Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL315578362M
Compliance #: HL315575140C

Date Concluded: February 20, 2025

Name, Address, and County of Licensee Investigated:
Farmstead Care of Moorhead
3200 28th Street South
Moorhead, MN 56560
Clay County

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

Evaluator's Name:
Katherine Barnhardt 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 facility staff failed to implement cares and interventions to meet the resident's needs when the resident had multiple falls, experienced a significant weight loss, and developed a sacrum (tail bone) wound.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility's assessments did not accurately depict the resident's health care status and failed to provide unlicensed staff with interventions or directions to meet the resident's changing needs.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a hospice agency. The investigation included review of the resident record, death record, hospital records, pharmacy

records, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed facility staff provide direct cares.

The resident resided in an assisted living memory care unit. The resident's diagnoses included severe protein malnutrition and Alzheimer's dementia. The resident's service plan included assistance with medication administration, safety checks, fall interventions as needed, dressing, grooming, toileting, bathing, housekeeping, and laundry. The resident was on hospice care and was unable to answer questions due to altered mental status, required assistance of one for ambulation, utilized a wheeled walker, was independent with bed mobility, and was educated to wait for staff to assist with toileting transfers.

The resident's record indicated the resident had numerous falls and a significant weight loss while a resident at the facility. The resident's record included fall incident summaries, recorded weights and progress notes that indicated the facility's licensed staff had knowledge of the resident's changes in condition. Fall incident summaries indicated the resident had four falls within 48 hours during the six days prior to the resident death and weight reports indicated the resident had a 35 lb. weight loss over the last six months the resident resided at the facility. The resident's record indicated licensed staff completed three comprehensive reassessments during the last month the resident resided at the facility and all three inaccurately depicted the health status of the resident at the time the reassessments were completed.

The resident's third and last assessment completed two days prior to the resident's death, indicated the resident required one staff to assist with ambulation, transfers, toileting and the resident was independent with bed mobility, however, at the time the third reassessment was completed the resident was bed bound, non-verbal and non-ambulatory. The resident's assessments lacked interventions or directions for unlicensed personnel to assist the resident with fall prevention, repositioning, or nutritional monitoring leading up to, during, and following the resident's changing needs.

The resident's progress notes indicated four falls occurred during the last six days prior to the resident death. Progress notes indicated the resident was found by family on the floor, however, did not include information the resident was found by family laying on the floor with a blanket over him, a slipper under his head and was extremely cold. The progress note did not include what unlicensed staff reported to family and a social worker, that they had no idea how long the resident had been on the floor. Progress notes indicated the resident was too cold to obtain an accurate oxygen saturation level by unlicensed staff when found by family.

The resident's clinic provider record indicated the resident was seen by his provider two and a half weeks prior to his hospice admission and the provider noted a 35 lb. weight loss. The provider ordered the resident to have good size lunches with a nutritional supplement drink daily. The facility added the supplemental nutrition drink to the resident's electronic medication record (EMAR) once daily, however, failed to assess and implement any meal assistance

services or provide unlicensed staff with meal support interventions and the resident was hospitalized 17 days later.

Hospital records indicated the resident was hospitalized for two days with bloody vomiting, was treated with fluid resuscitation and the resident stabilized. Hospital records indicated medications were suspected to have caused the complication and medication adjustments were made. The hospital discharged the resident back to the facility in stable condition with recommendations for physical and occupational therapy and hospice support. The resident admitted to hospice the day after returning from the hospital.

Hospice records indicated the resident admitted for severe protein calorie malnutrition. Hospice records indicated the resident was declining foods, however, would eat select favorites when offered. Hospice records indicated hospice staff would effectively collaborate with facility staff to promote individualized, safe and effective care after each visit. Hospice records indicated caregivers (facility staff) were educated on fall prevention strategies and encouraged to implement practices to reduce the resident's fall risk and interventions to prevent skin breakdown. Hospice records indicated hospice staff assessed the resident after falls, at each visit and made attempts to collaborate with facility licensed staff, however, were unable to complete collaboration at times due to unavailability of facility licensed staff.

The resident's death record indicated the cause of death was severe protein calorie malnutrition and Alzheimer dementia.

During an interview facility licensed staff stated there was a second licensed staff overseeing the resident during the last month the resident resided at the facility. Licensed staff stated she was new to the role and found there had not been enough follow up assessments following falls in the past. Facility licensed staff stated fall interventions were implemented based on resident need and stated it was possible the facility could have done more but felt the facility did its part and notified hospice each time the resident fell. Facility licensed staff stated hospice assessed the resident at the facility after each fall, but hospice had not made recommendations or initiated new orders to prevent the resident's falls and licensed staff felt hospice would instruct facility staff to make changes if it was needed. Facility licensed staff stated the facility licensed staff did not assess the resident after each fall or review the resident's 35 lb. weight loss because hospital discharge paperwork indicated those were expected changes for the resident, even though the resident's significant weight loss occurred over a six-month period prior to the hospice admission. Facility licensed staff stated an expected event would not be considered a change in condition and the licensee did not monitor the resident's weight loss because the licensee was not given orders to monitor or track eating, drinking or weight loss. Additionally, facility licensed staff were unaware the resident had an open wound and "couldn't speak to why it wasn't addressed".

During an interview a family member stated communication with facility licensed staff was difficult and communication occurred only when the resident fell. A family member stated the

resident had falls in his past however, the last month of the resident's life, seemed "excessive", and the family noticed bruises on the resident's head and arms. A family member stated the family was concerned that the facility's licensed staff had not attempted to implement interventions to prevent the falls. A family member stated the family found the resident on the floor on two occasions during the week prior to the resident's death and one incident when family found the resident, the resident was on the floor, cold, and uncomfortable, "his hands were freezing" with a blanket over him, a slipper under his head as a pillow and "he was there a long time". A family member phoned the hospice agency to request the resident be assessed and the resident be transferred out of the facility due to safety concerns. Family collaborated with the hospice agency to find new placement, however, due to the holidays and the resident's rapid decline a transfer at the time was not possible so a family member stayed with the resident to assure the resident's safety. A family member stated they were unaware the resident had not been eating and at one point asked the unlicensed staff how long it had been going on that the resident had not been eating. The family member stated the facility's staff had not implemented interventions to address the resident's falls or weight loss and was unsure if facility staff had done anything about the resident's wound.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.
Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: No. Resident deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
Facility caregivers assisted the resident with assigned tasks and notified on-call triage nurses of falls after hours.

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
Clay County Attorney
Moorhead City Attorney
Moorhead Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31557	A. BUILDING: _____ B. WING _____	C 02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FARMSTEAD CARE OF MOORHEAD LP	3200 28TH STREET SOUTH MOORHEAD, MN 56560

(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: #HL315578362M/#HL315575140C On February 11, 2025, 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 82 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL315578362M/#HL315575140C, tag identification 1620.	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.	
01620 SS=G	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring	01620		

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01620	Continued From page 1 (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to complete an accurate comprehensive reassessment by a registered nurse (RN) for one of one resident (R1) with a change of condition, including addition of interventions as needed for falls, significant weight loss and a wound. 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	01620		

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01620	Continued From page 2 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 severe protein malnutrition and Alzheimer's dementia. R1's Service Plan dated September 9, 2024, indicated R1 received services to include: medication administration, safety checks, fall interventions as needed, dressing, grooming, toileting, bathing, housekeeping, and laundry. R1 lacked an updated service plan to include transfers and repositioning. FALLS R1's Incident Summary dated October 31, 2024, through December 31, 2024, indicated R1 had falls on December 10, 16, 23, 25, 2024, and two falls on December 24, 2024. R1's progress note dated December 7, 2024, written by clinical nurse supervisor (CNS)-A at 8:25 p.m., indicated R1 returned from a hospitalization at baseline with no changes to assessment. However, R1's hospital discharge orders included medication changes, physical therapy, occupational therapy, and a recommendation for hospice. R1's clinical monitoring and reassessment dated December 7, 2024, noted "hospital return no changes to services" and indicated the following: - full help with bathing; - full help with dressing; - some help with grooming;	01620		

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01620	Continued From page 3 - utilized wheeled walker; - independent with bed mobility; - needs assistance with transferring; - independent with toileting; - code status: CPR and DNR; - needs help reducing fall risk; actions taken : escort to and from meals, walk with to assist with fall reduction (not implemented on services or delegated to ULP's); - evaluate and treat physical therapy; - evaluate and treat occupational therapy; - possible hospice; - current review of medications completed; - needs assistance with glucose checks (R1 did not require or receive glucose checks); - decreased strength/endurance; - needs cues and directions; - history of anxiety; - balance problem while walking; and - review of health history and current health condition completed and electronically signed by CNS-A. R1 admitted to hospice on December 8, 2024. R1's 90-day clinical assessment dated December 12, 2024, indicated the following: - full help with bathing; - full help with dressing; - full help with grooming; - assist of one with gait belt and wheeled walker; - independent with bed mobility; - assist of one with gait belt and walker with transferring; - assist of one every four hours with toileting and as needed; - code status: CPR and DNR; - needs help reducing fall risk (no interventions provided for ULP's); - hospice;	01620		

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01620	Continued From page 4 - current review of medications completed; - assistance with glucose checks (R1 did not require or receive glucose checks); - decreased strength/endurance; - needs cues and directions; - history of anxiety; - balance problem while walking; and - review of current health condition, medication and non-medication interventions completed and electronically signed by a RN. R1's physician orders dated December 9, 2024, included an order for lorazepam 0.5 milligrams (mg) by mouth every four hours as needed (PRN) for anxiety to start on December 11, 2024. R1's electronic medication record (EMAR) dated December 2024, included lorazepam 0.5 mg available by mouth every four hours as needed for anxiety to start on December 11, 2024, and scheduled every six hours starting on December 27, 2024. R1's EMAR indicated the anti-anxiety medication was not offered or administered between December 11, 2024, through December 27, 2024, to alleviate R1's anxiety or restlessness in an attempt to reduce falls. R1's hospice progress note dated December 8, 2024, at 3:53 p.m., indicated R1 was too weak to ambulate with a four-wheel walker, utilized a wheelchair, had communication barriers and cognitive limitations. R1's hospice progress note dated December 9, 2024, at 1:53 p.m., indicated R1 repeatedly requested assistance lowering recliner "only to put up his feet immediately". R1's progress note dated December 9, 2024, at 10:54 p.m., indicated R1 was found on the floor in	01620		

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01620	Continued From page 5 front of his bed with a fever of 102.7 Fahrenheit (F). Staff reported to triage R1 had been "refusing medications lately" and staff were directed to attempt administration of PRN acetaminophen to R1. Staff were directed to observe for pain or injury and hospice was notified. Family was notified and family "tightened the recliner" preventing it from spinning. R1's hospice progress note dated December 11, 2024, at 2:05 p.m., indicated R1 would be able to verbalize techniques to decrease anxiety levels even though R1 had been combative and refusing cares. Additionally, the hospice progress note indicated hospice had spoken with facility unlicensed personnel (ULP) and the ULP stated R1 was non-compliant with care. R1's hospice progress note dated December 13, 2024, at 1:40 p.m., indicated R1 was "frustrated with his recliner and not being able to get his feet down". R1's progress note dated December 16, 2024, at 2:21 p.m., indicated R1 had a "near miss" and was observed sitting on the foot of his recliner. R1's progress note dated December 20, 2024, at 6:37 p.m., indicated ULP's phoned triage to report a kitchen staff found R1 on the floor and notified caregivers. R1 indicated he had hit his head, pointed to "upper right side of head" and ULP's noted a slight redness present. R1 reported head and right elbow pain a 6 out of 10 on the pain rating scale. Triage directed two ULP's with a gait belt to assist R1 up and phone triage back if any changes. Vital signs obtained. R1's progress note dated December 21, 2024, at 4:33 p.m., indicated cause of fall "resident sliding	01620		

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01620	Continued From page 6 off his recliner" family providing non-slip grip pads for recliner. R1's hospice progress note dated December 23, 2024, at 3:07 p.m., indicated R1 had "another fall since last visit", tried to get up from recliner and was impulsive. R1's hospice progress note dated December 24, 2024, at 2:00 p.m., indicated hospice would arrange a care conference with facility to "go over concerns". R1's progress note dated December 25, 2024, at 10:02 a.m., indicated incident follow up "updated hospice nurse on 12/23/24 of fall". R1's progress note dated December 25, 2024, at 10:58 a.m., indicated incident follow up " power of attorney (family) and hospice updated of fall". R1's progress note dated December 25, 2024, at 11:04 a.m., incident follow up "increase toileting to every 2 hours, service plan updated". (Service plan dated September 9, 2024, lacked inclusion of toileting every two hours) R1's progress note dated December 25, 2024, at 3:17 p.m., indicated ULP's found resident lying on the floor in his living room. ULP's reported walker and wheelchair out of reach. R1 complained of pain to his bottom. No evidence of head strike, oxygen saturation 83%. ULP's instructed by triage nurse to recheck oxygen saturation and to update the triage nurse with new reading and to get R1 up off floor. Family present. Hospice updated.. R1's progress note dated December 25, 2024, at 3:42 p.m., indicated oxygen saturation 75%, poor circulation in hands. ULP's warmed hands,	01620		

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01620	Continued From page 7 fingers still cold. ULP's report hospice RN to make assessment visit. R1's hospice progress note dated December 25, 2024, at 7:23 p.m., indicated ULP's requested a hospice nurse visit, however, when the hospice RN arrived at the facility the hospice RN was unable to locate facility licensed staff to check in with. Family reported to the hospice RN that R1 had several falls over the previous couple days and the hospice RN completed an assessment. Progress notes indicated the hospice RN indicated multiple bruises in various stages of healing throughout his upper and lower extremities and family reported bruises were from multiple falls. The hospice RN wrote she spoke with facility dietary staff that reported R1 laying on his right side on the floor with a blanket over him and a slipper under his head for a pillow. The hospice RN and family members collaborated on a plan to assure R1's safety and a family member remained overnight with R1. The hospice RN updated a facility ULP of the plan. R1's progress note dated December 26, 2024, at 3:33 p.m., indicated R1 experienced three falls in two days, two on December 24th and one on December 25, 2024.. The progress note indicated the falls were caused by R1 sliding off a recliner, however, the falls were unwitnessed. A hospital bed was ordered. Additionally, R1's toileting schedule adjusted to every two hours instead of every four hours and two staff for transfers. (Service plan dated September 9, 2024, lacked inclusion of two staff transfers or every two hour toileting). R1's progress note dated December 27, 2024, at 4:01 p.m., indicated a hospice RN visited and wrote new orders to include; reposition every 2	01620		

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01620	Continued From page 8 hours, R1 may stay in bed per family request and eat if alert. Service plan updated. (Service plan dated September 9, 2024, lacked inclusion of repositioning) R1's progress note dated December 27, 2024, at 7:51 p.m., indicated a change of condition assessment was completed. R1's clinical monitoring and change in condition reassessment dated December 27, 2024, indicated the following: - assist of one for showers; - on hospice, unable to answer questions at this time due to altered mental status; - assist of one with gait belt and walker for ambulation; - utilizes wheeled walker; - independent with bed mobility; - assist of one with gait belt for transfers; - assist of one with transfers for toileting; - refuses meals often; (no interventions for ULP's) - weight loss of 18.7 lbs.; (R1 had a cumulative weight loss of 35 lbs since September 2024) - unable to activate emergency call system, safety checks every two hours; - fall risk actions: proper footwear with ambulation and education provided to wait for staff to assist with bathroom transfers; (R1 was bed bound, non-verbal and non-ambulatory) - code status: CPR and DNR; and - review of current health condition, medication and non-medication interventions completed and electronically signed by an RN. R1 was bed bound, non-verbal and non-ambulatory on December 27, 2024, at the time the reassessment was completed. R1's assessments dated December 7, 2024,	01620		

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(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
01620	Continued From page 9 December 12, 2024, and December 27, 2024, respectively, lacked accuracy and provided conflicting instructions for ULP's who provided cares and services for R1. WEIGHT LOSS/WOUND R1's Weight report dated January 12, 2024, through December 30, 2024, indicated a 35 lb. weight loss and documented weights as follows: - June 6, 2024 - 170.8 lbs. - August 1, 2024 - 165.8 lbs. - September 12, 2024 - 154.5 lbs. - December 12, 2024 - 135.8 lbs. R1's clinical monitoring and reassessment dated December 7, 2024, noted "hospital return no changes to services" and indicated the following: - possible hospice; - nutrition status: good; -hydration status: good; -weight gain/loss: 13.2 lbs. in two months; (no implementation of new services or interventions for ULP's to encourage or monitor intake); - escort to and from meals (not implemented on services or delegated to ULP's); - needs assistance with glucose checks (R1 did not require or receive glucose checks); - decreased strength/endurance; - needs cues and directions; and - review of health history and current health condition completed and electronically signed by CNS-A. R1's 90-day clinical update assessment dated December 12, 2024, indicated the following: - hospice; - nutrition status: refuses meals often (no interventions for ULP's to encourage intake); - hydration status: good;	01620		

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	31557	A. BUILDING: _____ B. WING _____	C 02/11/2025

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01620	Continued From page 10 - no risk for dehydration- drinks independently in room; - weight gain/loss: 18.7 lbs; (no interventions or direction for ULP's to encourage fluids or nutrition); - escort to and from meals (not implemented on services or delegated to ULP's); - needs assistance with glucose checks (R1 did not require or receive glucose checks); - review of current health condition, medication and non-medication interventions completed and electronically signed by an RN. R1's clinical monitoring and change in condition reassessment dated December 27, 2024, indicated the following: - on hospice, unable to answer questions at this time due to altered mental status; - independent with bed mobility; (R1 bed bound in hospital bed and required staff assist to reposition every two hours); - refuses meals often (no interventions or direction for ULP's to encourage fluids or nutrition); - hydration status good; - weight loss of 18.7 lbs.; (accumulated weight loss 35 lbs. as of December 12, 2024) - code status: CPR and DNR; - skin - wound assessment, no wound present (hospice progress notes indicated sacrum (lower back) wound covered with Mepilex or foam dressing); and - review of current health condition, medication and non-medication interventions completed and electronically signed by an RN. R1's clinical monitoring and change in condition reassessment dated December 27, 2024, lacked information or an assessment of R1's sacrum wound.	01620		

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01620	Continued From page 11 R1's clinic after visit summary (AVS) dated November 18, 2024, indicated R1's blood pressure reducing medication was stopped by the physician due to a weight loss of 35 lbs. R1's physician ordered for R1 to have a "good size lunch" and a liquid nutritional supplement daily. R1's hospice progress note dated December 8, 2024, at 3:53 p.m., indicated a facility licensed staff was not available over the weekend, however, a hospice RN contacted an on-call nurse to inform licensee R1 was admitted to hospice. The on-call nurse was unable to change the resident's resuscitation status at the time. Progress note indicated R1's primary diagnosis severe protein malnutrition with Alzheimer's and dementia. Progress note indicated no licensed staff available at the facility to get full plan of care made or review medication list with. R1's hospice progress note dated December 11, 2024, at 2:05 p.m., indicated R1 was no longer wanting to eat and had lost 40 lbs in last six months. R1's hospice progress note dated December 13, 2024, at 1:30 p.m., indicated R1 reported "he only wants to eat venison or potato pancakes". R1's hospice progress note dated December 16, 2024, indicated R1 was not eating, however, had ice cream while hospice present. R1's hospice progress note dated December 27, 2024, at 1:37 p.m., indicated R1 had pain and was uncomfortable with a malodorous (unpleasant smelling) wound on the sacrum, shifting weight often. "Writer would anticipate this wound is causing some discomfort, new orders	01620		

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01620	Continued From page 12 for scheduled morphine". The hospice RN noted R1's spouse stated R1 had not "eaten" since Thanksgiving other than a "bite or two here and there" and ice cream. R1's hospice progress note dated December 28, 2024, at 12:13 p.m., indicated the hospice RN assessed R1's wound on his sacrum. The wound was odorous with minimal drainage noted to sacral Mepilex (foam dressing). R1's Documentation of Death record indicated R1 died on December 29, 2024, with the cause of death listed as severe protein calorie malnutrition and Alzheimer's dementia. On February 6, 2025, at 3:30 p.m., a family member (FM)-D stated licensed staff communication occurred only when R1 fell and it was "hard to find people". FM-D stated the family participated in providing cares because R1 had fallen prior but R1 had "lots of falls" in December that seemed excessive. FM-D stated the family could not understand why the licensee was not increasing safety checks or implementing interventions to prevent falls. FM-D stated on two occasions it was the family that found R1 on the floor and on December 25, 2024, the family found R1 laying on the floor with a blanket over him and a slipper under his head for a pillow. FM-D stated R1 was uncomfortable, cold and his hands were freezing, "he was there a long time". FM-D stated ULP's told FM-D that R1 hadn't been eating and was refusing medications and FM-D asked how long that had been going on. FM-D stated a hospice RN came to the facility to assess R1 at the family's request and could not get an oxygen saturation reading due to R1's cold hands. On February 13, 2025, at 11:01 a.m., clinical	01620		

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01620	Continued From page 13 nurse supervisor (CNS)-A stated there was another licensed staff in the CNS role during the month of December 2024. CNS-A stated the licensee found there was not enough follow up for falls in the past and changes had been implemented since she took the position. CNS-A stated fall interventions are implemented based on resident need and evaluated for effectiveness now. CNS-A stated the licensee could have done more, even though hospice was notified of R1's falls. CNS-A stated hospice assessed R1 at the facility after each fall but did not make recommendations for changes or initiate new orders to prevent R1's falls. CNS-A stated the licensee would not assess after each fall or with R1's 35 lb. weight loss because the hospital discharge paperwork on December 7, 2024, indicated those were changes to expect. CNS-A stated it would not be a change in condition when it occurred if it was expected and the licensee did not monitor R1's weight loss because the licensee did not receive orders to monitor or track R1's eating, drinking or weight loss. Additionally, CNS-A was unaware R1 had an open wound and "couldn't speak to why it wasn't addressed". On February 18, 2025, at 3:00 p.m., RN-H stated she had attended a care conference with the family and licensed facility staff to review "care concerns". RN-H stated the family had expressed concern for lack of the facility's response to falls and family had found R1 on the floor twice when visiting in the last few days. RN-H stated R1 displayed restless behavior and likely had discomfort and pain due to his sacrum wound. RN-H stated R1 nodded yes when asked about pain, however RN-H was unsure if medications ordered for R1's restlessness and comfort had been administered.	01620		

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01620	Continued From page 14 Licensee's Initial Reviews, Assessments, and Monitoring policy updated May 2, 2024, indicated topics listed in the Uniform Assessment tool must be assessed by an RN and a resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01620		
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 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		