DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL336019925M
Compliance #: HL336018044C

Date Concluded: May 21, 2024
Date Revised: July 10, 2025

Name, Address, and County of Licensee Investigated:
D & D's Caring Hearts
1426 Pamela Ct. NW
Bemidji, MN 56601
Beltrami County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:
Jana Wegener, RN, Special Investigator
Reconsideration Analyst: Jacci Nickell

Finding: ~~Substantiated, facility and individual responsibility~~ Not Substantiated

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

Initial Investigation Allegation(s):
The resident was neglected when the facility and alleged perpetrator (AP) failed to provide appropriate care, services, and supervision with falls. The resident fell and sustained serious injuries. Then, the AP, a nurse, failed to thoroughly assess the resident for injuries causing a delay in treatment and unnecessary pain and suffering. The resident required surgical repair and hospitalization for her injuries.

Investigative Findings and Conclusion:
~~The Minnesota Department of Health determined neglect was substantiated. The facility and AP were responsible for the maltreatment. The facility failed to ensure staff had clear direction to assist the resident with ambulation.~~ While ambulating unassisted, the resident fell sustaining a hip fracture and open elbow fracture (a fracture where the end of a broken bone breaks through the skin). ~~The AP was responsible for neglect when she failed to thoroughly assess the~~

~~resident for injuries after the fall occurred and failed to promptly call 911 despite the resident being unable to bear weight and reporting pain.~~

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member. The investigation included review of the resident record(s), hospital records, emergency medical service (EMS) reports, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed resident's and staff in the facility.

The resident resided in an assisted living facility with diagnoses including anxiety, and Alzheimer's Disease.

The resident's 90-day assessment indicated the resident was severely cognitively impaired and had difficulty communicating. The assessment identified the resident was at a risk for falls, and occasionally unsteady on her feet related to dizziness. The assessment indicated the resident was able to walk, wandered, and required supervision and stand by assistance from 1 staff with ambulation as needed.

The residents individual abuse prevention plan (IAPP) identified the resident was at a risk to be abused related to cognitive impairment, was unable to provide care for herself, make reasonable or informed decisions, recognize health and safety needs, and unable to protect herself adequately against neglect or abuse. The IAPP indicated staff were to immediately report any concerns of abuse or neglect.

The facility failed to ensure the resident's care plan clearly instructed staff on the level of assistance the resident needed with transfers and ambulation for falls prevention as indicated on the resident's service plan. The resident's care plan updated by the AP the day of the incident indicated staff should provide supervision to ensure safety with transfers related to unsteadiness and occasional dizziness. The care plan had unclear direction to staff indicating they were to observe and supervise the resident during transfers and ambulation and assist the resident as needed, but also included fall risk interventions which indicated the resident required 1 staff assistance with ambulation using a walker.

The resident's services/service plan indicated the resident required 1 staff assistance with mobility and ambulation.

The resident's services check list included a list of services the resident was provided with instructions for staff. The services fall risk interventions indicated staff provided 1 staff assistance using her walker for mobility.

The facility incident report documented by an unlicensed staff person (ULP) witness indicated the resident was in the living room while the ULP was in the kitchen. The resident stood up to walk to the table for lunch without staff assistance, lost her balance, and fell. The incident report indicated the resident was not using her walker or staff assistance at the time of the incident. The ULP documented the resident hit her head, and complained of pain in her shoulder, hip, leg, and elbow. The incident report indicated when the resident fell staff went to get the AP from her office. The incident report indicated the AP completed a body assessment for injuries, and all were with in normal limits. The incident report indicated the AP called the resident's family member at 11:56 a.m. who instructed the AP to call an ambulance to have the resident brought in to be checked.

A progress note indicated the AP documented the resident got up from the couch to go to the table for lunch when she lost her balance, fell backwards to her right side, and hit her head on the wall. The AP documented the resident was laying on the floor, flat on her back, with a small pillow under her head. The AP documented the resident denied pain in her head, and the AP felt the resident's skull for lumps, and completed neuro checks. The AP documented the resident was able to gently squeeze the AP's hands and move her arms. The AP indicated the resident's pelvis was equal and slightly painful on her right side. The AP documented assisting the resident to the couch with pain on her right side noted. The note indicated the AP expected the resident to have pain, and Tylenol was given. Another progress note indicated leadership staff documented the resident's family member reported concerns with the resident's fall incident, and the AP's failure to adequately assess the resident for injuries after the fall occurred, prior to moving the resident.

The resident's medication administration record (MAR) indicated Tylenol was administered to the resident post fall for head pain at 11:36 a.m. The incident report, AP progress note, interviews, indicated the resident fell and was assisted off the floor by the AP prior to the documented Tylenol administration time.

The residents outside medical record indicated the AP called 911 at 12:11 p.m. (approximately 40 minutes after the incident occurred). The EMS run report indicated the AP called the ambulance for a resident who had fallen and was "unable to bear weight". The report indicated when EMS arrived on scene the resident was seated on the couch reporting pain. The EMS report indicated the resident had traumatic injuries of her right upper extremity with deformities, pain, swelling, and bleeding noted from the resident's right elbow.

The resident's emergency and hospital record indicated the resident had a displaced open fracture of her elbow, and mildly displaced fracture of her right hip. The record indicated the resident required surgical repair of her injuries which included debridement and antibiotics for the open fracture of her right elbow. The resident was discharged to a rehab facility 9 days later.

A review of photographs of the resident's injuries after the incident occurred showed a large open bleeding laceration extending the length of the resident's elbow with extensive swelling and deformity noted.

When interviewed family member(s) stated the resident had obvious deformities of her hip and arm after her fall occurred with bone sticking out of her elbow and blood dripping from the wound. The family members stated an unlicensed staff person (ULP) witness reported she instructed the resident to get up and come to the table for lunch, the resident got up unassisted and fell. The ULP reported the AP had the resident squeeze her fingers, then picked the resident up alone and moved her to the couch without assessing the resident for injuries. The family indicated when the AP called reporting the fall the AP was instructed to call the ambulance. The family stated a reasonable person would know not to move the resident and call 911 immediately, but the AP who was a registered nurse neglected the resident when she failed to do so. The family members stated the resident was no longer able to walk and had ongoing pain as a result of the incident. The family indicated they expressed concerns to the facility with the AP's lack of assessment and delay in treatment after the incident occurred.

When interviewed leadership staff stated although the resident was cognitively impaired and would get up independently at times, the resident required 1 staff assistance with ambulation at all times. Leadership staff stated it would be unusual for the resident to report pain or be unable to bear weight. Leadership staff stated after the incident occurred the family expressed concerns of neglect and reported the AP failed to assess the resident for injuries. Leadership staff stated despite the family reporting concerns the AP had neglected the resident they did not investigate or report the incident.

When interviewed the ULP witness at the time the incident occurred stated the resident's care plan directed staff to provide assistance with ambulation only if the resident was noted to be unsteady or dizzy. The ULP stated the day the incident occurred the resident stood up, appeared wobbly, but fell before the ULP could get to the resident. The ULP stated the resident hit her head on the wall hard enough to dent the wall, was moaning in pain, dazed, and not responding normally. The ULP stated she knew something was seriously wrong and did not want to move the resident. The ULP stated the AP was onsite, so she placed a pillow behind the resident's head and went outside to the garage to get the AP for help. The ULP stated "the AP supposedly checked the resident for injuries", then picked the resident up alone by grabbing the resident under her arms using a bear hug and put the resident on the couch approximately 2 feet away. The ULP stated the resident was unable to get up on her own, unable to participate in the AP's transfer, and unable to bear any weight when the AP moved the resident. The ULP stated she did not observe the AP complete neuro checks or assess the resident for injuries. The ULP stated the AP left the resident seated on the couch and returned to her office outside in the garage. The ULP stated 5-10 minutes later she gave the resident Tylenol and brought the resident lunch while she was seated on the couch. The ULP stated the resident was unable to move or lift her right arm and complained of pain. The ULP stated she

again went out and told the AP who then looked at the resident “more carefully” and noticed a bump on the resident’s arm. The ULP stated the resident had a major fall with obvious injuries, should not have been moved, and 911 should have been called immediately, but the AP was the nurse in charge, and she left what to do up for the AP’s judgment.

When interviewed another ULP stated the resident was cognitively impaired, unsteady, and required assistance from one staff with ambulation using a transfer belt and walker at all times. The ULP stated it would be unusual for the resident to report pain or be unable to bear weight.

When interviewed the AP stated she assessed the resident for injuries after the fall occurred with no abnormalities noted. The AP stated when she lifted the resident off the floor, the resident favored her right side, but she expected the resident to have pain because the resident had just fallen. Although documentation and interviews indicated the resident had pain after the incident occurred and when EMS arrived on scene. The AP denied the resident had any expression of pain and indicated she had no concerns of injury prior to or after moving the resident. The AP denied any concerns were identified after assisting the resident off the floor then later called the ambulance for the resident “unable to bear weight”. The AP stated after she assessed the resident and assisted the resident off the floor, she instructed the ULP to give the resident Tylenol, and have the resident eat lunch on the couch, then left the resident to call the family. Although documentation indicated the family instructed the AP to call an ambulance, the AP denied that occurred. The AP stated a few minutes later the ULP reported the resident was unable to cross her legs or feed herself, then she called 911. The AP stated when the ambulance arrived, they removed the resident’s jacket to obtain the resident’s blood pressure and noticed an intact hematoma on the resident’s elbow. The AP denied the resident’s elbow was open, bleeding, or deformed. The AP stated she did not remove the resident’s jacket to assess for injuries or obtain the resident’s blood pressure prior to EMS arrival.

In conclusion, the Minnesota Department of Health determined neglect was <u>not</u> 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, not able to be interviewed.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility: Staff who witnessed the incident, reported it to the nurse in charge. The resident was transferred for evaluation and treatment of her injuries.

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
Beltrami County Attorney
Bemidji City Attorney
Bemidji Police Department
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33601	A. BUILDING: _____ B. WING _____	C 04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
D & D'S CARING HEARTS	1426 PAMELA COURT NW BEMIDJI, MN 56601

(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: #HL336019925M/#HL336018044C On April 23, 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 9 residents receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL336019925M/#HL336018044C, tag identification 0620, and 2360.	0 000		
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	0 620		

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0 620	Continued From page 1 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 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	0 620		

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0 620	Continued From page 2 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 report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment for one of one residents (R1) reviewed. R1 was neglected when the licensee failed to ensure staff had clear direction to assist R1 with ambulation. While ambulating unassisted, R1 fell sustaining a hip fracture and open elbow fracture (a fracture where the end of a broken bone breaks through the skin). Then, a nurse failed to thoroughly assess R1 for injuries after the fall occurred, and promptly call 911 despite R1 being unable to bear weight and reporting pain. Although the family reported concerns of neglect, the facility failed to investigate or report the incident to MAARC. 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	0 620		

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0 620	Continued From page 3 a limited number of staff are involved or the situation has occurred only occasionally). Findings Include: R1 was admitted to the licensee on August 1, 2020, with diagnoses including anxiety, left hip fracture, and Alzheimer's Disease. R1's 90-day assessment dated October 23, 2023, indicated R1 was severely cognitively impaired and had difficulty communicating. The assessment identified R1 was at a risk for falls, and occasionally unsteady on her feet related to dizziness. The assessment indicated R1 was able to walk, wandered, and required supervision and stand by assistance from 1 staff with ambulation as needed. R1's care plan updated by the AP the day of the incident on December 11, 2023, indicated staff should provide supervision to ensure safety with transfers related to unsteadiness and occasional dizziness. The care plan had unclear direction to staff indicating they were to observe and supervise R1 during transfers and ambulation and assist R1 as needed, but also included fall risk interventions which indicated R1 required 1 staff assistance with ambulation using a walker. The licensee failed to ensure the R1's care plan clearly instructed staff on the level of assistance R1 needed with transfers and ambulation for falls prevention as indicated on R1's service plan. The residents individual abuse prevention plan (IAPP) dated December 11, 2023, identified R1 was at a risk to be abused related to cognitive impairment, was unable to provide care for herself, make reasonable or informed decisions, recognize health and safety needs, and unable to	0 620		

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0 620	Continued From page 4 protect herself adequately against neglect or abuse. The IAPP indicated staff were to immediately report any concerns of abuse or neglect. R1's services/service plan at the time the incident occurred indicated R1 required 1 staff assistance with mobility and ambulation. The resident's services check list on December 11, 2023, included a list of services R1 was provided with instructions for staff which indicated staff provided 1 staff assistance using R1's walker for mobility. A incident report dated December 11, 2023, documented by an unlicensed staff person (ULP)-B who witnessed the incident indicated R1 was in the living room while the ULP was in the kitchen. R1 stood up to walk to the table for lunch without staff assistance, lost her balance, and fell at 11:40 a.m. The incident report indicated R1 was not using her walker or staff assistance at the time of the incident. The ULP documented R1 hit her head, and complained of pain in her shoulder, hip, leg, and elbow. The incident report indicated when R1 fell staff went to get registered nurse (RN)-A from her office. The incident report indicated RN-A completed a body assessment for injuries, and all were with in normal limits. The incident report indicated the RN-A called R1's family member at 11:56 a.m. who instructed RN-A to call an ambulance to have R1 brought in to be checked. On December 11, 2023, at 3:41 p.m. a progress note indicated RN-A documented R1 got up from the couch to go to the table for lunch when she lost her balance, fell backwards to her right side, and hit her head on the wall. RN-A documented R1 denied pain in her head, R1's pelvis was equal and slightly painful on her right side. RN-A	0 620		

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0 620	Continued From page 5 documented assisting R1 to the couch with pain on her right side noted. The note indicated RN-A expected the resident to have pain, and Tylenol was given. On December 14, 2023, at 10:09 a.m. a progress note indicated the licensed assisted living director (LALD)-C documented R1's family member reported concerns with R1's fall incident, and RN-A's failure to adequately assess R1 for injuries after the fall occurred, prior to moving R1. R1's medication administration record (MAR) indicated Tylenol was administered to R1 post fall for head pain at 11:36 a.m. The incident report, progress notes, and interviews, indicated R1 fell and was assisted off the floor by the RN-A prior to the Tylenol administration time documented. R1's outside medical record indicated RN-A called 911 at 12:11 p.m. (approximately 40 minutes after the incident occurred). The EMS run report indicated RN-A called the ambulance for R1 who had fallen and was "unable to bear weight". The report indicated when EMS staff arrived on scene R1 was seated on the couch reporting pain. The EMS report indicated R1 had traumatic injuries of her right upper extremity with deformities, pain, swelling, and bleeding noted from R1's right elbow. R1's emergency and hospital record indicated R1 had a displaced open fracture of her elbow, and mildly displaced fracture of her right hip. The record indicated R1 required surgical repair of her injuries which included debridement and antibiotics for the open fracture of her right elbow. R1 was discharged to a rehab facility 9 days later. A review of photographs of R1's injuries after the	0 620		

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0 620	Continued From page 6 incident occurred showed a large open bleeding laceration extending the length of R1's right elbow with extensive swelling and deformity noted. On April 23, 2024, at 11:04 a.m. and on May 1, 2024, at 11:34 a.m. when R1's family member(s) were interviewed they stated R1 had obvious deformities of her hip and arm after her fall occurred with bone sticking out of her elbow and blood dripping from the wound. The family members stated an ULP-B reported she instructed R1 to get up and come to the table for lunch, R1 got up unassisted and fell. The ULP reported the RN-A had R1 squeeze her fingers, then picked R1 up alone and moved her to the couch without assessing R1 for injuries. The family indicated when RN-A called reporting the fall the AP was instructed to call the ambulance. The family stated a reasonable person would know not to move R1 and call 911 immediately, but the RN-A who was a registered nurse neglected R1 when she failed to do so. The family members stated R1 was no longer able to walk and had ongoing pain as a result of the incident. The family indicated they expressed concerns to the facility with the RN-A's lack of assessment and delay in treatment after the incident occurred with no action taken by the licensee. On April 23, 2024, at 11:26 a.m. LALD-C stated although R1 was cognitively impaired and would get up independently at times, R1 required 1 staff assistance with ambulation at all times. Leadership staff stated it would be unusual for R1 to report pain or be unable to bear weight. Leadership staff stated after the incident occurred the family expressed concerns of neglect and reported RN-A failed to assess the resident for injuries. Leadership staff stated despite the family	0 620		

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0 620	Continued From page 7 reporting concerns the AP had neglected R1 they did not investigate or report the incident to MAARC. On May 2, 2024, at 10:25 a.m. ULP-B stated she witness the incident occur and R1 care plan directed staff to provide assistance with ambulation only if R1 was unsteady or dizzy. ULP-B stated the day the incident occurred R1 stood up, appeared wobbly, but fell before she could get to R1. ULP-B stated R1 hit her head on the wall hard enough to dent the wall, was moaning in pain, dazed, and not responding normally. ULP-B stated she knew something was seriously wrong and did not want to move R1. ULP-B stated the RN-A was onsite, so she placed a pillow behind R1 head and went outside to the garage to get RN-A for help. ULP-B stated "RN-A supposedly checked R1 for injuries", then picked R1 up alone by grabbing R1 under her arms using a bear hug and put R1 on the couch approximately 2 feet away. ULP-B stated R1 was unable to get up on her own, unable to participate in the transfer, and unable to bear any weight when RN-A moved R1. ULP-B stated she did not observe the RN-A complete neuro checks or assess R1 for injuries. ULP-B stated RN-A left R1 seated on the couch and returned to her office outside in the garage. ULP-B stated 5-10 minutes later when she brought lunch to R1 seated on the couch, R1 was unable to move or lift her right arm and complained of pain. ULP-B stated she again went out and told the RN-A who then looked at R1 "more carefully" and noticed a bump on the resident's arm. ULP-B stated R1 had a major fall with obvious injuries, should not have been moved, and 911 should have been called immediately, but the RN-A was the nurse in charge, and she left what to do up for her judgment.	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33601	A. BUILDING: _____ B. WING _____	C 04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
D & D'S CARING HEARTS	1426 PAMELA COURT NW BEMIDJI, MN 56601

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0 620	Continued From page 8 On April 23, 2024, at 11:04 a.m. ULP-D stated R1 was cognitively impaired, unsteady, and required assistance from one staff with ambulation using a transfer belt and walker at all times. ULP-D stated it would be unusual for R1 to report pain or be unable to bear weight. On May 13, 2024, at 8:51 a.m. RN-A stated she assessed R1 for injuries after the fall occurred with no abnormalities noted. RN-A stated when she lifted R1 off the floor, R1 favored her right side, but she expected R1 to have pain because R1 had just fallen. Although documentation and interviews indicated R1 had pain after the incident occurred and when EMS arrived on scene. RN-A denied R1 had any expression of pain and indicated she had no concerns of injury prior to or after moving R1. RN-A stated she instructed the ULP-B to give the resident Tylenol and have R1 eat lunch on the couch, then the RN-A left to call R1's family. Although documentation indicated the family instructed RN-A to call an ambulance, RN-A denied that occurred. RN-A stated a few minutes later ULP-B reported R1 was unable to cross her legs or feed herself, and she called 911. The RN-A stated when the ambulance arrived, they removed R1's jacket to obtain a blood pressure and noticed an intact hematoma on R1's elbow. RN-A denied R1's elbow was open, bleeding, or deformed when EMS assessed R1 onsite. RN-A stated she did not remove R1's jacket to assess for injuries or obtain R1's blood pressure after the fall occurred prior to EMS arrival. The licensee provided policy and procedure titled " Vulnerable Adult Maltreatment Prevention and Reporting" revised August 1, 2021, indicated maltreatment was defined as neglect, abuse, and	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33601	A. BUILDING: _____ B. WING _____	C 04/23/2024

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0 620	Continued From page 9 exploitation/theft. The policy indicated staff would report any suspected maltreatment of a vulnerable adult to MAARC. The licensee provided an algorithm for determining how to respond to injured and when to report to MAARC indicated in the event an injury was reported or discovered, staff would take immediate action to provide appropriate necessary medical care and interventions. The document indicated if the source of the injury was explained or known the incident was not reportable. The document directed staff to the footnote at the bottom of the page which indicated injuries may be reportable at alleged abuse, neglect, or mistreatment as defined on page 2, which indicated neglect was a failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. No further information provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	0 620		
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: Based on interview and document review, the facility failed to ensure one of one of one residents reviewed, (R1) was free from maltreatment.	02360		

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02360	Continued From page 10 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. No plan of correction is required for this tag.	02360		