Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL307456021M
Compliance #: HL307458700C

Date Concluded: November 18, 2024

Name, Address, and County of Licensee Investigated:
Lino Lakes Assisted Living
725 Town Center Parkway
Lino Lakes MN, 55014
Anoka County

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

Evaluator's Name: Kris Detsch, RN
Special Investigator

Finding: Substantiated, facility and 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):
The alleged perpetrator (AP), who was a nurse, neglected the resident when she failed to follow a physician's order to complete an X-ray after the resident fell and sustained injury. As a result, the resident's fractures went untreated for seven days.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility and the AP were responsible for the maltreatment. The AP, a registered nurse, failed to follow the physician's order to obtain an X-ray until five days after he gave the order. The AP failed to follow up on the resident's change in health status after a fall with injury, develop a plan of care, and instruct the unlicensed personnel (ULP) how to provide care to the resident with increased pain and inability to bear weight on her ankle. Multiple ULP observed the resident's injury but failed to consult with the AP or other facility nurses on direction to address the resident's swelling, bruising and pain in her right lower leg. The resident did not receive pain medication for seven days after the injury occurred. X-ray results revealed the resident had

tibial and fibular fractures (broken bones of the lower leg). She required hospitalization and surgical repair of her broken bones.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family members. The investigation included review of the resident records, hospital records, X-ray report, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed toured the facility and observed the staffing structure, documentation systems, and medication administration.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia and neuropathy (nerve damage). The resident's service plan included assistance with dressing, bathing, hygiene, toileting, and medication administration. The resident's nursing assessment indicated she had moderate cognitive (memory) impairment, and poor judgment. The resident required safety checks every two hours because she wandered in the common areas of the facility.

The resident's incident report indicated a staff member called a nurse manager to the resident's room because the resident fell. The report indicated the nurse manager observed the resident lying on her back, on the floor, in front of her bed. The report indicated the resident told the nurse manager her leg hurt. The report indicated there was bruising and a "bump" on the resident's inner right calf (lower leg), but she could move her leg and toes. The report indicated the nurse manager elevated the resident's leg and applied an ice pack to the injured area.

Progress notes lacked documentation from the nurse manager about the fall including further actions to direct ULP's to provide care. The resident's fall occurred early in the afternoon. There were no further progress notes completed until the following afternoon when the AP documented she observed the resident in bed with an ice pack on her ankle. The AP's documentation indicated the resident "jumped" when the AP touched her foot, and told her it was "very painful." The AP documented the resident's right foot was warm and replaced the ice pack. The AP documented she sent the resident's physician a message to inquire about obtaining an X-ray. Approximately three hours later the AP documented she communicated with the resident's physician over the message portal, and she told him the resident was not getting up (out of bed) because of the pain. The AP's documentation indicated she told the physician the resident refused Tylenol (pain medication), but she also said the resident did not ask for Tylenol. There were no further progress notes completed by the AP or ULPs the next day.

The physician communication portal notes indicated the note from the physician prior to the AP's last response indicated if the resident was unable to bear weight on her ankle, an X-ray could be done onsite. The portal notes indicated the AP's last message to the resident's physician and her last documented progress note of the day both was at 3:36 p.m. At 3:50 p.m., the physician responded with orders to X-ray the resident's right ankle due to pain and swelling.

Two days after receiving the physician's X-ray order, the AP documented in a progress note she received an order from the resident's physician to complete an X-ray of the resident's right ankle. The AP documented she would contact the portable X-ray company. The same day, a ULP wrote in a progress note the resident could not transfer and remained in bed because of her bruised ankle and pain.

The resident's record lacked any further documentation from staff regarding the resident's status.

On the sixth day after the resident fell, the resident's progress notes indicated the AP called in the morning to schedule an X-ray for the resident. The X-ray company completed the X-ray in the afternoon and the AP faxed the results to the resident's physician. The AP's documentation failed to identify what the results were, however indicated she advised ULP to keep pressure off the resident's foot/ankle, to elevate her leg, and offer her as needed (PRN) Tylenol. The AP's documentation indicated she added transfer assistance and safety checks to the resident's service plan. There were no further progress notes from the AP or ULPs until the following day.

The resident's medication administration record (MAR) indicated the resident did not receive any pain medication for six days after the fall and ankle injury occurred.

The resident's record lacked a change in condition assessment assessing the resident's injured right ankle, mobility changes, pain and identifying the resident's pain indicators due to cognitive deficits to reliably report pain.

The resident's service delivery records indicated prior to the fall, the resident had a service to monitor, and document pain every shift. The records indicated the only date ULP documented monitoring pain was the day the X-ray was ordered. The service records failed to include instructions on changes to transfer and elevating her right leg.

On the seventh day, the resident's progress notes indicated the resident's physician was at the facility to assess the resident and told the AP he had not received the X-ray results. The AP provided the results to him. The resident stayed in bed because of pain in her ankle and was unable to move or turn for staff to provide cares. The AP's documentation indicated the resident has been in bed for "days" and refused to move. The AP's documentation indicated the resident's physician told the AP to give the resident Tylenol.

The resident's MAR indicated the resident received Tylenol for the first time since her fall, on the seventh day in the afternoon. The ULP documented it was effective.

Later in the evening of the seventh day, the resident's progress notes indicated the director of nursing (DON) received a call from the resident's physician and he told her he received information from orthopedics (bone specialist) the resident required hospitalization for the

fractures of her leg. The DON's documentation indicated the resident went to the hospital late in the evening.

Hospital records indicated there was deformity of the resident's right lower leg and an X-ray at the hospital showed three parts of the ankle fractured and the talus bone (the bone that connects the ankle to the foot) was partially dislocated. The hospital record indicated the resident received surgical repair (open reduction internal fixation) of her ankle. She remained in the hospital for six days, then returned to the facility.

During investigative interviews, multiple ULP's indicated the resident's injury to her leg was noticeable and caused her pain. One ULP described the resident's right leg as being double in size with bruising around the ankle and up above the back of her calf. Multiple ULP's indicated the resident remained in bed because of the injury. Multiple ULP's acknowledged there was a nurse available (other than the AP) during the day, and after hours, but multiple ULP's failed to call them to further report the change in resident's status. Additionally, ULP's reported conflicting information regarding the resident's mobility status. The resident attended an activity (senior prom) two days after she fell which required her to be out of her bed and in her wheelchair. Because there were no instructions given to the ULP about how to transfer her, it was unclear how they got her out of bed, into her wheelchair. The resident did not have a Hoyer (mechanical lift) during this time, which would indicate the resident had to stand (on her broken bones) for the transfer into her wheelchair to have occurred. It was unclear how many times the ULP's attempted to get her out of bed, or how often they got her out of bed during the time she fell to when she went to the hospital.

During an interview, the nurse manager said she worked the day the resident fell, and she responded to the fall because the AP left for the day. The nurse manager said she discovered the injury to the resident's leg but described it at a "bump" the size of a golf ball. The bump was "black and blue", but the resident could move her ankle, so she applied ice and elevated her leg. The nurse manager said she filled out the incident report and sent it to the DON electronically. The nurse manger said she checked on the resident before she left the facility at the end of the day and told the ULP's to also check on her and call the "on-call" (after hours) nurse if there were any changes. The nurse manager said she checked on the resident the next morning and the "bump" was gone, so she told the AP about the incident. The nurse manager said she had no further conversations with the AP about the resident and did not see the resident thereafter. The nurse manger said she would have expected the ULP's to inform the on-call nurse about changes to the resident's condition. The nurse manager said any ULP could have called the on-call nurse. The nurse manager said she provided verbal instruction to the ULPs at the time of the resident's fall but did not document those instructions in the resident's clinical record. During the interview, the nurse manager reviewed the resident's MAR and confirmed its accuracy. The resident did not receive pain medication for seven days after the injury occurred. The nurse manager said this was sad.

During an interview, the director of nursing (DON) said the AP was the nurse responsible for the memory care residents. The DON said the AP reported the resident's fall to the resident's physician the following day and he gave the order for an X-ray. The AP electronically signed and acknowledged the physician's order, however, did not complete it. The DON said the AP did not complete the required nursing assessment and failed to direct ULP staff how to provide care for the resident. The DON said she removed the AP from providing direct resident care and required her to work alongside the nurse manager. The DON said the AP could not explain the error other than she was busy with facility meetings. The DON said, the facility meetings were only a couple of hours. The DON said she met with the AP and developed a performance improvement plan.

During an interview, the AP described the resident as very forgetful and quite confused. The AP said she was not at the facility when the resident fell but became aware of the resident's fall the following morning and checked on her. The AP said the resident told her she had pain in her right calf, but there were no visible injuries. The AP said she updated the physician and asked him for an X-ray, but he told her the resident did not need an X-ray and denied her request. The AP said the physician told her he would assess the resident at his next visit. The AP said the resident's leg swelled and reddened. She notified the resident's physician when this occurred, and he eventually sent the resident to the hospital. The AP said she gave verbal instruction to ULPs to give the resident Tylenol, elevate her leg, and not to stand her. The AP said she monitored the resident's MAR and believed the pain medications managed the resident's pain. The AP said she could not explain why there was a delay in obtaining the X-ray for the resident.

During an interview, a family member said she received notification the resident fell, but she was unaware the resident sustained injury. The family member said she received no further communication with the facility about the resident's health status until the day the resident went to the hospital. The family member said she received communication from the resident's physician (office) seven days after she fell. The family member said the physician's office told her the resident required urgent treatment because of her fractures. The family member said was concerned the facility let the resident suffer and wondered why the facility waited so long to obtain medical treatment.

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.

Mitigating Factors considered, Minnesota Statutes, section 626.557, Subd. 9c(f):

(1) The facility and the AP did not follow an erroneous order, direction or care plan with awareness and failure to take action.

The facility and the AP did not direct an erroneous order, direction, or care plan.

(2) The facility was not in compliance with regulatory standards.

The facility provided proper training and/or supervision of staff.

The facility provided adequate staffing levels.

The facility and the AP failed to follow the facility directive and/or policies and procedures.

(3) The facility and the AP failed to follow professional standards and/or exercise professional judgement.

The facility and the AP failed to act in good faith interest of the vulnerable adult.

The maltreatment was not a sudden or foreseen event.

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility provided supervision and re-education to the AP.

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
Anoka County Attorney
Lino Lakes City Attorney
Lino Lakes Police Department
MN Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30745	A. BUILDING: _____ B. WING _____	C 10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINO LAKES ASSISTED LIVING	725 TOWN CENTER PARKWAY LINO LAKES, MN 55014

(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: HL307458700C/HL307456021M On October 15, 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 76 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for HL307458700C/HL307456021M, tag identification 1960, 2310, and 2360.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
01960 SS=G	144G.72 Subd. 5 Documentation of administration of treatments	01960		

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01960	Continued From page 1 Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement a treatment order for an X-ray following a fall with injury for one of one residents (R1) reviewed. R1 had a fall with ankle injury and failed to have an X-ray five days after it was ordered. R1 had fractures in her ankle requiring hospitalization and 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, 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 admitted to licensee's memory care unit for diagnoses including dementia, depression, and neuropathy. R1's service plan dated October 16, 2024, indicated R1 required assistance with dressing, grooming, bathing, pain monitoring three times per day, and medication	01960		

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01960	Continued From page 2 administration. R1's progress notes dated September 10, 2024, indicated unlicensed personnel (ULP)-I discovered R1 fell during her safety check at 2:00 p.m. . R1's incident report dated September 10, 2024, at 3:00 p.m., indicated assistant director of nursing (ADON)-G responded to ULP request for assistance because R1 fell. The incident report indicated R1 was on the floor, in front of her bed, laying on her back. R1 said her leg hurt and ADON-G observed a "bump" on R1's right inner calf. ADON-G applied an ice pack to the area and elevated R1's leg. R1's progress notes dated September 11, 2024, at 12:02 p.m. indicated registered nurse (RN)-H met with R1. R1 was in bed with an ice pack on her right ankle. RN-H assessed R1's right calf, ankle, and foot. The notes indicated R1 "jumped" when RN-H touched the pad of her right foot and said it was "very" painful. RN-H noted R1's foot was warm and so was the ice pack, so RN-H placed a new ice pack. RN-H wrote a message via the message portal to R1's physician for an X-ray. At 3:36 p.m., RN-H documented she received a note from the physician and responded. Physician portal communication notes indicated on September 11, 2024, at 12:17 p.m., RN-H wrote to R1's physician R1 was in bed with an ice pack and touch to her foot was very painful. R1's left foot was cold and her right foot was warm. At 1:24 p.m., RN-H wrote another note to R1's physician, indicating R1 was in bed, RN-H was following up with her fall on September 10, 2024, her head hurt and she was nauseous. At 2:52	01960		

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01960	Continued From page 3 p.m., the physician's nurse responded with questions regarding the ankle inquiring if there was any bruising, was the injury due to a fall, was R1 able to bear weight on it, and if R1 received any as needed acetaminophen. At 3:36 p.m., RN-H responded indicating she provided ice for swelling and R1 reports it makes her ankle feel better. RN-H indicated R1 did not think the injury was from a fall, but was not sure. RN-H wrote she did not note any bruising this day, R1's foot and ankle hurt and she had not been getting up due to the pain. At 3:50 p.m., R1's physician responded indicating if R1 was not bearing weight on the right ankle, an X-ray can be done onsite and agreed with ice for comfort and acetaminophen as needed. Physician order via communication portal system dated, September 11, 2024, at 3:50 p.m., indicated the physician ordered the licensee to obtain an X-ray of R1's right ankle and right foot for diagnoses of pain, cognitive impairment, and swelling. R1's progress notes dated September 13, 2024, at 3:34 p.m., by RN-H, indicated she received an order from R1's physician to X-ray R1's ankle, apply ice and to use acetaminophen as needed. RN-H indicated she was going to contact the portable X-ray company. R1's progress notes dated September 16, 2024, at 8:56 a.m., by RN-H indicated she called the X-ray company to order an X-ray for R1. At 10:10 a.m., the X-ray company arrived to take the X-rays. At 2:00 p.m., RN-H documented she received the X-ray results, reviewed with the technician and then faxed the results to R1's physician.	01960		

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01960	Continued From page 4 R1's X-ray report dated September 16, 2024, at 1:52 p.m., indicated R1's right ankle had right tibial and fibular bone fractures. R1's progress note dated September 17, 2024, at 10:45 a.m., indicated R1's physician was at the facility and stated he did not receive the X-ray results. RN-H provided him a copy. The licensee failed to implement R1's X-ray order for five days after receiving the order and R1's physician was delayed receiving the results for an additional day. R1's progress notes dated September 17, 2024, at 7:27 p.m., by director of nursing (DON)-A indicated she receive a call from R1's physician because R1 needed to go to the emergency room (ER) for treatment of her tibia and fibula fractures. R1's hospital records dated September 17, 2024, indicated orthopedic (bone) specialist evaluated R1 when she went to the hospital. Orthopedic records indicated R1 sustained injury to her ankle a week prior and x-rays confirmed she had fractures. The notes indicated it was unclear if R1 was able to bear weight after the injury and staff at the licensee were concerned because R1 was unable to stand and pivot into her wheelchair due to pain. The notes indicated the physician could not perform a range of motion exam because it caused R1 pain. The notes indicated there was deformity of R1's right lower extremity. X-ray results indicated the fractures showed a broken ankle where the talus bone (the bone that connects the ankle to the foot) was partially dislocated, and three parts of the ankle were fractured. The notes indicated R1 required surgical repair.	01960		

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01960	Continued From page 5 On October 15, 2024, at 3:33 p.m., DON-A said it was RN-H's responsibility to manage care and services to memory care residents. DON-A said RN-H reported the fall to R1's physician the following day and he gave the order for an x-ray. RN-H electronically signed and acknowledged the physician's order, however, did not complete it. DON-A said RN-H could not explain the error other than she was busy with facility meetings. DON-A said, the facility meetings were only a couple of hours. DON-A said she met with RN-H and developed a performance improvement plan. TIME PERIOD OF CORRECTION: Seven (7) Days	01960		
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 staff provided basic first aid (rest, ice, elevation), ongoing monitoring of an injury, and pain management after a fall with injury for one of one resident (R1) with records reviewed. R1 did not receive intervention, or pain management until seven days after a post fall, right ankle injury occurred, although her leg was bruised and swollen. R1 had tibia and fibular (lower leg bones) fractures. At the time of hospitalization the fractures were unstable and required surgical repair.	02310		

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02310	Continued From page 6 This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The finding include: R1's admitted to licensee's memory care unit for diagnoses including dementia, depression, and neuropathy. R1's service plan dated October 16, 2024, indicated R1 required assistance with dressing, grooming, bathing, pain monitoring three times per day, and medication administration. R1's nursing assessment dated August 8, 2024, indicated R1 required one staff member to assist her with transferring. R1 could walk with assistance and required occasional help moving her wheelchair. R1 required medication management. R1 was disorientated to person, place, and time. R1 had early dementia with frontotemporal neurocognitive disorder. R1 had poor judgement and insight related to short term memory deficits. R1 required safety checks every two hours because she was confused. R1's medication administration record (MAR) dated August 2024, indicated R1 had an existing order for acetaminophen (pain medication) 1000 milligrams (mg) three times a day as needed. R1's progress notes dated September 10, 2024, indicated unlicensed personnel (ULP)-I	02310		

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	30745	A. BUILDING: _____ B. WING _____	C 10/15/2024

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LINO LAKES ASSISTED LIVING	725 TOWN CENTER PARKWAY LINO LAKES, MN 55014

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02310	Continued From page 7 discovered R1 fell during her safety check at 2:00 p.m. . R1's incident report dated September 10, 2024, at 3:00 p.m., indicated assistant director of nursing (ADON)-G responded to ULP request for assistance because R1 fell. The incident report indicated R1 was on the floor, in front of her bed, laying on her back. R1 said her leg hurt and ADON-G observed a "bump" on R1's right inner calf. ADON-G applied an ice pack to the area and elevated R1's leg. R1's progress notes dated September 11, 2024, at 12:02 p.m. indicated registered nurse (RN)-H met with R1. R1 was in bed with an ice pack on her right ankle. RN-H assessed R1's right calf, ankle, and foot. The notes indicated R1 "jumped" when RN-H touched the pad of her right foot and said it was "very" painful. RN-H noted R1's foot was warm and so was the ice pack, so RN-H placed a new ice pack. RN-H wrote a message via the message portal to R1's physician for an X-ray. At 3:36 p.m., RN-H documented she received a note from the physician and responded. RN-H told the physician R1's swelling was down, and the ice made her ankle feel better. R1 did not get out of bed due to the pain. RN-H reported to R1's physician R1 had not used acetaminophen and had not asked for any. The note further indicated RN-H was waiting for the physician to respond again. There were no progress notes/documentation from RN-H or ULPs until September 13, 2024, at 2:00 p.m. Physician order via communication portal system dated, September 11, 2024, at 3:50 p.m., indicated the physician ordered the licensee to obtain an X-ray of R1's right ankle and right foot for diagnoses of pain, cognitive impairment, and	02310		

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02310	Continued From page 8 swelling. R1's progress notes dated September 13, 2024, at 2:00 p.m., by ULP-C, indicated R1 remained in bed because of her "bruised" ankle. R1 had ankle pain, and she required incontinence care while she remained in bed. The note lacked indication of what was done for R1's pain. R1's progress notes dated September 13, 2024, at 3:34 p.m., by RN-H, indicated she received an order from R1's physician to X-ray R1's ankle, apply ice and to use acetaminophen as needed. R1's record lacked any further progress notes for three days. R1's progress notes dated September 16, 2024, at 8:56 a.m., by RN-H indicated she called the X-ray company to order an X-ray for R1. The notes further indicated RN-H reviewed the X-ray results with the X-ray technician and then faxed the results to R1's physician. The progress notes failed to identify what the results were but indicated RN-H instructed ULPs to keep pressure off R1's foot and elevate her leg on a pillow. The notes indicated RN-H told ULPs to offer R1 Tylenol. The notes indicated RN-H added transfer assistance and safety check services for R1. R1's X-ray report dated September 16, 2024, at 1:52 p.m., indicated R1's right ankle had right tibial and fibular bone fractures. R1's record lacked a change condition assessment assessing R1's injured right ankle, mobility, pain and identify R1's pain indicators due to cognitive deficits to reliably report pain and any other changes in needs related to R1's ankle injury.	02310		

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02310	Continued From page 9 R1's MAR dated September 2024, indicated R1 had no administrations of acetaminophen from the date of injury on September 10, 2024, through September 16, 2024. The MAR had no order to apply ice as directed by her physician. Service delivery records dated September 2024, indicated R1 had a service to record pain every shift pre-existing to her injury. The service record from R1's fall on September 10, 2024, through September 16, 2024, failed to include services or directive to apply ice or elevate her right leg. Additionally, ULP documented pain monitoring one time, on September 13, 2024. R1's progress notes dated September 17, 2024, at 10:45 a.m., by RN-H, indicated R1's physician told her he did not receive the X-ray results, so she gave them to him. R1's progress notes dated September 17, 2024, at 2:00 p.m., by ULP-C, indicated R1 was having ankle pain. R1's progress notes dated September 17, 2024, at 2:13 p.m., by RN-H, indicated R1 was unable to move or turn for ULPs to provide care. R1 remained in bed for several days and refused to move but was telling ULPs she had no pain. The notes indicated the physician ordered pain medications for R1 and requested R1 receive as needed acetaminophen, until the other medications arrived. The notes indicated RN-H told a ULP to give R1 acetaminophen, but R1 refused and said she had no pain. R1's progress notes dated September 17, 2024, at 3:06 p.m., by a ULP, indicated medication assistance follow up "was effective."	02310		

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02310	Continued From page 10 R1's MAR dated September 2024, on September 17, 2024, acetaminophen 1000 mg three times per day was scheduled to start at 3:00 p.m., ibuprofen 400 mg three times per day was scheduled to start at 6:00 p.m. The MAR indicated on September 17, 2024, at 2:06 p.m., R1 received acetaminophen, but did not receive ibuprofen due to no supply. R1's progress notes dated September 17, 2024, at 7:27 p.m., by director of nursing (DON)-A indicated she receive a call from R1's physician because R1 needed to go to the emergency room (ER) for treatment of her tibia and fibula fractures. R1's hospital records dated September 17, 2024, indicated orthopedic (bone) specialist evaluated R1 when she went to the hospital. Orthopedic records indicated R1 sustained injury to her ankle a week prior and x-rays confirmed she had fractures. The notes indicated it was unclear if R1 was able to bear weight after the injury and staff at the licensee were concerned because R1 was unable to stand and pivot into her wheelchair due to pain. The notes indicated the physician could not perform a range of motion exam because it caused R1 pain. The notes indicated there was deformity of R1's right lower extremity. X-ray results indicated the fractures showed a broken ankle where the talus bone (the bone that connects the ankle to the foot) was partially dislocated, and three parts of the ankle were fractured. The notes indicated R1 required surgical repair. On November 4, 2024, at 3:05 p.m., ULP-I said she worked with the resident the afternoon she fell. ULP-I said she did not receive instructions from the nurses regarding how often to apply ice	02310		

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02310	Continued From page 11 packs, or when to elevate R1's leg. ULP-I said she provided cares to R1 and R1 complained of pain when she moved her. ULP-I said she was unsure if R1 received pain medication. ULP-I said it was the medication passer responsibility to call the on-call nurse. On November 4, 2024, at 3:48 p.m., ULP-J said she worked with R1 two days after she fell. ULP-J said R1 remained in bed because she was in so much pain. ULP-J said the nurses said to keep her in bed and elevate her leg. ULP-J said it was her responsibility that day to administer medications to R1. ULP-J said she only saw R1 once in the morning because R1 only received morning medications. ULP-J said she did not receive instructions on the frequency or duration of applying ice to the resident's leg. ULP-J said she did not see R1 again until September 17, 2024. ULP-J said she was working in a different area outside of memory care and received a call from DON-A who told her to go to memory care and call 911 because R1 had three broken bones and needed to go to the hospital. ULP-J said she went to the memory care unit and observed R1's leg. ULP-J said R1's leg was "puffy", and her ankle was black and blue. ULP-J said emergency responders took R1 to the hospital. ULP-J said the licensee did not have a universal pain tool for assessing memory impaired resident's pain level. On October 15, 2024, at 3:33 p.m., DON-A said it was RN-H's responsibility to manage care and services to memory care residents. DON-A said RN-H reported the fall to R1's physician the following day and he gave the order for an x-ray. RN-H electronically signed and acknowledged the physician's order, however, did not complete it. DON-A said RN-H did not complete the required nursing assessment and failed to direct ULPs	02310		

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02310	Continued From page 12 how to provide care to R1. DON-A said she removed RN-H from providing direct resident care and required her to work alongside the nurse manager. DON-A said RN-H could not explain the error other than she was busy with facility meetings. DON-A said, the facility meetings were only a couple of hours. DON-A said she met with RN-H and developed a performance improvement plan. DON-A said it was RN-H's responsibility to add services to R1's plan of care including monitoring for swelling, range of motion, and verbal signs and symptoms of pain. Once the services are added, the ULPs could then observe what needed to be completed. DON-A said there were no instructions for ULP's to monitor pain, swelling or bruising and this was very concerning. On October 22, 2024, at 10:05 a.m., ULP-B said she worked with R1 after she fell and heard about the fall from other ULPs. ULP-B said she administer medications and observed her in bed. She did not observe R1's leg because that was not in her work description. She worked with R1 again and said she received no instructions how to move her. On October 22, 2024, at 10:36 a.m., ULP-C said she worked in memory care with R1 four days after R1 fell. ULP-C said she entered R1's room to complete a safety check and R1 told her she fell. ULP-C said she was unaware R1 fell until she entered R1's room. ULP-C said R1's ankle was black and blue, so she asked her if she went to the hospital and R1 told her she had not. ULP-C said R1 could not get out of bed, stand on her leg, or go to the bathroom, so she remained in bed. ULP-C said it bothered her R1 had not been in the hospital and felt it was neglectful. ULP-C said she could not find ice packs for R1. ULP-C said she told the ULP who administered	02310		

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02310	Continued From page 13 medication to give R1 pain medication. ULP-C said nobody instructed her to put pillows under R1's leg. ULP-C said she attempted to stand R1, however she could not get out of bed. ULP-C said she did not call an on-call nurse that day because she got side-tracked. ULP-C said she continued to work with R1 prior to her going to the hospital on September 17, 2024, and observed R1's leg to be worse. ULP-C said R1's facial expressions indicated the pain was bad. ULP-C said she told RN-H about R1's injury. ULP-C said RN-H told her to keep R1 in bed and do not get her up because they did not know if her leg was broken. On October 22, 2024, at 2:03 p.m., ULP-D said she provided care to R1 on and off during her employment at the licensee. ULP-D said R1's memory was not good and it was difficult for R1 to take medications because she did not always remember why she needed them. ULP-D said she worked with R1 after she fell and described her ankle as being discolored, bruising on her calf and "very swollen." ULP-D said R1's ankle was double in size, and the injury was noticeable. ULP-D said she noticed this injury when she went to get R1 up for the day. She was unaware R1 fell prior to entering her room. On October 23, 2024, at 10:21 a.m., ULP-E said when she worked with R1 she went into her room to give her medications and attempted to help R1 sit up in bed. R1 said her ankle hurt, so she looked at R1's ankle and saw it was bruised, but she did not notice any other injuries. ULP-E said she notified one of the facility nurses. ULP-E said she received no further instructions from the nurses on how to provide care to R1. On October 25, 2024, at 1:08 p.m., ADON-G said she worked the day R1 fell and responded to the	02310		

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02310	Continued From page 14 fall because RN-H left for the day. ADON-G said she discovered the injury to R1's leg and described it as a "bump" the side of a golf ball. The bump was black and blue, but R1 could move her ankle, so she applied ice and elevated her leg. ADON-G said she filled out an incident report and sent it to DON-A electronically. ADON-G said she checked R1 before she left that day and told ULPs to call the "on-call" nurse if there were changes. ADON-G said she saw R1 the next morning and the bump was gone so she told RN-H about the incident. ADON-G said she did not see R1 thereafter. ADON-G said any ULP could have called the on-call nurse. ADON-G said she gave verbal instructions to ULPs but did not document those instructions in R1's clinical record. ADON-G reviewed R1's MAR and confirmed its accuracy, R1 did not receive pain medication for seven days after the injury occurred. ADON-G said this was sad. On October 31, 2024, at 4:15 p.m., RN-H said R1 was very forgetful and quite confused. RN-H said she updated R1 physician the day after R1 fell and requested an X-ray but the physician denied the request and told her he would assess R1 at his next visit. RN-H said she gave verbal instruction to the ULP's to give R1 acetaminophen and to elevate R1's leg. RN-H said she could not explain why there was a delay in obtaining the X-ray. RN-H said she monitored the MAR and felt R1's pain was managed with pain medication. RN-H said she thought R1 had scheduled pain medication, but when MAR reviewed with the surveyor, RN-H said that would be her lack of follow up. Web MD article titled, RICE Method for Injuries, dated April 24, 2024, located at web address https://www.webmd.com/first-aid/rice-method-inju	02310		

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02310	Continued From page 15 ries, indicated basic first aide care to ankle injuries included the RICE method (rest, ice, compression, elevation). This method is used to reduce swelling, ease pain, and speed healing. Ice packs should be used for 15-20 minutes every 2 to 3 hours during the first 24-48 hours. The licensee's policy titled, When to Call the On-Call Nurse, dated 2023, indicated ULPs should call the on-call nurse any time they are unsure about a resident including pain or changes in health status. The licensee's policy titled, Resident Initial and On-going Assessments, dated June 19, 2023, indicated the licensee would assess the resident if there was a change in condition, review the resident's service plan, communicate any new problems to the resident's physician or health care providers, and updated the service plan based on the resident's needs. Time period for correction: 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. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH)	02360	No plan of correction is required for this tag.	

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02360	Continued From page 16 issued a determination maltreatment occurred, and the facility and an individual person were responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		