lobby. Between 8:04 p.m. and 8:15 p.m., R1 used the lobby restroom. Between 8:31 p.m. and 8:45 p.m., R1 rummaged through the lobby desk drawers. At 8:51 p.m. took the elevator up to his apartment. At 8:54 p.m., R1 entered his apartment. LALD-H confirmed between 8:54 p.m. and 8:07 a.m. no staff entered R1's apartment. LALD-H indicated RN-C was in contact with evening shift ULP-I and overnight ULP-F. LALD-H indicated ULP-F passed by R1's apartment on October 6, 2024, at 11:54 p.m. and October 7, 2024, at 2:44 a.m., and 4:16 a.m. but never entered. LALD-H indicated, "Appropriate action will be taken with these staff members along with re-education of all ULPs on the importance of following the scheduled services for all residents." Review of ULP-I's corrective action document dated October 11, 2024, completed by RN-C, indicated ULP-I stated on October 6, 2024, she made multiple attempts to get R1 to comply with	02310		

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02310	Continued From page 6 evening cares however she was unable to complete the cares so she asked ULP-F to return to R1's apartment for the night check and finish R1's cares. ULP-I's corrective action plan included following up with residents who have poor judgement and cognitive decline. Review of ULP-I's corrective action document dated October 11, 2024, indicated on October 7, 2024, R1 was found on the floor and the facility was unsure if R1 laid on the floor all night. At 10:00 p.m. shift change, ULP-I reported to ULP-F the resident was still awake. During her interview, ULP-I stated on October 6, 2024, she made multiple attempts to get R1 to comply with evening cares, stating she set out R1's clean clothes and all of his care supplies but stated R1 was up and downstairs multiple times during her shift and kept putting off going to bed, stating she was unable to monitor R1's every move. ULP-I stated she asked ULP-F to return to the resident's apartment for a night check and finish up with R1's cares. ULP-I indicated she last saw R1 at 9:00 p.m. in the lobby. The corrective action plan included following up with residents who have poor judgement and cognitive decline. Review of ULP-F's corrective action document dated October 11, 2024, completed by RN-C, indicated ULP-F documented R1's 2:00 a.m. safety check was completed even though LALD-H saw ULP-F never provided R1's safety check. Corrective action plan included at the beginning of each shift, ULP-F was to read and perform all scheduled services and to document if the services were completed or provide a reason if not completed. RN-C indicated ULP-F would be monitored closely along with her documentation. During an interview on January 16, 2025, at 3:30	02310		

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02310	Continued From page 7 p.m., RN-C stated R1 always lost his pendant and was unsure the last time he used it. RN-C stated she was unable to complete a full assessment on R1 after his fall because R1 wanted to immediately lie down and sleep. RN-C stated she "assessed" R1 by taking his vital signs even though his record lacked documentation they were obtained and confirmed she never completed a full assessment on R1. RN-C stated stated she periodically checked R1's oxygen saturation levels throughout the day because she was "worried about his ribs and stated, "somebody who has that kind of pain and has a fall like that; I was concerned about rib fractures." During an interview on January 17, 2025, at 9:00 a.m., FM-D stated on October 7, 2024, around 8:00 a.m. they received a call from R1's personal caregiver (PC)-G stating the resident fell, was not doing well and complained of pain. FM-D stated PC-G observed R1's bed was still made and not slept in. FM-D stated at 10:00 a.m. they asked RN-C to review facility camera footage to determine when R1 and staff entered his apartment. FM-D stated at 4:45 p.m. they got an "icky feeling" after talking to an ULP who stated the resident was "doing great," and ate all of his supper. FM-D stated they drove to the facility to check on R1 after they never heard back from the facility after they requested the facility call them back. FM-D stated they found R1 in his recliner; his lunch and supper were untouched. R1 appeared confused, calling out, "What is going on? Help me, help me. During an interview on January 17, 2025, at 12:35 p.m., ULP-F stated she normally worked the overnight shift stating most of the residents slept during her shift. ULP-F stated, "All in all it is pretty laid back. I am not overworked by any means."	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30490	A. BUILDING: _____ B. WING _____	C 12/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLSTREAM COMMONS	210 WEST 8TH STREET NORTHFIELD, MN 55057

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02310	Continued From page 8 ULP-F stated R1's 2:00 a.m. scheduled service was not a safety check only to pick up his dirty clothes off the floor and put them in R1's hamper located in his bedroom. ULP-F stated on October 7, 2024, at 2:00 a.m. she did not perform R1's task. ULP-F stated she initially told RN-C she entered R1's room that night but then changed her story stating she "accidentally" confirmed she performed R1's 2:00 a.m. service instead of canceling it. ULP-I stated she was never retrained after the incident only told to not do that again. During an interview on January 22, 2025, at 9:30 a.m., PC-G stated on October 7, 2024, around 7:45 a.m. she arrived at the facility to get R1 ready for the day. PC-G stated she heard "moaning and groaning" coming from R1's bedroom. PC-G stated she found R1 lying naked on his bedroom floor with a bedspread pulled over him. PC-G observed R1's bed was still made stating, "I said something like it doesn't look like he was in bed." PC-G stated she saw blood on his bedspread, blood on the floor and noticed R1's arm was bleeding. PC-G stated it took RN-C and staff 15 minutes to get R1 off the floor due to R1's complaints of pain, stating R1 wanted to lie down because his back hurt. PC-G stated R1 continued to moan and groan whenever RN-C and staff tried to reposition R1 stated R1 said, "Oh, my back hurts." PC-G stated at 3:00 p.m. she went to a store and purchased ice packs because the facility did not have any and when she arrived at the facility a ULP went to apply them on R1 but PC-G stated, "No, I just got them and they are not frozen." PC-G stated the ULP replied, "I'll come back in 10 minutes and put them on him." During an interview on January 23, 2025, at 3:00 p.m., LALD-H stated she was unaware if the	02310		

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02310	Continued From page 9 ULPs were retrained after the incident stating, "RN-C talked about doing that." During an interview on January 24, 2025, at 11:00 a.m., ULP-I stated on October 6, 2024, she was the only ULP who worked the evening shift stating another ULP called in sick so she was the only ULP responsible for providing services for 25 residents that night. ULP-I stated she administered R1's medications in his apartment around 7:00 p.m. then continued to set up R1's nightly routine but was unable to provide the cares due to being short staffed and extremely busy. ULP-I stated she made multiple attempts to try and get R1 upstairs and ready for bed but was unable to persuade him so during shift change at 10:00 p.m. she asked ULP-F if she could go in R1's room and complete R1's services ULP-I was unable to perform. ULP-I stated ULP-F agreed she would stating she fully expected ULP-F to go in R1's room and finish the tasks because ULP-F said she would do so. The licensee policy titled Nursing Assessment, updated April 2022, indicated facility RNs would perform comprehensive nurse assessments whenever a resident experienced a change in condition. Ongoing monitoring and review would be conducted as needed based on changes in the resident's needs. TIME PERIOD TO CORRECT: Seven (7) days.	02310		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act.	02360		

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02360	Continued From page 10 This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and individual persons were responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		