Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL356606822M
Compliance #: HL356601381C

Date Concluded: April 30, 2025

Name, Address, and County of Licensee Investigated:
Carver Ridge Senior Living
920 6th street west
Carver, MN 55315
Carver County

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

Evaluator's Name: Erin Johnson-Crosby, 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 staff failed to provide necessary care and services to address the resident's frequent falls and decline in condition.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to assess the resident's risk for falls and implement individualized interventions relevant to the causative factors to prevent falls or reduce risk of serious injury. The resident had approximately 14 falls within in four months, the last fall resulted in a hip fracture which required surgical intervention. In addition, the facility failed to implement interventions following a 12-pound weight loss in three months following admission.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record,

facility documents, facility incident reports, staff schedules, and related facility policy and procedures. During an onsite visit, the investigator observed cares, and staff interactions with residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia and a history of a stroke. The resident's service plan included assistance with dressing, grooming, meal escorts, bathing, toileting, medication administration and stand by assist for transfers. The resident's admission assessment indicated the resident had not had any falls in the last three months and was able to ambulate safely, however the resident's progress notes indicated the resident fell at home three days prior to admission.

The resident's assessment indicated the resident frequently refused medications and assistance with dressing. The resident walked with a walker, was at high risk for falls and received around the clock safety checks. The resident's individual abuse prevention plan indicated the resident was able to ambulate independently and had not fallen since the last assessment. The assessment lacked an individualized assessment of the resident's current health status or individualized needs including interventions to prevent falls.

The assessment also indicated the resident had a 12-pound weight loss in the last three months. The resident's record did not include interventions to attempt to decrease the resident's weight loss.

The resident's progress notes, and incident reports indicated the resident fell two times in the first 30 days. Toileting services were added to the resident's service plan but there was no documentation to assess if the intervention was appropriate. There also was not a focused fall assessment completed following the falls.

The next month the resident fell four times. The residents medical record did not include focused fall assessments following the fall, a change in condition assessment related to the resident's decline, or individualized interventions related to the root cause of the fall.

The third month the resident fell five times. The resident's medical record did not include a focused fall assessment, change in condition assessment related to the resident's decline, or individualized interventions related to the root cause to prevent falls.

The fourth month the resident fell three times. Following the 12th fall the primary care provider made order changes including monitoring of the resident's weight, blood pressure, pulse, and medication changes. The residents medical record did not include a focused fall assessment, change in condition assessment related to the resident's decline, or additional interventions to prevent falls.

The resident's progress notes and incident reports indicated the resident's 14th fall resulted in a hip fracture requiring surgical repair. The resident was hospitalized and then discharged to a higher level of care.

During an interview, licensed practical nurse (LPN) stated the resident had a walker but would not use it. The resident refused medications, and only allowed certain people to care for him. The nurse was responsible for implementing interventions and she had never reviewed falls with the director of nursing (DON). The resident fell a lot more when he started to decline since he wasn't eating or taking his medications. It was the DON's responsibility to make changes or additions to a resident's service plan. The LPN stated at times they worked short staffed due to call in's and could be a cause for an increase in falls.

During an interview, the registered nurse (RN) stated normally the floor nurse would come up with an immediate fall intervention. The resident was admitted from home and did not adjust well and would not come out of his apartment. The care conferences referenced in the incident reports included her and the resident's family members and did not include an interdisciplinary team and were not documented. The resident's family members did not want the facility to add services because the resident was applying for medical assistance. The RN did not know why there was over a one month wait for initiation of therapy services. The RN stated there should have been a change in condition assessment completed and should have been completed after every three falls. Fall interventions should have been developed and implemented related to the root cause of the fall. The RN stated there were no documented interventions to prevent the resident's weight loss and did not know if the resident's primary care provider was notified of the resident's weight loss.

During an interview, the resident's family member (FM) stated they met with the RN three or four times with concerns about resident's care and services. The FM would share their concerns with the RN but would never receive a follow up regarding their repeated care concerns. The FM stated there were many times the resident was not checked on hourly and was left in his room most days with little encouragement from staff to come out and eat or attend activities. The FM was concerned with the number of falls but did not feel facility staff was concerned. A few times resident's FM has had to call and tell staff that the resident was on the floor and required assistance.

During an interview, the resident's family member stated the family went to management multiple times with concerns regarding services not being provided per the service plan.

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. The resident was deceased.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
No action taken

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
Carver County Attorney
Carver City Attorney
Carver Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35660	A. BUILDING: _____ B. WING _____	C 03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARVER RIDGE SENIOR LIVING	920 6TH STREET WEST CARVER, MN 55315

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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: #HL356601381C/#HL356606822M On March 12, 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 66 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for ##HL356601381C/#HL356606822M, tag identification 0460, 2310, and 2360.	0 000		
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the	0 460		

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0 460	Continued From page 1 assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week. This had the potential to affect all memory care residents. 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's uniform disclosure of Assisted Living Services and Amenities (UDALSA) dated September 24, 2024, indicated an emergency call	0 460	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	

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0 460	Continued From page 2 system included pendants. The UDALSA also indicated 15 minute, 30 minute, and hourly safety checks may be available in short term, emergent situations and an available fee may apply. The UDALSA also indicated there were motion sensors in memory care bathrooms and alert alarms on apartment doors during certain hours. R2 was admitted March 3, 2021, with diagnoses of cognitive impairment and anemia. R2's service plan dated August 6, 2024, indicated R2 required assistance with medication administration, toileting, safety checks every two hours, turning and reposition, dressing, and grooming. R2's 90 day assessment dated January 18, 2025, indicated R2 required assistance with activities of daily living (ADLs), was cooperative with cares, but declined to transfer to bed and preferred to sleep in her chair. R2 often appeared to to be unable to understand simple instructions, had impaired memory, and undiagnosed dementia. R2 had three falls in the last three months and displayed intermittent confusion or disorientation. Interventions included on the assessment included safety checks, use of a walker, call pendant, and monitoring of R2. R2's medical record did not indicate if R2 received a call pendant. R2's individual abuse prevention plan (IAPP) dated January 18, 2025, indicated R2 had a pendant and was able to call for assistance. R2 was alert and oriented with intermittent forgetfulness at times. R2's IAPP indicated R1 was able to ambulate safety and had not fallen since the last assessment. The IAPP did not	0 460	FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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0 460	Continued From page 3 include the falls identified on the assessment that was also completed on January 18, 2025. On March 12, 2025 at 10:15 a.m. unlicensed personnel ULP-I was interviewed. ULP-I stated there were no call pendants used on the memory care unit. ULP-I stated that the pager/walkie-talkie system used by ULPs was connected to motion sensors in resident rooms. However, ULP-I stated not every room had a motion sensor in the room or in the bathroom and could not identify which rooms had one and which ones did not and did not know the reason why some rooms had motion sensors and some did not. ULP-I also stated that motion alarms in some of the resident bathrooms on the memory care unit were only on at night from 11pm - 8 am but did not know the reason why motion sensors were only utilized at night. On March 12, 2025, at 10:25 a.m., unlicensed personnel (ULP)-G stated there were motion sensors in every memory care bathroom and some residents had alarms on the outside of their doors. ULP-G did not know what times the motion sensors were activated. On March 12, 2025, at 11:05 a.m., the investigator observed R2's room was located at the end of a long hallway in the memory care unit. The investigator observed unlicensed personnel (ULP)-G and ULP-H transfer R2 with a hoyer lift to bed. The investigator observed there was no means for R2 to summon assistance. Despite the IAPP and assesssment from January 18, 2025, indicating R2 had a pendant light to call for assistance. ULP-G stated residents in memory care did not have pendants like the residents had in assisted living. ULP-H stated residents in memory care were checked on hourly but the	0 460		

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0 460	Continued From page 4 checks were not documented. ULP-H was not aware of when the motion sensors were activated. On March 12, 2025, at 12:40 p.m., RN-C stated the memory care bathroom motion sensors were activated from 11:00 p.m., to 8:00 a.m. RN-C stated the magnets outside of residents doors were not activated and were not used and did not know why the magnets were attached to some of the doors of the rooms in the memory care unit. The Safely You motion video surveillance system was fall detection system that utilized artificial intelligence to detect and alert staff when a resident fell. RN-C stated customer service rounds were completed hourly but that the checks were not documented and confirmed there was not a system in place to audit if the checks were completed. RN-C stated pendants were not issued to memory are residents and stated there was not an assessment related to pendant use or ability to use pendants completed for memory care residents. On March 12, 2025, at 1:00 p.m., the MDH investigator observed ULP-G assisting R2 with eatting in bed. ULP-G stated he left R2's door open, but normally the bedroom doors would be closed if a resident was napping. On March 12, 2025, at 1:40 p.m., ULP-G stated residents in memory care were monitored every hour so they did not need to have pendants to call for assistance. On March 12, 2025, at 1:50 p.m., RN-C stated there was no way for residents in memory care to summon assistance in the bathroom but bathroom sensors were utilized in memory care bathrooms 24 hours a day.	0 460		

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0 460	Continued From page 5 On March 12, 2025, at 3:20 p.m., the investigator requested a pendant policy. LALD-F stated call pendants would be issued for everyone in memory care. LALD-F asked if the licensee had an assessment indicating residents could not use the call pendant due to cognition did they need to provide a call pendant to that resident. RN-E stated there was not an assessment related to pendant use. During observation of the memory care unit on March 12, 2025, at 3:22 p.m., an MDH investigator observed R2's bedroom door was closed. The investigator knocked and requested permission to enter R2's room. R2 was asked how she contacts staff for assistance when needed, and R2 stated she yelled, "Help!" The investigator left the room after conversing with R2 and closed the door. After closing the door, the investigator heard R2 yell for help but R2's request could only be heard just outside of the door. From 3:22-3:26 the investigator stood outside of R2's room looking for staff assistance. R2 could be heard outside the door continuously yelling for help but no staff were observed in the memory care hallway. During the four minutes outside of the doorway, the investigator opened the door and told R2 they would look for help from staff. At 3:26 p.m. the investigator opened R2's door again and told R2 they were going to leave the door open while they went to find staff to help R2. R2 continued yelling help. The MDH investigator asked R2 what she needed help with and R2 replied "pajamas" and pointed at her incontinent product and said "help" again as the investigator left the room to find staff. The investigator walked to the end of the memory care unit and did not see any staff in the hallway on the way down the hall. At 3:28 p.m. a staff	0 460		

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0 460	Continued From page 6 member entered the unit through the secured door and the investigator reported to the staff member that [room number] was yelling for help and was worried she might try to get up soon. The staff member looked at the investigator, then told a second staff member in the dining room that R2 in room [room number] needed help. The second staff member nodded and walked down the hallway. The investigator followed the second staff member down the hall and the staff member went into room number 10 (not R2's room) and did not check on R2. At 3:29 p.m. the staff member remained in room 10 as R2 continued to yell for help at the end of the hallway (two doors down from where the staff member was). The staff member did not come to R2's room and was not seen by the investigator again. At 3:31, R2 continued to yell for help in bed and the investigator walked down the hall to the dining room and found a third staff member who was cleaning up dining tables. At 3:31 the investigator told the third staff member that R2 was yelling for help and needed assistance. The staff member then went to R2's room to assist at 3:33 p.m. At 4:17 p.m. on March 12, 2025, RN-C and LALD-F were interviewed. The MDH investigator reported the observation of the memory care unit from 3:22 - 3:33 p.m. RN-C and LALD-F acknowledged they expected staff to assist residents when the called for help and confirmed there was not a system in place for residents to summon assistance other than the hourly checks that were not documented by staff and that residents could yell for help. RN-C also stated she had to check on when the motion detection systems were turned on as she was not sure of the specific times. RN-C and LALD-F were asked about R2 who stated R2 had moved to the memory care unit over the past year from the	0 460		

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0 460	Continued From page 7 assisted living and previously had a call light pendant but upon move to the memory care unit R2 no longer had a pendant light to summon for assistance. LALD-F and RN-C confirmed that there were two additional residents in the memory care unit who had moved from the assisted living unit who still had pendant lights. LALD-F and RN-C could not explain why some residents kept or had pendant call lights and the remainder of memory care residents did not. LALD-F and RN-C could not provide details on if there was an audit or review of the motion alert system utilized and could not report in which bathrooms or units the system was utilized and why it was utilized in some memory care units and/or bathrooms and not in others. LALD-F and RN-C also confirmed there was no system in place to monitor or audit the alert systems utilized. LALD-F and RN-C confirmed that upon being informed of concerns they were working on issuing pendants to all memory care residents so there was a system in place for residents to summon for assistance in the memory care unit. A review of recent falls in the memory care unit was also discussed with LALD-F and RN-C. The MDH investigator questioned fall reports provided which indicated staff acknowledged reasoning for falls as resident did not call for assistance and interventions implemented to prevent further falls included for resident to call for assistance. LALD-F and RN-C again confirmed although fall reports included these statments the resident(s) were not provided with a way to call for or summon assistance. An email from the RN-C dated April 11, 2025, indicated the motion sensors in memory care were set up for motion detection from 9:00 p.m., to 7:00 a.m. A pendant policy and policy on resident request to	0 460		

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0 460	Continued From page 8 summon assistance was requested but not provided. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 460		
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 facility failed to ensure care and services were provided according to a suitable and up-to-date plan, and subject to acceptable health care and medical, or nursing standards, for one of one resident (R1) reviewed. Nursing staff failed to assess, develop, and implement interventions to prevent falls or reduce the risk of serious injury following R1's multiple falls. In addition, the licensee failed to assess, implement interventions, and notify R1's healthcare provider regarding R1's ongoing weightloss. This practice resulted in a level three violation (a violation that harmed a client'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 clients are affected or one or a	02310		

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02310	Continued From page 9 limited number of staff are involved or the situation has occurred only occasionally). The findings include: Falls R1 admitted to the licensee on April 22, 2024, with diagnoses including dementia and a history of a stroke. R1's service plan dated May 3, 2024, indicated R1 required assistance with dressing, grooming, meal escorts, bathing, toileting, medication administration and stand by assist for transfers. R1's assessment dated July 22, 2024, indicated R1 frequently refused medication administration and assistance with dressing. R1 was independent with ambulation with a walker, and required stand by assist for transferring. R1 had severe cognitive impairment. The assessment indicated that R1 had three or more falls since the last assessment, was at high risk for falls, used a walker, and received around the clock safety checks. R1's individual abuse prevention plan (IAPP) dated July 22, 2024, indicated R1 was able to ambulate safety, and had not fallen since the last assessment. The IAPP did not include interventions to prevent falls. Fall 1: An incident report dated April 22, 2024, at 6:30 p.m., indicated another resident notified staff R1 was on the floor in the hallway. R1 was agitated and no injuries noted was found by staff on his apartment floor. Contributing factors listed included that R1 did not call for assistance and cognitive impairment. The intervention include a	02310		

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02310	Continued From page 10 physical therapy (PT) and occupational therapy (OT) order for opinion on wheelchair. R1's progress note dated May 1, 2024, indicated R1's family member (FM) noticed R1 urinated on the floor and toileting services were added to the service plan. Fall 2: An incident report dated May 22, 2024, at 7:45 a.m., indicated R1's FM called for staff to go and check on R1. R1 was lying in the bathroom entrance on his left side, unclothed, with incontinent bowel movement all of R1's body. R1 said he wanted to take a shower and while getting out of the shower he slid and fell. Contributing factors listed included: did not call for assistance and resistive to cares. The interventions included to educate R1, staffing patterns reviewed, and PT/OT was requested from the provider and to keep the resident's door opens. R1's medical did not include an assessment or interventions added to R1's service plan. R1's medical record did not include PT/OT notes. Fall 3: An incident report dated May 28, 2024, at 8:45 p.m., indicated R1's FM called the facility to notify them R1 had fallen. R1 was found near his bed and appeared to be trying to change his incontinent product. The unlicensed staff stated the facility monitoring system did not alert staff of R1's fall. R1's family was concerned the monitoring system did not detect R1's fall. R1's FM also stated there was a recent morning fall and she did not receive communication. R1's FM stated there was a care conference the next day and looked forward to discussing falls and fall protocols. The report indicated the reduction plan	02310		

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02310	Continued From page 11 included scheduled services, emergency pendant, and room free of clutter. Contributing factors of the fall included: decline in status, did not call for assistance, and cognitive impairment. After this fall R1 was given an emergency pendant and a care conference was held. R1' progress notes dated May 31, 2024, at 10:18 a.m., indicated the customized living tool was completed and sent to the case manager requesting additional services for R1, however, there were no changes to R1's service plan or additional documentation of the identified concerns with level of care and services required to maintain R1's health and safety. R1's medical record did not include documentation of the care conference that was held related to falls or documentation regarding the emergency pendant. R1's medical record did not include an assessment or additional interventions added to R1's service plan. R1's medical record did not include PT/OT notes. The medical record did not indicate why the monitoring system did not alert staff of R1's fall. Fall 4: An incident report dated June 1, 2024, at 11:20 a.m., indicated R1 was found lying on the floor in the dining room with his walker away from him. Contributing factors included a decline in status, did not call for assistance, and cognitive impairment. Interventions included requested PT/OT, urinalysis and vitamin B12. R1 was also given a call pendant to trial. R1's medical record did not include documentation regarding the emergency call pendant. R1's medical did not include an assessment or additional interventions	02310		

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02310	Continued From page 12 implemented to R1's service plan. R1's medical record did not include PT/OT notes. Fall 5: An incident report dated June 3, 2024, at 3:30 p.m., indicated the monitoring system detected R1 was on the floor. R1 was found lying on the floor near his window learning against a heating unit. The monitoring video system showed R1 using the walker, losing balance, falling to the floor, and hitting his head. Contributing factors included cognitive impairment, did not call for assistance, and cognitive impairment. Interventions included PT/OT orders. Care conference held with R1's family and they requested lab work. Recommended family to remove recliner from the apartment. An emergency pendent was trialed and R1 did not use appropriately and became upset when he received the pendant. R1's medical record did not include documentation regarding the pendant trial, pendant use, or care conference notes. R1's progress note dated June 7, 2024, at 3:07 p.m., indicated there was a mobility change when R1 laid in bed all day and when the staff assisted R1 with sitting up, R1 would fall back. The staff also had to assist R1 to stand. R1's progress note dated June 8, 2024, at 10:24 a.m., indicated R1 was screaming for help and was found in his bed. R1 told staff he wanted help getting up and going to the bathroom and had been screaming for an hour. R1 then screamed at staff and staff told R1 he could not talk to the staff like that. R1 told the staff to get out of his room.	02310		

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02310	Continued From page 13 R1's medical record did not include follow up documentation from June 7, and June 8, 2024 regarding R1's need for additional assistance. R1's progress note dated June 10, 2024, indicated R1 received therapy for strengthening. R1's progress note dated June 14, 2024, at 11:24 a.m., indicated staff heard R1 call for help from the hallway. R1 stated he needed help to use the bathroom and to get out of bed due to back pain. R1 refused medications. R1's progress note dated June 22, 2024, at 4:18 p.m., indicated staff found R1 in bed with no clothing on his bottom half and no incontinence product. R1's bedding was covered with urine and feces. The bathroom had urine and feces on the floor. R1's medical record did not include a change in condition assessment or follow up related to R1's change in condition, complaints of pain, or need for additional assistance. Fall 6: An incident report dated June 22, 2024, at 7:30 p.m., indicated staff received a call from the fall monitoring system. R1 was found lying on the floor in his room. The video showed R1 was got up from his bed in stocking feet, stepped sideways dragging his walker, and attempted to turn to sit in his chair. R1 was not close enough to the chair and fell to the floor. Contributing factors to the fall listed: decline in status, did not call for assistance, and cognitive impairment. Interventions included to remind resident to sleep in bed and requested gripper socks from family. R1's medical record did not include an	02310		

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02310	Continued From page 14 intervention related to the root cause of R1's fall or direction for staff to assist with applying gripper socks. R1's medical record did not contain information about the noted decline in status identified on the June 22, 2024 incident report. Fall 7: R1's progress note dated June 25, 2024, at 10:00 p.m., indicated unlicensed staff were notified by the video monitoring system R1 had fallen. R2 was found lying on his back near his bed. R1 reported tenderness on the left rib area. R1's FM requested staff contact R1's medical doctor primary care physician (PCP) regarding ongoing back pain. R1's medical record did not include an incident report or additional fall interventions following the fall. Fall 8: An incident report dated July 21, 2024, at 9:05 a.m., indicated staff received a call from the fall monitoring system. R1 was found lying on the floor in his room with his head against the TV stand. R1 had a possible bruise on the back of his head and complained of neck pain and pain with head movement. The video indicated R1 transferred from the recliner to the dining room chair; missed the chair and fell on the floor. Contributing factors for the fall listed by staff included: did not call for assistance, walker was out of reach, and cognitive impairment. Interventions included currently working with PT/OT and recommended family purchase color strips for recliner arms for better depth perception. R1 continuing to decline and is in the process of enrolling with the county for increase in supervision/cares.	02310		

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02310	Continued From page 15 R1's medical record indicated therapy discontinued services on July 15, 2024. The medical record also did not include a change in condition assessment related to R1's noted decline identified on the July 21, 2024 incident report. Fall 9: An incident report dated July 25, 2024, at 12:30 p.m., indicated R1 was found lying on the floor with his head hit on the wall by the bed and possible bruise by the right temple. R1 was transferring from the dining chair to the bed after he was done eating and did not wait for assistance. Contributing factors included did not call for assist, resistive to cares, and behaviors. Interventions indicated to continue to wait for county enrollment for elderly waiver and continue with therapy. Continues to have issues with vision deficits leading to misjudgment on where to sit. Staff suggested family bring in bright color top stripping to help point out edges for resident. R1's medical record did not include an assessment, changes to a service plan, related to R1's change in condition or follow up details related to bright color stripping. Fall 10: An incident report dated August 17, 2024, at 10:00 p.m., indicated R1 got up from the dining room chair, lost his balance and fell. R1's walker was not near where R1 fell. Contributing factors included poor safety awareness, history of falls, decline, and recent falls. Interventions included to educate staff to keep walker near R1 and instructed family to provide non skid slippers. R1's medical record did not include an assessment regarding R1's change in condition	02310		

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02310	Continued From page 16 or instruction for staff to assist with putting on non-skid slippers. Fall 11: An incident report dated August 19, 2024, at 10:30 a.m., indicated R1 was lying on the floor on his left side with his walker next to him and was wearing shoes in his apartment. Contributing factors included did not call for assist, cognitive impairment, and recent falls. Interventions included requested PT/OT and a care conference was scheduled with R1's family on August 22, 2024. R1's medical record did not include documentation of R1's care conference or an assessment related to R1's change in condition or additional interventions to prevent falls. R1's medical record indicated therapy services were discontinued on July 15, 2024. Fall 12: R1's progress note dated August 23, 2024, at 5:05 a.m., indicated R1 fell at 3:20 a.m., and was found on the floor after he tried to get out of bed. R1 was yelling and staff heard him. RN-C advised staff to complete more frequent rounding/safety checks, and call with an acute changes. R1's medical record did not include an incident report. R2's medical record did not include documentation of increased safety checks. Safety checks were not added to R1's service plan. R1's progress notes dated August 29, 2024, at 1:02 p.m., included a referral to PT/OT and skilled nursing. R1's medical record did not include a change in condition assessment.	02310		

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02310	Continued From page 17 Fall 13: An incident report dated August 31, 2024, at 4:45 p.m., indicated the video monitoring system notified staff that R1 was on the floor. R1 was found lying on his back in the doorway between the bedroom and bathroom. R1 got up from his bed, went to the closet, bent down to pick up a shoe, lost his balance and fell backward. Contributing factors included history of falls, behaviors, resistive to cares and cognitive impairment. R1's medical record did not include additional interventions to prevent falls. Fall 14: An incident report dated August 31, 2024, at 11:30 p.m., indicated R1 charged towards a staff member and fell backward into his room and was found lying on the floor in his apartment. R1 was unable to reposition independently and unable to tolerate repositioning due to excruciating pain. R1 was transported to the hospital and admitted with a hip fracture. R1's progress note dated September 1, 2024, indicated R1 had surgery that evening related to a hip fracture. On April 3, 2025, at 2:00 p.m., licensed practical nurse (LPN)-A stated R1 had a walker but would not use it. R1 refused a lot of medications, and only allowed certain people to care for him. LPN-A stated the nurse was responsible for implementing interventions. LPN-A stated she had never reviewed falls with the director of nursing (DON). R1 fell a lot more when his condition started to decline since he wasn't eating or taking his medications. LPN-A stated she was	02310		

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02310	Continued From page 18 not able to add services and that would be the DON (RN-C) responsibility. LPN-A stated at times they worked short staffed due to call in's and that short staffing could be a cause for an increase in falls. On April 9, 2025, at 11:30 a.m., RN-C stated normally the floor nurse would come up with an immediate fall intervention. RN-C stated R1 was admitted from home and did not adjust well and would not come out of his apartment. RN-C stated the care conferences referenced in R1's incident reports included her and R1's family members and did not include an others from the interdisciplinary team. RN-C stated the care conference notes were not documented. R1 was given an emergency pendant after a fall but he became agitated so it was taken away. RN-C stated there was no documentation regarding the trial of the emergency pendant. RN-C stated they identified a need and requested for additional services to be added for R1 but could not add services because R1 was applying for medical assistance and the family didn't want to pay more. RN-C did not know why therapy was not started for over one month after initially determining it as an intervention for fall prevention. RN-C also stated there was not a change in condition assessment completed but there should have been as R1 had a noted decline in condition. RN-C stated fall interventions should correlate to the root cause of the fall and acknowledged that many of R1's fall incident reports indicated a cause for the fall was not calling for help and that this was also an identified intervention on incident reports but there was not a means provided to R1 to call for help and there was no documentation of the call pendant trial. RN-stated the provider should have been notified of R1's change in condition and information should have been	02310		

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02310	Continued From page 19 documented in R1's medical record. On April 9, 2025, at 3:00 p.m., R1's family member (FM)-D stated they met with RN-C three to four times and brought up multiple concerns related to inadequate care being provided and concerns with the ongoing falls. RN-C would listen and tell them she would investigate the concerns but would never follow up with the family. R1's FM was informed upon admission that the facility had a monitoring system that would detect falls, however, there were a couple times the family had to notify the facility that R1 had fallen. FM-D stated after one of the falls they gave R1 an emergency pendant, but the next day the battery fell out. The facility said they would replace the battery and bring the pendant back to R1, and it was never returned to R1 since facility staff said he would not remember to use it. FM-D stated there were mutliple occassions houly checks were not completed. FM-D was not aware of what interventions were in place regarding falls. FM-D provided the investigator with documentation from a notebook that was kept in R1's room during his stay at the facility that the family wrote notes and maintained logs during their visits at the facility. The notebook documentation indicated R1's service level was increased to the next level and after that hourly checks were still not completed. It seemed as though most staff were not trained for dementia care and staff invested little time in trying to get R1 out of his room and encourage socialization. It appeared the memory care wing was always short staffed and standard cleaning procedures were not followed. The letter indicated the family had three to four care conference with RN-C regarding the concern and lack of assistance for R1. RN-C would tell the family she would, "look into it," but there was never any follow up related	02310		

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02310	Continued From page 20 to the concerns. On May 31, 2024, a call button necklace was given to R1 due to many falls, lack of staff awareness, and response time. Within one day the device had been dropped and the battery fell out. Facility staff said they would replace the device and return it but was never returned to R1 even after several inquiries. The facility decided the pendant would not be helpful since R1 would probably not remember how to use it. On June 11, 2024, at 3:33 p.m., no staff were found in memory care, FM could hear R1 yelling help, hallway down the hallway while approaching his room. The FM had to leave memory care and find staff behind the reception desk. FM-D informed staff R1 had been yelling for help for 40 minutes there was no sense of urgency and no one followed FM-D back into memory care. FM-D again left memory care to request staff assistance again. The staff signed and followed FM-D to R1's room. R1 was unable to get out of bed and had soiled himself. FM-D reported this to RN-D. On April 9, 2025, at 4:25 p.m., LPN-E stated R1 started falling more frequently towards the end of his facility stay. LPN-E stated a contributing factor on the incident report should not have included, "call for assistance," since R1 did not have a call pendant. LPN-E stated there should have been a change in condition assessment completed and interventions should correlate with the root cause of the fall. The licensee's Fall Risk and Prevention policy reviewed May 2024, indicated if a resident had more than three falls within 90 days, discuss with the interdisciplinary team and qualified for a re-assessment. A post fall huddle is to be be completed as soon as possible after the fall, but before the end of the shift. It is the responsibility	02310		

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02310	Continued From page 21 of the director of health services to monitor preventative measures to assure they are in place. Weight Loss R1 admitted to the licensee on April 22, 2024, with diagnoses including dementia and a history of a stroke. R1's service plan dated May 3, 2024, indicated R1 required assistance with dressing, grooming, meal escorts, bathing, toileting, medication administration and stand by assist for transfers. The service plan also included meal assist to ensure adequate meal intake. R1's assessment dated April 22, 2024 indicated that R1's weight was 196 pounds. R1's assessment dated July 22, 2024, indicated R1 frequently refused medication administration and assistance with dressing. R1's weight was184 pounds, down twelve poiunds from 196 pounds on April 22, 2024. No interventions were added to the assessments or service plans regarding the identified weight loss. R1's service checkoff list indicated staff should physically assist R1 to eat and drink and record meal intake for memory care tenants. R1's medical record did not include any documentation of meal intakes. R1's May 2024, service check off list indicated R1 refused meal assistance seven times. R1's monthly vital signs were blank and zero was listed as R1's weight. R1's medical record did not include documentation of meal intake. There was no documentation of why R1's weight was not obtained and R1's meal refusals were not	02310		

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02310	Continued From page 22 addressed. R1's June 2024, service check off list indicated R1 refused meal assist three times. R1's weight was 184 pounds. R1's medical record did not include documentation of meal intake. R1's record did not contain information addressing the noted weight loss. R1's July 2024, service check off list inidcated R1 refused meal assist eight times. R1's weight was documented as zero pounds. R1's medical record did not include documentation of meal intake. There was no additional documentation of why R1's weight was not obstained and no follow-up was completed on why R1 refused meal assistance. R1's August 2024 Service check off list indicated R1 refused meal assist three times. R1's weight was documented as 182 pounds. R1's medical record did not include documentation of meal intake and did not address R1's refusals of meals or noted weight loss. R1's progress notes indicated: - April 24, 2024, indicated R1 refused to eat both meals. - April 25, 2024, indicated R1 refused dinner. - April 27, 2024, indicated R1 refused dinner. - May 31, 2024, indicated R1 refused dinner. - June 1, 2024, indicated R1 refused dinner. - July 5, 2024, indicated R1 refused breakfast.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35660	A. BUILDING: _____ B. WING _____	C 03/12/2025

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02310	Continued From page 23 - July 10, 2024, indciated R1 refused breakfast and lunch. - August 18, 2024, indicated R1 refused breakfast and lunch. R1's medical record did not include interventions or notification to R1's primary care physician (PCP) related to weight loss or refusals for meal asssistance. R1 was not assessed for the weight loss or ongoing refusals of meal asssitance. No follow-up was completed regarding the identified and noted refusals for meal assistance and weight loss and no interventiosn were implemented. On April 9, 2025, at 11:30 a.m., RN-C acknowledged there was no assessment completed regarding R1's noted weightloss or ongoing refusals of meal assistance and indicated an assessment should have been completed with the change in R1's condition. On April 9, 2025, at 3:00 p.m., R1's family member (FM)-D stated there were many times facility staff would bring in R1's food and set it next to him and would not assist him with eating. When the family would visit, the food remained on the tray uneaten. FM-D stated they spoke with RN-C several times regarding concerns with inadequate care but was not aware of interventions weight loss. RN-C would tell the family she would, "look into it," but there was never any follow up related to the concerns. The licensee's change in condition assessment revised May 2024, indicated a change in condition may include if the resident has disruptions or aggression toward others, rejection of care, three or more falls over the course of a	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02310	Continued From page 24 90 day period of time or a fall with significant injury, or the resident shows weight loss/gain of 10% or more during the previous 6 months. No further information was provided. 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) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No plan of correction is required for this tag.	