Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL305969387M
Compliance #: HL305967123C

Date Concluded: January 12, 2024

Name, Address, and County of Licensee Investigated:
Garden Court Chateau LLC
2495 SW 8th Street
Grand Rapids, MN 55744
Itasca County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Barbara Axness, RN
Special Investigator

Finding: Substantiated, facility responsibility

Nature of Investigation:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
The facility neglected the resident when the nurse failed to reassess the resident after he fell and reported ten out of ten pain for two days. Facility staff failed to immediately report the fall and the increasing complaints of pain to the nurse. The resident was diagnosed with a femur fracture and required surgery.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The resident was lowered to the floor during a staff-assisted transfer and later complained of severe pain. The resident was not assessed following the incident, as facility staff did not report the incident or the resident's complaints of pain to the registered nurse (RN) until the next day. The RN was notified of concerns by the resident's family the next day when they questioned why the resident was still in bed at noon and complaining of pain. The resident was sent to the hospital for further evaluation 17 hours after the initial fall, where he was diagnosed with a femur fracture that required surgical repair.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of employee training records, facility policies and procedures, resident medical records, and emergency room records. At the time of the onsite visit, the investigator observed transfers in the facility.

The resident resided in an assisted living facility. The resident had a diagnosis of rheumatoid arthritis (a chronic inflammatory disease that affects the joints, resulting in painful joints, swelling, and stiffness in the joints). The resident's record lacked a signed service plan. The resident's assessment indicated the resident used adaptive equipment to transfer. The resident had a specialized walker and required the assist of two staff and a T-belt (gait belt) to transfer. The resident was noted to drive his motorized wheelchair into the bathroom and use his specialized walker, with assistance from staff, to transfer onto the toilet.

One evening, the resident was lowered to the floor during a staff-assisted transfer from the toilet to his wheelchair. No documentation was completed at the time of the incident.

The following day, a progress note was entered in the resident's medical record which detailed the registered nurse (RN) was notified of "an incident last night resulting in right leg/knee pain." The RN was notified after unlicensed personnel (ULP) reported the resident was still in bed at noon, due to increased pain in his right knee. The RN interviewed the resident who reported he lost his balance during a staff-assisted transfer and a staff member's knee went into his knee. The resident reported his pain level was a nine out of ten and Tylenol and an ice pack were administered. The resident declined further evaluation.

A few hours later, the resident's family came to the facility and voiced concern when the resident was still in bed. The resident's family spoke with the nurse and the resident was transferred to the hospital for further evaluation. The resident's emergency room records indicated the resident was diagnosed with an acute distal femoral (thighbone) fracture which required surgical repair. The resident was admitted to the hospital and did not return to the facility.

A facility incident report was completed later that day. The incident report indicated the resident was lowered to the floor last night at 7:15 p.m., after he lost his balance during a transfer from the toilet to his wheelchair. The incident report indicated the resident was unable to bear weight, his legs gave out, and he was lowered to the ground. The resident was given "Tylenol at 2:07 a.m. for pain in right leg and feet rating ten out of ten." The incident report indicated the physician was not notified as "at time of the accident, deviation in standard protocol occurred in that the direct caregivers did not notify an RN of the witnessed near miss." The RN was not notified until noon the following day. The resident's family was not immediately notified. The incident report further indicated the "standard is to notify an RN of all accidents/near miss lowered to floor."

The facility completed an internal investigation to review the incident. Internal investigation documentation included screenshots of text messages between the RN and the temporary staff unlicensed personnel (ULP) #1 who was working at the time of the incident. The text messages indicated ULP #1 did not feel the resident fell, as he was lowered to the floor, and required herself and four other staff members to get off the floor. ULP #1 wrote she took the resident's vitals, informed a facility ULP (ULP #2) of the resident's knee pain, and was told ULP #2 would give that information to the RN. A written statement from ULP #2 indicated she was given the resident's vitals, put the note in her pocket, and told ULP #1 she "would get ahold of a RN." ULP #2 wrote the night was a busy night and several tasks were not completed. ULP #2 wrote she checked on the resident overnight and he reported his right leg hurt and requested pain medications. ULP #2 gave the resident Tylenol and put Vick's vapor rub on the resident's leg. Written statements from additional ULP involved with the incident, indicated they received conflicting information on if the incident was a fall and whether it should be reported to the nurse.

ULP #1 was a temporary agency staff employee. The facility did not have an employee file for ULP #1, and no documentation was available to verify if ULP #1 was trained on how to transfer the resident or informed on how to report falls or other incidents to the RN.

During an interview, the resident's family member indicated they were not notified of the resident's fall or complaints of pain. The resident's family member came to the facility around noon the next day because it was the resident's birthday, and he was having a party. The family member was surprised to see the resident was still in bed when they arrived, as that was not normal for him. The family member noticed he had an ice pack on his knee and complained of severe pain. The family member spoke with the RN and told her the resident needed to go to the emergency room but instead of immediately calling for an ambulance, the RN left and administered a treatment to another resident for about 20 minutes. The family member stated she was concerned about what would have happened if she hadn't come in that day, since there was no incident report created and neither the family, nor the physician, were updated.

During an interview, the clinical nurse supervisor (CNS) stated the resident used a specialized walker and had a specific way he used the walker to get on the toilet. The CNS stated given the complexity of the transfer and the use of the specialized walker, she care-planned for two staff to transfer the resident. The CNS confirmed the facility's process was not followed and the RN should have been notified immediately after the resident was lowered to the floor and when the resident reported severe pain. The CNS stated she previously informed ownership that temporary ULP would have to be trained and since she did not have direct supervision of the ULP, the facility owners informed her they would handle it.

During an interview, the RN stated when the resident fell, she was working full time as the nurse manager. The RN indicated the facility was very short staffed at the time and many of her hours were spent working as a ULP. The RN stated the ULP who helped with the transfer was a temporary/agency employee who was not trained on how to transfer the resident with his

specialized walker. The RN stated she did not supervise the ULP, as that was the responsibility of the owners. The RN stated she was working on the floor as a ULP the morning after the resident fell and had come into the facility around 8 or 9 a.m. Staff did not tell her about the fall until around 11:00 a.m. when they reported the resident didn't want to get out of bed due to pain. The resident rated his pain a "ten out of ten" and she was concerned as the resident usually did not report high pain levels. The RN called the CNS to get more information since there was not an incident report or any notes about why the resident was in such severe pain. The RN stated about 30-40 minutes later, while she was trying to figure out what happened, the resident's family came in and began asking questions. The family agreed to send the resident to the emergency room. The resident was diagnosed with a fracture and did not return to the facility. The RN stated she did not know why staff did not immediately report the fall or why they didn't tell her when she came in the next morning.

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: Attempts to interview were unsuccessful.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility investigated the incident and retrained staff on nurse notification procedures.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

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

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

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Itasca County Attorney
Grand Rapids City Attorney
Grand Rapids Police Department
Minnesota Board of Executives for Long Term Services and Supports
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30596	A. BUILDING: _____ B. WING _____	C 12/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN COURT CHATEAU	2495 SW 8TH STREET GRAND RAPIDS, MN 55744

(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: #HL305969387M/HL305967123C On December 26, 2023, 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 immediate correction order is issued. Correction orders with a period to correct that are not immediate may be issued at a later date during the investigation. The following immediate correction order was issued on December 27, 2023, for #HL305969387M/HL305967123C, tag identification 1350. Immediacy was removed on December 29, 2023, however noncompliance remains at a scope and severity of F.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance 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 surveyors' 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 subd. 1, 2, and 3.	

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0 000	Continued From page 1 The following correction order is issued/orders are issued for #HL305969387M/HL305967123C, tag identification 0430, 0470, 0620, 2320, 2360.	0 000		
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the uniform checklist disclosure of services (UDALSA) accurately reflected services provided by the licensee. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not	0 430		

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0 430	Continued From page 2 affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On December 26, 2023, at 2:15 p.m., two assisted living director licenses were observed near the entry way door. One license was for licensed assisted living director (LALD)-B, and the other was for registered nurse (RN)-I. RN-I's assisted living director license expired October 31, 2023. A review of the Board of Executives for Long-Term Services and Supports website on December 26, 2023, at 2:46 p.m., indicated RN-I's LALD license was expired and had not been renewed. The licensee's UDALSA, dated May 7, 2023, indicated an assisted living director was on site both full and part time. On December 26, 2023, at 2:40 p.m., licensed assisted living director (LALD)-B stated RN-I obtained her license so she could assist her with various tasks. LALD-B stated RN-I was only casual status and worked limited hours per pay period and mostly performed nursing related duties. LALD-B confirmed RN-I's license was expired and was not aware it had expired. On December 26, 2023, at 4:05 p.m., clinical nurse supervisor (CNS)- stated LALD-B did not work full time in the facility. On December 27, 2023, at 1:30 p.m., registered	0 430		

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0 430	Continued From page 3 nurse (RN)-H stated LALD-B works maybe 20 to 30 hours in the facility each week. RN-H stated RN-I only worked casual hours and did not have a set schedule. RN-H stated RN-I only worked remotely and did not come into the facility. On December 27, 2023, at 1:45 p.m., owner (O)-C stated, "I don't know how many hours she [LALD-B] works there a week. It's not like 40 hours a week, I don't think. But she does a lot of stuff like decorating the Christmas tree, putting up decorations, she goes in and cooks sometimes, if someone doesn't show up she might go in and do nails for someone." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (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 (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; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the	0 470		

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0 470	Continued From page 4 requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (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; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the clinical nurse supervisor (CNS) developed and implemented a staffing plan to determine staffing levels to meet the needs of all residents. This had the potential to affect all residents, staff, and visitors. 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living facility license and was licensed for a capacity of 24 residents, with a census of 23 residents. Throughout the course of the investigation, the licensee's staffing plan was requested by the MDH investigator on four separate occasions.	0 470		

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0 470	Continued From page 5 During observations on December 26, 2023, unlicensed personnel (ULP)-J stated they were currently short-staffed and she was having difficulty finding another ULP to help her with a transfer. ULP-J stated she was going to be working a double (16 hour) shift today. ULP-J stated it was not uncommon to work short-staffed. Staffing hours posted in the kitchen of the facility for December 26, 2023, indicated only one ULP was scheduled for the overnight shift and the second overnight shift was open. The day shift posting indicated a float ULP and ULP on the north end were working but the shift for a ULP on the south end was open. The evening shift posting indicated a float ULP and a ULP on the north end were scheduled but the shift for a ULP on the south end was open. On December 26, 2023, at 2:10 p.m., licensed assisted living director (LALD)-B was asked about the facility's staffing plan and how staffing is determined. LALD-B described how many staff they schedule per shift. LALD-B was asked how they determined sufficient staffing was in place or what metrics were used to determine staffing was appropriate. LALD-B stated the facility was currently doing two admissions today and one more later this week and the facility would then be at 100% occupancy. LALD-B was asked if the facility had considered limiting admissions until staffing could stabilize. LALD-B stated "You still need money to pay extra bonuses, you can't have five empty beds."LALD-B was asked about staff working double shifts or additional hours and LALD-B stated "the ones really putting forth a lot of time, they really don't mind doing it. I've found I can leave a note that beds need to be ready and that's never done. If we have more empty beds,	0 470		

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0 470	Continued From page 6 they seem to slough off more. They could get it done if they wanted. It can be done." LALD-B added, "we still have to bring in revenue, we've had a few empty beds for close to a month and we're always trying to find people who will stay. Those who are older are much better workers. The younger ones call in, it's just the circumstances." On December 26, 2023, at 3:30 p.m., R2 stated, "They're pretty much always short handed, it drives us all crazy. Almost every day staff calls in." R2 stated staff "use me as a sounding board so I hear a lot of what's going on." R2 stated there have been various agency ULP in the facility and "it angers me they have to use agency staff because they don't know anything about us." R2 stated she had to train all the agency staff who came because they didn't know how to do her cares. On December 26, 2023, at 3:40 p.m., R3 stated sometimes the facility seems like it's short staffed. On December 26, 2023, at 4:10 p.m., clinical nurse supervisor (CNS)-A stated "This is the first position I've had absolutely no say in nursing, the budget, who is hired, terminated, or other performance issues. That is all reviewed by owner (O)-C and LALD-B. CNS-A stated she is not the direct supervisor of the unlicensed personnel and several people are responsible for supervising ULP including nurse managers who may only work once or twice a pay period, and O-C and LALD-B. CNS-A stated she often works upwards of 120 hours per pay period because full time registered nurses who are hired do not last more than a few months due to workload. CNS-A stated she has raised concerns about staffing	0 470		

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0 470	Continued From page 7 levels to O-C and LALD-B but was told O-C had called other facilities to see how they staff and they felt the facility was appropriately staffed. CNS-A stated, "My response was that's apples to oranges, did they look at how many lifts we have, or hospice or shared care residents, other needs of the residents?" On December 27, 2023, at 1:45 p.m., O-C stated she felt the facility was sufficiently staffed and was able to identify how many ULP are scheduled per shift but was unable to describe the facility's staffing plan and how staffing metrics are determined. O-C stated they had a policy on staffing and it was her understanding that "whoever is the nurse on call for staffing, when there's a staffing issue they send out messages to all of the staff looking for help." O-C stated they have about 210 to 240 hours of RN coverage per pay period and they had been using agency staff to fill ULP shifts. O-C stated they had left some beds open for a few weeks but felt comfortable resuming admissions and took two admissions on December 26, 2023. On December 28, 2023, at 2:20 p.m., registered nurse (RN)-H stated she had been the full time nurse manager for a few months before reducing her hours to casual (around one day a pay period). RN-H stated the facility was very short staffed and many of her hours were spent working the floor as a ULP. RN-H stated she resigned her full time position due to the workload of the position. RN-H stated staffing decisions were made by the two facility owners, O-C and LALD-B and she did not have much of a say in it. The licensee's Staffing and Scheduling policy, dated June 26, 2023, indicated the clinical nurse supervisor will develop and implement a written	0 470		

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0 470	Continued From page 8 staffing plan that provides an adequate number of qualified direct-care staff to meet the residents' needs 24-hours a day, seven-days a week. No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	0 470		
0 620 SS=D	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined	0 620		

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0 620	Continued From page 9 in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to submit a report to the Minnesota Adult Abuse Reporting Center (MAARC) for one of one resident (R1) who had a delay in care after staff failed to immediately report a fall and reports of increased pain to the nurse. The resident experienced ten out of ten pain but was not sent	0 620		

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0 620	Continued From page 10 to the emergency room until 17 hours after falling. 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). The findings include: The licensee held a current assisted living license. R1 was lowered to the floor while being transferred from the toilet to his wheelchair. Facility staff failed to report the incident to the registered nurse (RN). Shortly after, the resident began to report pain up to a ten out of ten, which facility staff again failed to report to the RN. The resident's family came to visit the day after his fall and raised concerns to the RN after the resident was still in bed at noon and complaining of pain. The resident was sent to the hospital for further evaluation 17 hours after the initial fall. The resident was diagnosed with a type of fracture that occurs after a high energy trauma like a fall and required surgery to repair it. R1's diagnoses included Rheumatoid arthritis, adjustment disorder with mixed anxiety and depressed mood. R1's record lacked a signed service plan. R1's assessment dated September 11, 2023, indicated the resident used adaptive equipment to	0 620		

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0 620	Continued From page 11 transfer. The resident had a specialized walker and required an assist of two with a T-belt (gait belt) as preferred by the resident. The resident was noted to drive his motorized wheelchair into the bathroom and then used his specialized walker with assistance from staff to transfer onto the toilet. R1's progress notes contained an entry from RN-H on October 30, 2023 which read, "This writer was notified around 1200 (noon) that resident had an incident last night resulting in right leg/knee pain. PCA [personal care attendant/unlicensed personnel] stated resident was still in bed at this time due to increased pain in right knee. Upon face to face with resident, he indicated that last evening (October 29, 2023) he had lost balance while transferring and when staff went to brace themselves to bear his weight, that a staff member's knee went into his. Resident denied being on the floor during this incident. Resident was asked to rate pain, in which he rated it nine out of ten. Tylenol was administered. Resident declined further evaluation at this time and requested ice pack. Resident's daughter arrived to facility in which she inquired about the incident report of resident's fall last evening. This writer informed her of what I was notified of in which she stated the power of attorney (POA) was on her way and will further discuss plan going forward. Upon [POA's] arrival, discussion for further evaluation was made and current finding of internal investigation were relayed. 911 was phoned at 1425 (2:25 p.m.)...internal investigation continues at this time." A progress note entered later that day indicated the resident was diagnosed with a fracture above the right knee replacement which would require surgical intervention. The resident was admitted to the hospital and did not return to the facility.	0 620		

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0 620	Continued From page 12 R1's record contained an incident report completed by RN-H for a witnessed fall dated October 29, 2023, at 7:15 a.m. The incident report indicated the resident was last seen safe at 1915 (7:15 p.m.) in his apartment. The incident report indicated the resident "stated to this writer the following morning that he had lost balance and when staff went to bear his weight, ones knee his his own (sic). Resident initially stated to this writer that he was never on the floor, stated to his daughter at a later time that he was on the floor. As reported by PCAs [ULP] resident had been transferring from toilet to wheelchair, his legs became week (sic) and gave out, in which PCAs [ULP] were able to get him to the edge of his wheelchair. When resident stood up, to position himself back farther, his legs gave out again. Unable to bear his weight, PCAs [ULP] lowered resident to the ground." The resident was given "Tylenol at 0207 (2:07 a.m.) for pain in right leg and feet rating ten out of ten." The incident report indicated the physician was not notified as "at time of the accident, deviation in standard protocol occurred in that the direct caregivers did not notify an RN of the witnessed near miss." The RN was not notified until noon the following day. The resident's family was not immediately notified. The incident report further indicated the "standard is to notify an RN of all accidents/near miss lowered to floor." The facility's internal investigation included screenshots of text messages and written statements from employees involved with the incident. A text message between ULP-D and RN-H included the following response from ULP-D "I was getting [R1] off the toilet and into his wheelchair witness gate belt (sic) on me and another CNA [ULP-N} she was wiping him	0 620		

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0 620	Continued From page 13 because he had a BM [bowel movement] and I told her she needed to go faster because his legs might give out. He started to pivot towards the wheelchair. And his legs gave out, we were trying to hold him up. He did not fall to the ground. When he first sat down in the wheelchair, he was on the edge. We had to lift him back up. So he could be scooted back and his legs gave out. We wind up (sic) letting him slide down to the floor I guess that's how he started complaining that his right knee was hurting. We, it took me and four other team members to get him off the floor. The floor I took his vitals (sic) gave them to [ULP-M] told her about his knee pain. And she said she would give the information to the RN. I even asked him if he wanted to go to the hospital before I put him into bed, he said no. Thank you." A written statement from ULP-M dated October 31, 2023, indicated ULP-D "came up to me and said [R1] fell. I said if he fell you need to do vitals on him...ULP-D's shift done at 9:00 p.m., I was in with [another resident] for a half hour. ULP-D gave me the vitals on [R1]. I put it in my pocket. ULP-D kept telling me he didn't fall she caught him. I ask did he hit the floor, ULP-D said no. I told her I would get ahold of a RN. ULP-D left, everything went crazy. I'm behind on meds...ULP-N trying to keep up with [another ULP] they're both new, hardly any training. Earlier they're asking ULP-D and another ULP where is ULP-N and I don't know. Night shift started, laundry not done. Kitchen counters not wiped off. Rounds took long. Call lights going off...another light went off, it was [R1] he told me his right leg hurts. He wanted something for pain. I went to check what he had for pain med, Tylenol. I check his leg, got it comfortable on the pillow he said he hurts. I ask [R1] what happened he told me it's my fault not ULP-D and the staff. I said ok, also	0 620		

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0 620	Continued From page 14 wanted Vick's rub on his leg, he said it's helping the pain. Rest of the night he didn't' ask for anything else for pain. He told me he wasn't going to the Y this morning, I said ok I'll let them know.: R1's emergency room records from October 30, 2023, indicated the resident was diagnosed with acute fracture through the distal femoral metadiaphysis extending to the femoral component of the right knee (a type of fracture of the thigh/above the knee caused by high energy trauma like a fall from a height) which would require surgical repair. On December 26, 2023, at 4:05 p.m., CNS-A stated R1 used a specialized walker and had a specific way he would use the walker to get on the toilet. CNS-A stated R1 would line himself up onto non-skid strips placed on the floor and then he'd shut off his motorized scooter and put his stand up walker in front of him. CNS-A stated, "he's very rheumatoid arthritic, his hands, fingers, how he was able to do this I'm not even sure...the resident would do his own maneuvering and he'd have a transfer belt on and he'd grab the handles and put his arms on the arm supports and start to tip, then you'd take a hold of the belt to get him forward, then he'd inch to pivot until he got to the toilet and would ask if he's close enough to sit down." CNS-A stated given the complexity of the transfer and the specialized walker, she had care planned for two staff to always transfer the resident. CNS-A confirmed the facility's process was not followed and the RN should have been notified immediately after the resident was lowered to the floor and also notified when the resident reported severe pain. CNS-A stated she was not sure if the incident was reported to MAARC.	0 620		

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0 620	Continued From page 15 On December 28, 2023, at 1:45 p.m., family member (FM)-K stated neither she nor her mother had been notified of any fall or any complaints of pain for R1. FM-K stated she came in around noon on October 30, 2023, because it was R1's birthday and he was having a party and she was surprised to see him still in bed as that was not normal for him. FM-K stated R1 reported he was having severe pain and there was an ice pack on his knee. FM-K stated she spoke to RN-H and they told her R1 needed to be sent to the emergency room. FM-K stated instead of immediately calling for an ambulance, RN-H went and administered a treatment to another resident for about 20 minutes. FM-K stated she was concerned on what would have happened if they didn't come in that day since there had not been an incident report created and neither the family nor the physician were updated. FM-K stated R1 used a specialized walker and she wasn't sure if ULP had been trained on how to use it with transferring the resident. On December 28, 2023, at 2:20 p.m., RN-H stated at the time the resident fell, she was working full time as the nurse manager and her primary responsibilities included being on call, onboarding new employees, supervising unlicensed personnel, and general day to day nursing tasks. RN-H stated the facility was very short staffed at the time and many of her hours were spent working the floor as a ULP. RN-H stated the agency staff member, ULP-D was not trained on how to transfer R1 with his specialized walker as she had only trained the permanent facility staff. RN-H stated, "I wasn't made aware I was their [the temporary agency ULP] direct supervisor it was my understanding it fell under [CNS-A] and when she expressed concerns [over training of the temporary agency ULP], the	0 620		

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0 620	Continued From page 16 supervisor was changed to [LALD-B] because we [RN-H and CNS-A] can only do so much when we get blocked by ownership [LALD-B and O-C]. I was told from [O-C] we just had to do an initial have someone at the facility give a walk thru to know the facility and [CNS-A] questioned that and [O-A] explained that agency training, they only need to get a quick understanding of the facility." RN-H stated she resigned her full time position shortly after the resident fell due to the workload of the position. RN-H stated she was not the nurse on call when the fall happened but she was working the floor as a ULP the next day, October 30, 2023, and came in around 8 or 9 in the morning. RN-H stated she was not updated by staff until around 11:00 a.m. when the ULP from that side reported the resident didn't want to get up and was rating his pain as ten out of ten. RN-H stated, "If he's saying it's ten out of ten, something's going on" as the resident usually did not like to report high pain levels. RN-H stated she called CNS-A to get some more information since there was not an incident report or any notes about why the resident was having such severe pain. RN-H stated while she was trying to figure out what happened, the resident's family came in about 3-40 minutes later and began asking questions. RN-H stated family agreed to send R1 to the emergency room and the resident was diagnosed with a fracture and did not return to the facility. RN-H stated she did not know why staff did not immediately report the fall on October 29, 2023, or why they didn't tell her when she came in the morning of October 30, 2023, other than the ULP working "usually won't notify me because she thinks I'm too young to be a nurse." RN-H stated she was not sure if the incident was reported to MAARC. The resident's emergency room records indicated	0 620		

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0 620	Continued From page 17 the resident was diagnosed with acute fracture through the distal femoral metadiaphysis extending to the femoral component of the right knee (a type of fracture of the thigh/above the knee caused by high energy trauma like a fall from a height) which would require surgical repair. The licensee's Vulnerable Adult policy, dated May 11, 2023, indicated mandated reporters are required to report any actual or suspected maltreatment, abuse, or neglect immediately (defined as no longer than 24 hours from the time the incident occurred). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
01350 SS=I	144G.60 Subd. 5 Temporary staff When a facility contracts with a temporary staffing agency, those individuals must meet the same requirements required by this section for personnel employed by the facility and shall be treated as if they are staff of the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure contracted staff met all requirements for training and competency evaluation for four of four temporary unlicensed personnel ((ULP)-D, ULP-E, ULP-F, ULP-G) with records reviewed. This practice resulted in a level three violation (a violation that harmed a resident's health or safety,	01350		

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01350	Continued From page 18 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). This resulted in an immediate correction order on December 27, 2023, at approximately 3:30 p.m. The findings include: On December 26, 2023, at 2:05 p.m., licensed assisted living director (LALD)-B confirmed the facility utilized agency unlicensed personnel (ULP) and figured there had been about five different ULP who had come in to the facility to work as temporary staff. LALD-B stated she was not sure what the name of the staffing agency was, as it was handled by the other owner, owner (O)-C. LALD-B stated they did not complete competency training or additional training with agency staff because "the agency only sends us competent people with experience." LALD-B stated the reason they did not do additional orientation or competency training with agency staff is because "it's pages and pages of stuff...for us to test them and with everything we're already doing and being short a person, it takes a full day to do it. If we were going to do that, why have them [agency staff] then?" On December 26, 2023, at 2:45 p.m., the investigator requested documentation related to agency staff use including the name of the staffing agency and evidence the agency was registered with the state, names and dates worked for all agency employees used the past six months, and employee records to include	01350		

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01350	Continued From page 19 training records for all agency employees. On December 26, 2023, at 3:15 p.m., the investigator requested documentation related to agency staff use including the name of the staffing agency and evidence the agency was registered with the state, names and dates worked for all agency employees used the past six months, and employee records to include training records for all agency employees. On December 26, 2023, at 3:34 p.m., the investigator emailed a request for documentation related to agency staff use including name of the staffing agency and evidence the agency was approved by the state, names and dates worked for all agency employees used the past six months, and employee records to include training records for all agency employees to be sent no later than 6:00 p.m. on December 26, 2023. On December 26, 2023, at 4:00 p.m., clinical nurse supervisor (CNS)-A stated the facility began using agency staff while she was on leave and when she returned, she was surprised to see agency ULP working as the building and her name listed as the primary contact for coordinating agency ULP. CNS-A stated she told management to remove her name because there was a lot of training and coordination required with bringing on agency staff and if she wasn't going to get support with onboarding, she did not want to be responsible for it. CNS-A stated she was not sure of the name of the staffing agency. CNS-A stated she brought concerns to management after she noticed agency ULP did not have access to the electronic medical record, as no one had set it up for them. CNS-A stated she is not given any responsibility over scheduling and the ULP report to LALD-B and O-C so she	01350		

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01350	Continued From page 20 was not given much involvement with the decision on using agency ULP. On December 26, 2023, at 4:35 p.m., the investigator told LALD-B about the email request and that the records needed to be received by 6:00 p.m. On December 26, 2023, at 8:00 p.m., the investigator emailed to confirm the facility was not going to be submitting any additional documentation. On December 27, 2023, at 12:22 a.m., owner (O)-C emailed the investigator screen shots of the staffing agency's record for one agency ULP. On December 27, 2023, at 7:13 a.m., the investigator emailed O-C to provide documentation related to agency staff use including name of the staffing agency and evidence the agency was registered with the state, names and dates worked for all agency employees used the past six months, and employee records to include training records for all agency employees. On December 27, 2023, at 9:00 a.m., the investigator called the facility to inquire about the status of the records request. Registered nurse (RN)-H stated she was not sure. CNS-A advised the investigator to contact O-C to inquire about the status as she did not have any involvement with the agency staff. On December 27, 2023, at 10:04 a.m., O-C emailed the investigator the following, "It's my understanding the staff were extremely busy with 2 new admits. They did call in another RN and had paperwork completed but our scanner to	01350		

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01350	Continued From page 21 email stopped working. I called our computer guy and he thinks he fixed it last night. They were going to try again this morning. I'm very sorry your information has not been provided to you in a timely manner under unusual circumstances." On December 27, 2023, at 1:45 p.m., O-C stated the facility maintained employee records for the agency ULP and the records were at her home. O-C stated, "It's my assumption that they're [agency ULP] trained and ready to go and they just need basically an orientation where things are in the facility." O-C stated the facility provided all the training and the staff were competent based off the training provided by the agency and they did not provide any additional training. O-C stated one of the agency ULP had been medication trained by the staffing agency and was administering medications to residents in the facility. O-C confirmed competency testing for medication administration had not been completed. O-C confirmed the staffing agency was not on the Supplemental Nursing Services Agency Registration list with the Minnesota Department of Health. O-C stated she was not aware of the registry and was not aware it was a requirement for staffing agencies to be on the registry. O-C stated the staffing agency had called them one day asking if they needed temporary staffing services so they signed a contract with them. Employee records for ULP-E, ULP-F, and ULP-G were not provided. Information provided by O-A indicated four agency ULP worked approximately 35 shifts in September and October 2023. On December 27, 2023, at 12:25 a.m., O-C emailed the investigator a partial employee record for ULP-D. ULP-D's record contained the	01350		

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01350	Continued From page 22 following screenshots taken on a cell phone at 12:16 a.m.: -A copy of a Minnesota Nursing Assistant Registry Verification of Registration dated September 27, 2022 -A background study for an unrelated healthcare facility, not affiliated with the licensee or the staffing agency, dated March 21, 2023 ULP-D, ULP-E, ULP-F, and ULP-G's employee records lacked evidence of completed training and competency evaluation to include the following topics: (1) documentation requirements for all services provided (2) reports of changes in the client's condition to the supervisor designated by the home care provider (3) basic infection control, including blood-borne pathogens (4) maintenance of a clean and safe environment (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing (ii) care of teeth, gums, and oral prosthetic devices (iii) care and use of hearing aids (iv) dressing and assisting with toileting (6) training on the prevention of falls for providers working with the elderly or individuals at risk of falls (7) standby assistance techniques and how to perform them (8) medication, exercise, and treatment reminders (9) basic nutrition, meal preparation, food safety, and assistance with eating (10) preparation of modified diets as ordered by a licensed health professional (11) communication skills that include preserving	01350		

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01350	Continued From page 23 the dignity of the client and showing respect for the client and the client's preferences, cultural background, and family (12) awareness of confidentiality and privacy (13) understanding appropriate boundaries between staff and clients and the client's family (14) procedures to utilize in handling various emergency situations (15) awareness of commonly used health technology equipment and assistive devices In addition, ULP-D, ULP-E, ULP-F, and ULP-G's employee records also lacked training and competency evaluation to include; (1) observation, reporting, and documenting of client status (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel (3) reading and recording temperature, pulse, and respirations of the client (4) recognizing physical, emotional, cognitive, and developmental needs of the client (5) safe transfer techniques and ambulation (6) range of motioning and positioning (7) administering medications or treatments as required (d) other RN/professionally delegated tasks (e.g., monitor vital signs, catheter or stoma care, Broda chair, mechanical lifts) ULP-D, ULP-E, ULP-F, and ULP-G's employee records lacked orientation to assisted living to include: -overview of assisted living statutes; -introduction and review of the provider's policies and procedures related to the provision of AL services; -handling of emergencies and use of emergency	01350		

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01350	Continued From page 24 services; -compliance with reporting of maltreatment of vulnerable adults; -assisted living bill of rights; -handling of resident complaints, reporting of complaints, and where to report; -consumer advocacy services; -principles of person-centered planning and service delivery; and -review of the types of assisted living services the employee will be providing and the facility's category of license. In addition, ULP-D, ULP-E, ULP-F, and ULP-G did not have evidence of a background study being completed by the staffing agency or the licensee. R1 R1's diagnoses included rheumatoid arthritis. R1's record lacked a signed service plan. R1's assessment dated September 11, 2023, indicated the resident used adaptive equipment to transfer. The resident had a specialized walker and required an assist of two with a T-belt as preferred by the resident. The resident was noted to drive his motorized wheelchair into the bathroom and then used his specialized walker with assistance from staff to transfer onto the toilet. R1's record contained an incident report dated October 29, 2023, at 7:15 a.m., for a witnessed fall. The resident was being transferred from the toilet to his wheelchair by ULP-D and another facility ULP. The resident's "legs became weak and gave out, in which PCA's [ULP] were able to get him to the edge of his wheelchair. When the	01350		

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01350	Continued From page 25 resident stood up, to position himself back farther, this legs gave out again. Unable to bear weight, PCA's [ULP] lowered the resident to the ground." Four ULP were required to get the resident back in to the wheelchair. The "resident reported pain and inability to bear weight on right leg so sit to stand (a mechanical lift) was used to transfer resident into bed. Agency staff (ULP-D) took vitals, and routed them to float." The on-call RN was not notified about the fall until midnight. The incident report indicated emergency medical services were not called until October 30, 2023, at 2:25 p.m. On December 26, 2023, at 4:05 p.m., CNS-A stated R1 used a specialized walker and had a specific way he would use the walker to get on the toilet. CNS-A stated R1 would line himself up onto non-skid strips placed on the floor and then he'd shut off his motorized scooter and put his stand up walker in front of him. CNS-A stated, "he's very rheumatoid arthritic, his hands, fingers, how he was able to do this I'm not even sure...the resident would do his own maneuvering and he'd have a transfer belt on and he'd grab the handles and put his arms on the arm supports and start to tip, then you'd take a hold of the belt to get him forward, then he'd inch to pivot until he got to the toilet and would ask if he's close enough to sit down." CNS-A stated given the complexity of the transfer and the specialized walker, she had care planned for two staff to always transfer the resident. CNS-A stated she did not have direct supervision of the ULP, as that was managed by O-A and LALD-B who were also both RNs. CNS-A stated they would have been responsible for training and orientation of the agency staff. No further information was provided.	01350		

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01350	Continued From page 26 Immediacy was removed on December 29, 2023, however noncompliance remains at a scope and severity of F. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days	01350		
02320 SS=G	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure care was provided by staff who were properly trained and competent when a change in condition was not reported to the appropriate supervisor or health care professional following a fall with reports of increased pain for one of one resident (R1) reviewed. The resident fell during a transfer and complained of ongoing ten out of ten pain for approximately 17 hours. The resident was sent to the emergency room after family came to visit and noticed the resident was in significant pain. The resident was diagnosed with a femur fracture that required surgical repair. 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,	02320		

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02320	Continued From page 27 or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included Rheumatoid arthritis, adjustment disorder with mixed anxiety and depressed mood. R1's record lacked a signed service plan. R1's assessment dated September 11, 2023, indicated the resident used adaptive equipment to transfer. The resident had a specialized walker and required an assist of two with a T-belt (gait belt) as preferred by the resident. The resident was noted to drive his motorized wheelchair into the bathroom and then used his specialized walker with assistance from staff to transfer onto the toilet. R1's progress notes contained an entry from RN-H on October 30, 2023 which read, "This writer was notified around 1200 (noon) that resident had an incident last night resulting in right leg/knee pain. PCA [personal care attendant/unlicensed personnel] stated resident was still in bed at this time due to increased pain in right knee. Upon face to face with resident, he indicated that last evening (October 29, 2023) he had lost balance while transferring and when staff went to brace themselves to bear his weight, that a staff member's knee went into his. Resident denied being on the floor during this incident. Resident was asked to rate pain, in which he rated it nine out of ten. Tylenol was administered.	02320		

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02320	Continued From page 28 Resident declined further evaluation at this time and requested ice pack. Resident's daughter arrived to facility in which she inquired about the incident report of resident's fall last evening. This writer informed her of what I was notified of in which she stated the power of attorney (POA) was on her way and will further discuss plan going forward. Upon [POA's] arrival, discussion for further evaluation was made and current finding of internal investigation were relayed. 911 was phoned at 1425 (2:25 p.m.)...internal investigation continues at this time." A progress note entered later that day indicated the resident was diagnosed with a fracture above the right knee replacement which would require surgical intervention. The resident was admitted to the hospital and did not return to the facility. R1's record contained an incident report completed by RN-H for a witnessed fall dated October 29, 2023, at 7:15 a.m. The incident report indicated the resident was last seen safe at 1915 (7:15 p.m.) in his apartment. The incident report indicated the resident "stated to this writer the following morning that he had lost balance and when staff went to bear his weight, ones knee his his own (sic). Resident initially stated to this writer that he was never on the floor, stated to his daughter at a later time that he was on the floor. As reported by PCAs [ULP] resident had been transferring from toilet to wheelchair, his legs became week (sic) and gave out, in which PCAs [ULP] were able to get him to the edge of his wheelchair. When resident stood up, to position himself back farther, his legs gave out again. Unable to bear his weight, PCAs [ULP] lowered resident to the ground." The resident was given "Tylenol at 0207 (2:07 a.m.) for pain in right leg and feet rating ten out of ten." The incident report indicated the physician was not notified as	02320		

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02320	Continued From page 29 "at time of the accident, deviation in standard protocol occurred in that the direct caregivers did not notify an RN of the witnessed near miss." The RN was not notified until noon the following day. The resident's family was not immediately notified. The incident report further indicated the "standard is to notify an RN of all accidents/near miss lowered to floor." The facility's internal investigation included screenshots of text messages and written statements from employees involved with the incident. A text message between ULP-D and RN-H included the following response from ULP-D "I was getting [R1] off the toilet and into his wheelchair witness gate belt (sic) on me and another CNA [ULP-N] she was wiping him because he had a BM [bowel movement] and I told her she needed to go faster because his legs might give out. He started to pivot towards the wheelchair. And his legs gave out, we were trying to hold him up. He did not fall to the ground. When he first sat down in the wheelchair, he was on the edge. We had to lift him back up. So he could be scooted back and his legs gave out. We wind up (sic) letting him slide down to the floor I guess that's how he started complaining that his right knee was hurting. We, it took me and four other team members to get him off the floor. The floor I took his vitals (sic) gave them to [ULP-M] told her about his knee pain. And she said she would give the information to the RN. I even asked him if he wanted to go to the hospital before I put him into bed, he said no. Thank you." A written statement from ULP-M dated October 31, 2023, indicated ULP-D "came up to me and said [R1] fell. I said if he fell you need to do vitals on him...ULP-D's shift done at 9:00 p.m., I was in with [another resident] for a half hour. ULP-D	02320		

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02320	Continued From page 30 gave me the vitals on [R1]. I put it in my pocket. ULP-D kept telling me he didn't fall she caught him. I ask did he hit the floor, ULP-D said no. I told her I would get ahold of a RN. ULP-D left, everything went crazy. I'm behind on meds...ULP-N trying to keep up with [another ULP] they're both new, hardly any training. Earlier they're asking ULP-D and another ULP where is ULP-N and I don't know. Night shift started, laundry not done. Kitchen counters not wiped off. Rounds took long. Call lights going off...another light went off, it was [R1] he told me his right leg hurts. He wanted something for pain. I went to check what he had for pain med, Tylenol. I check his leg, got it comfortable on the pillow he said he hurts. I ask [R1] what happened he told me it's my fault not ULP-D and the staff. I said ok, also wanted Vick's rub on his leg, he said it's helping the pain. Rest of the night he didn't' ask for anything else for pain. He told me he wasn't going to the Y this morning, I said ok I'll let them know." A written statement from ULP-O dated October 30, 2023, indicated she was told by another ULP that R1 was on the floor and when she went in, three other ULP were with the resident. ULP-O wrote ULP-D was taking the resident's vitals and ULP-D said he had slid off the edge of his chair and "it wasn't a hard fall." ULP-D was "told to write a report by [another ULP], I was told by [ULP-M] not to write one because it wasn't a real fall, he slid off his chair." A written statement from ULP-N dated October 30, 2023, indicated she was transferring R1 with ULP-D and the resident got tired and wanted to sit down for a while. "A few seconds later, we helped him stand up again with the assistance of his gait belt. However, my coworker [ULP-D] who gave up holding his gait belt, thus all the pressure	02320		

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02320	Continued From page 31 turned on myself. But I still hold his gait belt without any loose (sic). My coworker [ULP-D] kept asking me letting him sit down on the floor. At last, I had to let him sit down because only myself holding him." R1's emergency room records from October 30, 2023, indicated the resident was diagnosed with acute fracture through the distal femoral metadiaphysis extending to the femoral component of the right knee (a type of fracture of the thigh/above the knee caused by high energy trauma like a fall from a height) which would require surgical repair. On December 26, 2023, at 4:05 p.m., CNS-A stated R1 used a specialized walker and had a specific way he would use the walker to get on the toilet. CNS-A stated R1 would line himself up onto non-skid strips placed on the floor and then he'd shut off his motorized scooter and put his stand up walker in front of him. CNS-A stated, "he's very rheumatoid arthritic, his hands, fingers, how he was able to do this I'm not even sure...the resident would do his own maneuvering and he'd have a transfer belt on and he'd grab the handles and put his arms on the arm supports and start to tip, then you'd take a hold of the belt to get him forward, then he'd inch to pivot until he got to the toilet and would ask if he's close enough to sit down." CNS-A stated given the complexity of the transfer and the specialized walker, she had care planned for two staff to always transfer the resident. CNS-A confirmed the facility's process was not followed and the RN should have been notified immediately after the resident was lowered to the floor and also notified when the resident reported severe pain. On December 28, 2023, at 1:45 p.m., family	02320		

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02320	Continued From page 32 member (FM)-K stated neither she nor her mother had been notified of any fall or any complaints of pain for R1. FM-K stated she came in around noon on October 30, 2023, because it was R1's birthday and he was having a party and she was surprised to see him still in bed as that was not normal for him. FM-K stated R1 reported he was having severe pain and there was an ice pack on his knee. FM-K stated she spoke to RN-H and they told her R1 needed to be sent to the emergency room. FM-K stated instead of immediately calling for an ambulance, RN-H went and administered a treatment to another resident for about 20 minutes. FM-K stated she was concerned on what would have happened if they didn't come in that day since there had not been an incident report created and neither the family nor the physician were updated. FM-K stated R1 used a specialized walker and she wasn't sure if ULP had been trained on how to use it with transferring the resident. On December 28, 2023, at 2:20 p.m., RN-H stated at the time the resident fell, she was working full time as the nurse manager and her primary responsibilities included being on call, onboarding new employees, supervising unlicensed personnel, and general day to day nursing tasks. RN-H stated the facility was very short staffed at the time and many of her hours were spent working the floor as a ULP. RN-H stated the agency staff member, ULP-D was not trained on how to transfer R1 with his specialized walker as she had only trained the permanent facility staff. RN-H stated, "I wasn't made aware I was their [the temporary agency ULP] direct supervisor it was my understanding it fell under [CNS-A] and when she expressed concerns [over training of the temporary agency ULP], the supervisor was changed to [LALD-B] because we	02320		

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02320	Continued From page 33 [RN-H and CNS-A] can only do so much when we get blocked by ownership [LALD-B and O-C]. I was told from [O-C] we just had to do an initial have someone at the facility give a walk thru to know the facility and [CNS-A] questioned that and [O-A] explained that agency training, they only need to get a quick understanding of the facility." RN-H stated she resigned her full time position shortly after the resident fell due to the workload of the position. RN-H stated she was not the nurse on call when the fall happened but she was working the floor as a ULP the next day, October 30, 2023, and came in around 8 or 9 in the morning. RN-H stated she was not updated by staff until around 11:00 a.m. when the ULP from that side reported the resident didn't want to get up and was rating his pain as ten out of ten. RN-H stated, "If he's saying it's ten out of ten, something's going on" as the resident usually did not like to report high pain levels. RN-H stated she called CNS-A to get some more information since there was not an incident report or any notes about why the resident was having such severe pain. RN-H stated while she was trying to figure out what happened, the resident's family came in about 3-40 minutes later and began asking questions. RN-H stated family agreed to send R1 to the emergency room and the resident was diagnosed with a fracture and did not return to the facility. RN-H stated she did not know why staff did not immediately report the fall on October 29, 2023, or why they didn't tell her when she came in the morning of October 30, 2023, other than the ULP working "usually won't notify me because she thinks I'm too young to be a nurse." The licensee's Resident Change in Condition or Need policy, dated June 26, 2023, indicated when changes in condition or need are identified, a	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30596	A. BUILDING: _____ B. WING _____	C 12/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN COURT CHATEAU	2495 SW 8TH STREET GRAND RAPIDS, MN 55744

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02320	Continued From page 34 Registered Nurse will initiate a change in condition assessment. The licensee's Availability of an RN for Staff policy, dated June 26, 2023, indicated registered nurses and/or therapists will be available to ULPs when delegated services are being provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one residents reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No plan of correction is required for this tag.	