Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL366015741M
Compliance #: HL366018001C

Date Concluded: December 19, 2024

Name, Address, and County of Licensee Investigated:
Suite Living Senior Care of Ramsey
7007 139th Lane Northwest
Ramsey, MN 55303
Anoka county

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

Evaluator's Name: Holly German, RN
Special Investigator
Rhylee Gilb, 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 they failed to thoroughly assess the resident for injuries after the resident sustained a fall. The resident went to the hospital two times after for the same fall, and admitted the second time for broken ribs, a hemothorax (a serious condition that occurs when blood collects in the pleural space, the hollow area between the lungs and rib cage), and blood clots in both legs.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility staff failed to assess and monitor the resident for injury post fall despite a skin tear, resident complaints of pain and change in condition. The facility staff failed to communicate changes in the resident's status between unlicensed

personnel (ULP) and nurses. The facility failed to coordinate care, ensuring the resident completed an ordered chest x-ray. The resident had significant bruising to her right ribs and experienced pain for seven days after the fall prior to admitting to the hospital with rib fractures, a large hemothorax and bilateral pulmonary emboli (a clot in the lungs). The resident required chest tubes and hospitalized for two weeks.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, unlicensed staff, and family members. The investigation included review of the resident records, death record, hospital records, medical provider portal notes, physician orders, facility internal investigation, facility incident reports, staff schedules, and related facility policy and procedures. Also, the investigator observed resident care provided by staff while on site.

The resident resided in an assisted living facility memory care unit. The resident's diagnoses included osteoporosis and muscle weakness. The resident's service plan included safety checks every two hours, assistance with medications, dressing twice daily, bathing three times a week, toileting every shift, transfers, and mobility to meals three times a day.

The resident's assessment indicated she was cognitively intact. Her baseline skin assessment included a scar on her tailbone. The resident's baseline pain assessment indicated she had right hip pain, scored the worst pain was 3 out 10 with movement and used Tylenol (over the counter pain medication) and rest for pain interventions. The resident's baseline pain did not affect her social activities or appetite and scored pain 1 out 10 at the time of the assessment.

A facility incident report indicated on an evening before a holiday (Wednesday), the resident sustained a fall while self-ambulating with her walker. Facility unlicensed personnel (ULP) 1 noted the resident on the floor, obtained vital signs, and called the on call registered nurse (RN) 1. RN 1 directed the ULP 1 to assist the resident back into her chair and to update her with any changes. The incident report indicated a skin tear was noted to the resident's right forearm. The incident report indicated RN 1 notified the resident's family and medical provider of the fall two days after it occurred, and an x-ray order was obtained. The incident report lacked follow up on assessing the resident or further fall interventions.

The resident's medication administration record (MAR) indicated she had 5 out 10 pain the day of the fall and received Tylenol.

The facility failed to initiate any post fall monitoring, including any further vital signs after the initial set, routine monitoring of pain and directive to ULP staff when increased pain occurs, monitoring for any developing signs or injury or changes in condition.

The day after the fall was a holiday (Thursday), and no nurse was scheduled to work in the facility. The resident's record lacked any information about her status, aside from the MAR. The

resident's MAR indicated she received Tylenol twice, once in the morning for pain 7 out of 10, and once in the evening for pain 9 out 10. The MAR indicated Tylenol was not effective.

The second day after the fall (Friday), the resident's medical record lacked documentation that indicated a RN physically assessed the resident for further injury after the fall, nor assessed her skin tear. The resident's records lacked evidence of the treatment and monitoring of the skin tear injury. The resident's progress notes indicated RN 1 received a phone call from ULP 1 regarding the resident's fall and notified the resident's medical provider due to the resident complaining of right hip and rib pain. An order for hip and chest x-ray was obtained.

The resident's MAR indicated she received Tylenol at 1:11 p.m. for pain 9 out of 10. The progress notes indicated later in the evening, the resident was sent to the emergency room per family request due to pain to be evaluated prior to the completion of the onsite x-rays.

The medical providers portal notes included the orders for x-ray of hip and x-ray of chest with attention to right ribs was given to the facility. The medical provider notes included documentation the resident was seen in the emergency room (ER) Friday at 7:51 p.m. and discharged at 12:12 a.m. Saturday.

The resident's hospital records indicated the resident completed a pelvic x-ray and pelvic CT scan, both of which did not indicate fracture or injury while in the ER. The resident did not obtain a chest x-ray while in the ER. The resident returned to the facility, after midnight, on Saturday.

The third day after the fall (Saturday), mobile x-ray provider orders indicated they received orders to complete the STAT x-ray of the right hip two days after the fall. There is no evidence the x-ray provider received the order to complete a chest x-ray. The mobile x-ray completed the hip x-ray on Saturday after the resident returned from the ER which did not indicate injury to the hip, same as the ER.

The medical providers portal notes indicated at 9:28 a.m., Saturday morning, the medical provider messaged the facility nursing staff their awareness of the resident's ER visit and requested nursing staff to provide an update on the resident.

The resident's MAR indicated she received Tylenol for 7 out of 10 pain.

The fourth day after the fall (Sunday), the medical provider portal notes indicated the medical provider's nurse messaged the facility again requesting an update on the resident's status. Additionally, the provider's nurse notified the facility nursing staff the resident was scheduled to be seen by the medical provider on Tuesday.

There was no nurse scheduled in the facility for Saturday and Sunday. The resident's record lacked progress notes on Saturday and Sunday. The facility nursing staff did not respond to the

medical's provider request for an update. The resident's MAR showed no administration of Tylenol on Sunday.

The fifth day after the fall (Monday), the resident's progress notes indicated the family voiced concern to the facility of no nursing assessment and communication. Facility RN 3 spoke to the family and provided education on the assessment, the nurse on-call process and communication workflow to them. The progress notes indicated the same day, the licensed practical nurse (LPN) faxed the mobile x-ray results to the resident's medical provider, but failed address the chest x-ray order was not completed. Additionally, the resident's record lacked evidence of a nursing assessment with a physical evaluation of the resident's body for injury following the fall with orders for a chest x-ray, increased pain requiring Tylenol for five days and post ER visit.

The residents MAR indicated she received Tylenol for 4 out of 10 pain on the fifth day.

The medical provider portal notes lacked evidence of the facility communicating the resident's continued pain above her baseline.

The sixth day after the fall (Tuesday), the resident's medical record lacked progress notes for the day the medical provider was scheduled to evaluate the resident. The resident's medical record lacked evidence of a nursing assessment.

The resident's care plan indicated she required assistance with walking, transfers, bed mobility and positioning, toileting, dressing assistance with resident participation, grooming assistance with resident participation, skin scare, and medication administration.

The resident's service records indicated prior to the fall; the resident ate her meals in the dining room. The days following the fall, the resident attended half of her meals in the dining room and had been staying in her room to eat the other times. The resident's service record failed to include assistance with dressing as required. The resident received direct care services including toileting assistance, grooming assistance, and one bath in the seven days post fall, by 15 different ULP.

The resident's record lacked any further vital sign monitoring after the initial set of vitals, lacked record of communicating and addressing increased pain between ULP, nurses and the medical provider and lacked communication of any further signs of injury, or changes in condition, including bruising and a decline from baseline attending meals in her room rather than the dining room.

The seventh day after the fall (Wednesday), the resident's progress notes indicated physical therapy reported the resident's oxygen saturation levels were low, between 82-85% on room air. The LPN updated the resident's medical provider. The LPN spoke with the resident's family and sent the resident to the ER for evaluation.

A photograph taken on Wednesday, the seventh day after the fall, showed the resident in a hospital bed with an oxygen mask. The resident's right side was exposed and showed dark purple bruising that spanned from the resident's armpit and breast to below the rib cage near the hip at the top of her incontinent brief. The purple bruising covered her entire rib area. Her right breast had purple bruising and some faded yellow bruising.

The resident's hospital record indicated the resident admitted to the hospital's intensive care unit with five broken ribs on the right side with hemothorax that required two chest tubes, bilateral pulmonary embolisms (a life-threatening blockage in a lung artery caused by a blood clot), and bilateral deep vein thrombosis (a serious condition that occurs when a blood clot forms in a deep vein of the body) in both legs. The resident required a blood transfusion, medication for blood clots and oxygen. After 14 days in the hospital, the resident admitted to a skilled nursing facility.

The resident's death record indicated the resident passed away approximately six months later.

During an interview, family member 1 stated she became aware of the resident had a fall when the resident told another family member about it, two days after it occurred. Family member 1 stated if they had known about the fall right away, they would have wanted the resident to be evaluated at the ER since they were not sure if the resident had hit her head or not. Family member 1 stated the resident complained of pain on the right side of her body and the resident was in noticeable pain and discomfort the days following the fall. Family member 1 stated she never saw any documentation of an assessment, reference to the fall, or if any monitoring had been done. Family member 1 stated the resident became tired and declined to go to meals due to pain. Family member 1 stated she did not understand how facility staff could not have noticed the large bruise on the resident's side being they help bathe and dress the resident.

During an interview, family member 2 stated the facility did not notify the resident's family about the fall. Family member 2 stated they were able to watch the fall on video from the camera that is in the resident's room. Family member 2 stated she expected a full head to toe assessment to be performed on the resident, but that never happened. Family member 2 stated she visited the resident and told the facility she wanted the resident to be checked out in the ER. Family member 2 stated the facility staff did not feel it was necessary, so she had to drive the resident to the ER herself. Family member 2 stated two days later, she returned to the facility to check on the resident, and the resident had declined greatly. Family member 2 stated she called for an ambulance and while at the ER with the resident, she saw a large bruise on the resident's side. Family member 2 stated there was no way the facility staff did not see that injury, and she was never told about a bruise. Family member 2 did not believe there was any additional monitoring of the resident after the fall. Family member 2 stated it was negligent of the facility to not check the resident over after a fall.

During an interview, RN 1 stated she received a call from ULP 1 about a resident fall. RN 1 stated she heard a different name given by ULP 1, and she called the family of the resident name that she heard, which was not the resident subject of this investigation. RN 1 stated when she returned to work two days later, she realized it was the wrong resident family she had called. RN 1 stated she called the correct family member and provided an update of no injuries. RN 1 stated she updated the correct medical provider by leaving a message because there were no injuries. RN 1 stated she did not remember if she saw the resident after the fall to assess her, and it would be shocking if she did not go see her.

During an interview, RN 2 stated there is no nurse in the building after 4:00 p.m. during the week or on weekends or holidays, and staff are to call the on-call nurse as needed during those times. RN 2 stated resident assessments were to be completed after a change of condition and should accurately reflect the resident's needs. RN 2 stated she would expect staff to be monitoring resident's skin during bathing and dressing and report any skin concerns to the nurse. RN 2 stated the facility RN would see a resident for assessment after a fall to look for any latent bruising or injury, checking range of motion, making sure the resident remains cognitively intact and at baseline.

During an interview, a LPN stated if a resident had a fall after regular business hours, the nurse would make a follow up visit the next time they were in the facility.

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

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

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

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

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

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

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

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

The facility provided adequate staffing levels.

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

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

The maltreatment was not a sudden or foreseen event.

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

Action taken by facility:
Staff notified the RN following the fall. The RN notified the medical provider to obtain x-ray orders. The facility nurses contacted family and coordinated transport of the resident to the ER.

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
Anoka County Attorney
Ramsey City Attorney
Ramsey Police Department
Minnesota Board of Nursing
Minnesota Board of Medical Practice

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36601	A. BUILDING: _____ B. WING _____	C 11/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING OF RAMSEY	7007 139TH LANE NW RAMSEY, MN 55303

(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: HL366018001C/HL366015741M On November 12, 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 21 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for HL366018001C/HL366015741M, tag identification 0450, 1620, 2360.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 450 SS=G	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall:	0 450		

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0 450	Continued From page 1 (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced by: Based on interview and document review the licensee failed to provide person centered care and services in compliance with the nurse practice act including coordination and communication of changes in care for one of one residents (R1) reviewed. R1 had a fall with right hip and rib pain. R1 had significant bruising to her right ribs and experienced pain for seven days after the fall prior to admitting to the hospital with rib fractures, a large hemothorax and bilateral pulmonary emboli (a clot in the lungs). R1 required chest tubes and hospitalized for two weeks. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	0 450		

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0 450	Continued From page 2 The findings include: An Agency for Healthcare Research and Quality weblink https://www.ahrq.gov/patient-safety/settings/long-term-care/resource/injuries/fallspx/man2.html, titled The Falls Management Program: A Quality Improvement Initiative for Nursing Facilities, last reviewed December 2017, indicated for the first 72 hours after a resident fall, the nurse should do an immediate evaluation for injuries and the residents condition, including taking vital signs. A resident should be monitored for 72 hours; each shift should document in the resident's record a review of status and noting any worsening or improving symptoms. An intervention response should be in place to reduce the risk of a fall and the physician should be updated. The next action requires the nurse to complete a falls assessment including evaluation of fall risk factors, identifying need for additional interventions and coordination of the physician for any needed referrals, workup or order changes. R1 admitted on November 1, 2023. R1's diagnoses included osteoporosis and muscle weakness. R1's service plan dated November 1, 2023, indicated R1 received safety checks every two hours and assistance with dressing, bathing, transfers and medication administration. A facility incident report dated November 22, 2023, at 6:00 p.m., completed by unlicensed personnel (ULP)-H, indicated R1 had a fall and R1 sustained a skin tear to the right forearm. The incident report indicated ULP-H and ULP-E called registered nurse (RN)-C, obtained vitals and got R1 off the floor and into her recliner. R1's blood pressure was high, 194/99 and oxygen saturation was normal at 96%. ULP-H documented RN-C	0 450		

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0 450	Continued From page 3 instruction included monitor R1 and notify the RN of any changes. ULP-H documented a new action for fall prevention was to check on R1 by keeping her door open for the remainder of the shift. The report indicated RN-C notified R1's medical provider and R1's family on November 24, 2023, and ordered an x-ray. Medical provider portal notes dated November 24, 2023, at 1:48 p.m., indicated the medical provider ordered an x-ray of right hip and x-ray of chest with attention to right ribs. At 2:30 p.m., the note indicated the provider spoke with RN-C via phone, x-rays were ordered earlier, will order another x-ray STAT (immediately) and previous message had orders for x-ray of hip and ribs. The STAT order was for a STAT x-ray of the right hip. Mobile x-ray company orders dated November 24, 2023, indicated orders received for x-ray of hip with two to three views that was completed on November 25, 2023, at 8:45 a.m. The order lacked indication of x-ray of chest with attention to right ribs. R1's record lacked any follow up on coordinating with the mobile x-ray company, to ensure R1's chest x-ray order was completed. DIRECT CARE SERVICES R1's careplan dated November 1, 2023, indicated R1 required assistance with walking, transfers, bed mobility and positioning, toileting, dressing assistance with resident participation, grooming assistance with resident participation, skin scare, and medication administration. R1's service delivery record dated November 2023, included once monthly vital signs, completed on November 1, 2023.	0 450		

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0 450	Continued From page 4 R1's service delivery record dated November 2023, included a service for monitoring the skin with baths scheduled on Thursdays, however the bathing assistance service was scheduled on Tuesdays and Fridays. Following R1's fall on November 22, 2023, the skin check service was documented as completed on Thursday, November 23, 2023, at 8:19 p.m. Previous skin checks documented as complete were between 9:00 p.m. and 10:00 p.m. R1's service documentation report dated November 2023, showed the record key for bathing indicated 0 = tasked completed and not applicable was another option. All baths scheduled for Tuesdays was marked "NA." Following R1's fall on November 22, 2023, R1 received one bath on Friday November 24, 2023, at 9:44 a.m. R1's only other previously completed bath was completed on November 10, 2023, at 11:01 p.m. The other attempt on November 3, 2023, was at 10:42 a.m. R1 did not receive baths during the evening shift, inconsistent with documented skin checks occurring a day different than her scheduled bath day and at night. R1's service delivery record dated November 2023, included grooming assistance, peri-care assistance and incontinent product change scheduled every shift. R1 received grooming assistance, peri-care assistance and incontinent product change twice per day Between November 23 through 29, 2023, except on Saturday November 25, 2023, where she received those services once documented at approximately 11:00 a.m.	0 450		

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0 450	Continued From page 5 R1's service documentation report dated November 2023, staff documented bladder and bowel movements. R1 toileting frequency post fall on November 22, 2023, included: November 23, 2023, four times. November 24, 2023, three times. November 25, 2023, one time. November 26, 2023, two times. November 27, 2023, three times. November 28, 2023, three times. November 29, 2023, one time. R1's service delivery record dated November 2023, included escorts to and from the dining room scheduled every shift. R1's service documentation report dated November 2023, indicated from November 5, 2023 through November 22, 2023, R1 ate her meals in the dining room, with occasional refusal of the evening meal. Following R1's fall on November 22, 2023, R1 ate in her room 7 out 21 meals, refused 3 out of 21 meals (evening), ate in the family dining room 1 out of 21 meals and lacked any documentation for 1 out of 21 meals. R1 ate in the dining room, per her baseline, 9 out 21 times. R1's service delivery record November 2023, failed to include a service for assistance with dressing. The service delivery record indicated between November 22, 2023 through November 29, 2023, R1 receievd direct care from 15 different ULP. R1's service delivery record dated November 2023, and medication administration record (MAR) dated November 2023, lacked monitoring of R1's skin tear which resulted from on the November 22, 2023 fall, any further vital sign monitoring, and any scheduled/routine pain	0 450		

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0 450	Continued From page 6 monitoring. PAIN R1's admission skin care assessment dated November 1, 2023, indicated R1's baseline skin impairment included a scar on her coccyx. R1's cognitive assessment, Brief Interview for Mental Status (BIMS), dated November 1, 2023, indicated R1 scored 13 out of 15 possible points, indicating cognitively intact. R1's admission pain assessment dated November 1, 2023, indicated R1 had baseline right hip pain and scored her pain as 1 out 10 pain and "hurts a little bit" facial score. R1's assessment indicated Tylenol and rest were used for pain. Movement made pain worse and highest pain was 3 out of 10 and "hurts a little more" facial score. R1's pain did not affect her social activities or appetite. R1's careplan dated November 1, 2023, indicated R1 had baseline right hip/leg pain and pain management included medication. R1 was alert and oriented to person, place and time, with mild cognitive impairment. R1's MAR dated November 2023, indicated R1 had Tylenol 500 milligrams (mg) tablet, two tablets by mouth every six hours as needed for her only pain medication ordered. R1 received the following administrations of Tylenol: November 22, 2023, at 7:20 p.m., for 5 out of 10 pain. November 23, 2023, at 7:50 a.m., for 7 out of 10 pain. At 2:33 p.m., for 9 out of 10 pain. November 24, 2023, at 1:11 p.m., for 9 out of 10 pain.	0 450		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36601	A. BUILDING: _____ B. WING _____	C 11/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING OF RAMSEY	7007 139TH LANE NW RAMSEY, MN 55303

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0 450	Continued From page 7 November 26, 2023, no Tylenol was administered. November 27, 2023, at 9:29 a.m., for 4 out of 10 pain. November 28, 2023, no Tylenol was administered. November 29, 2023, at 9:27 a.m., for 5 out 10 pain. R1 had no as needed Tylenol administrations prior to her fall on November 22, 2023, and R1 reported pain levels above her baseline after the fall. R1's record lacked any changes to R1's medication orders between November 22, 2023 to November 29, 2023. R1's medical provider portal communication notes between the facility and the R1's medical provider. No communication notes were completed following R1's fall until November 24, 2023, when a new fall incident was entered. Between November 24, 2023 through November 28, 2023, included any communication between the facility and medical provider regarding R1's pain. The portal notes lacked follow up communication to the medical provider regarding the failure to complete R1's chest x-ray. R1's progress notes date November 22, 2023 through November 29, 2023, were reviewed. R1's progress notes did not include any note of R1's status from the last entry note regarding the occupational therapist visit on November 22, 2023, at 10:38 a.m. until November 24, 2023, at 7:09 p.m. R1's progress noted dated November 24, 2023, at 7:09 p.m., RN-I indicated R1 experienced	0 450		

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0 450	Continued From page 8 increased pain to her right hip and advised for non-emergency transport to hospital to prevent further injury if family transported. RN-I wrote R1 had not had portable imaging completed yet. At 7:15 p.m., RN-I documented 911 called and R1 transported to the hospital. R1's progress notes dated November 24, 2023, at 8:48 p.m., RN-C indicated R1 had a fall on November 22, 2023, and had complained of right hip and ribs pain. The progress notes indicated R1's doctor was notified, and x-ray was ordered. The notes did not included any documented direction for further monitoring of R1, including vital signs, routine monitoring of pain and directive for increased pain, monitoring for developing signs of injury, or changes in condition. R1's progress notes lacked any notes between November 24, 2023, at 8:48 p.m., until November 27, 2023, at 10:31 p.m., including documenting R1's return to the facility from the hospital and mobile x-ray's onsite Saturday, November 25, 2023. R1's progress note dated November 27, 2023, at 10:31 a.m., RN-G indicated she spoke on the phone with R1's family member regarding concerns of communication, fall assessments, and some other concerns. RN-G indicated she explained the assessment process and communication workflow. The progress note lacked any documented direction for further monitoring of R1, including vital signs, review of R1's pain, signs of injury, or changes in condition. R1's progress note dated November 27, 2023, at 10:42 a.m., indicated R1's hip x-ray was	0 450		

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0 450	Continued From page 9 completed. R1's progress notes lacked any note on November 28, 2023. R1's record lacked vital sign monitoring post November 22, 2023 fall, after the initial set of vitals, lacked record of further monitoring of R1, including vital signs, communicating and addressing increased pain between ULP, nurses and the medical provider, monitoring for any further signs of injury, or changes in condition, including skin and a decline from baseline attending meals in her room rather than the dining room. R1's progress notes dated November 29, 2023, at 12:00 p.m., licensed practical nurse (LPN)-F indicated physical therapy reported R1's oxygen saturation was low, between 82-85% on room air. LPN-F wrote she updated the medical provider and a chest x-ray, urine analysis and culture and antibiotics were ordered. LPN-F spoke with R1's family member and would send R1 to the hospital for evaluation. At 12:27 p.m., LPN-F documented R1 transported to the hospital. A photograph dated November 29, 2023, at 8:15 p.m., showed R1 in a hospital bed with a oxygen mask. R1's right side was exposed and showed dark purple bruising from her armpit to her hip at the top of her brief. The purple bruising covered her entire rib area. R1's right breast had purple bruising and some faded yellow bruising. R1's hospital record notes dated November 29, 2024, at 2:11 p.m., indicated imaging reports revealed R1 had five broken ribs on her right side with a large hemothorax and bilateral pulmonary emboli (a clot in the lungs). R1 required	0 450		

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0 450	Continued From page 10 placement of a chest tube, blood transfusion, medication for blood clots and oxygen. R1 had a second chest tube place on December 4, 2023 and R1 required intensive care unit during her hospitalization. R1 had chest tubes removed on December 6 and 7, 2023. R1 discharged from the hospital on December 12, 2023. During an interview on November 25, 2024, at 9:00 a.m., RN-C stated she received a call about a resident fall. Two days later when RN-C stated she then updated R1's family and medical provider of the fall with no injuries. RN-C stated she did not recall if she saw R1 after the fall to assess her but stated it would be shocking if she did not go see her. During an interview on November 25, 2024, at 11:05 a.m., RN-D stated she would expect staff to monitor resident's skin while assisting with bathing and dressing and report any skin concerns to the nurse. RN-D stated the nurse would see a resident for assessment after a fall to look for any latent bruising or injury, check for range of motion, and to make sure the resident remained cognitively intact and at baseline. During an interview on November 26, 2024, at 11:00 a.m., ULP-E stated if staff find bruising during rounds they report to the nurse. ULP-E stated after a fall, the nurse tells staff what to do, ULP staff keep an eye on the resident and update nurses with any changes. ULP-E stated she could not recall if R1 had any bruises following her fall. The licensee policy titled Incident Report/Falls Report, dated July 19, 2021, indicated if an incident happens outside of business hours, staff must report to the RN on-call who will contact the responsible party. If a severe incident or injury,	0 450		

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0 450	Continued From page 11 staff are to call 911. The policy lacked directive of monitoring of a resident following a fall. The licensee policy titled Resident Change in Condition or Need, dated July 20, 2021, failed to include directive on how to identify a change in condition. The policy indicated when a change in condition is identified, the RN will conduct an assessment. TIME PERIOD FOR CORRECTION: Seven (7) days	0 450		
01620 SS=G	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (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	01620		

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01620	Continued From page 12 resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and document review) the licensee failed to conduct a registered nurse (RN) assessment following a fall with injury, change of condition of increased pain, and post emergency room visit assessments, as required for 1 of 1 residents (R1) reviewed. R1 had a fall with right hip and rib pain. R1 had significant bruising to her right ribs and experienced pain for seven days after the fall prior to admitting to the hospital with rib fractures, a large hemothorax and bilateral pulmonary emboli (a clot in the lungs). R1 required chest tubes and hospitalized for two weeks. The licensee nursing staff failed to assess R1 at any point after her fall, resulting in failure to follow up on chest x-ray orders and timely treatment for R1's injuries. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: Minnesota Rules 4659.0140 Initial Assessments and Continuing Assessments, indicates a nursing assessment or reassessment required under 144G.70, subdivision 2, must include assessing components of the uniform assessment tool, defined in Minnesota Rule 4659.0150 and conducted in person. The uniform assessment	01620		

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01620	Continued From page 13 tool includes activities of daily living status; physical health status, including review of medications, recent emergency room visits, vital signs if indicated by health condition; skin condition; pain; potential needs for delegated nursing services; fall risks; and determine need for follow up referrals for additional medical health professionals. The nursing assessment must be in writing, dated and signed by a registered nurse (RN) who conducted the assessment. R1 admitted to the licensee on November 1, 2023. R1's diagnoses includes osteoporosis and muscle weakness. R1's service plan dated November 1, 2023, indicated R1 received safety checks every two hours and assistance with dressing, bathing, and medication administration. R1's admission skin care assessment dated November 1, 2023, indicated R1's baseline skin impairment included a scar on her coccyx. R1's cognitive assessment, Brief Interview for Mental Status (BIMS), dated November 1, 2023, indicated R1 scored 13 out of 15 possible points, indicating cognitively intact. R1's admission pain assessment dated November 1, 2023, indicated R1 had baseline right hip pain and scored her pain as 1 out 10 pain and "hurts a little bit" facial score. R1's assessment indicated Tylenol and rest were used for pain. Movement made pain worse and highest pain was 3 out of 10 and "hurts a little more" facial score. R1's pain did not effect her social activities or appetite. R1's careplan dated November 1, 2023, indicated R1 had baseline right hip/leg pain and pain management included medication. R1 was alert	01620		

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01620	Continued From page 14 and oriented to person, place and time, with mild cognitive impairment. A facility incident report dated November 22, 2023, at 6:00 p.m., completed by unlicensed personnel (ULP)-H, indicated R1 had a fall and sustained a skin tear to the right forearm. The incident report indicated ULP-H and ULP-E called RN-C, obtained vitals and got R1 off the floor and into her recliner. R1's blood pressure was high, 194/99. RN-C notified R1's medical provider and R1's family on November 24, 2023, and ordered an x-ray. The report did not indicate an assessment was completed by a nurse. The section titled "RN review, Additional Comments and Follow-up" was left blank on the incident report. R1's medication administration record (MAR) dated November 2023, indicated R1 complained of pain at a level of 5 out of 10 on November 22, 2023, at 7:20 p.m., and received two 500 milligrams (mg) tablets of Tylenol (pain medication). R1's MAR dated November 2023, indicated R1 complained of pain at a level of 7 out of 10 at 7:20 a.m. and again at a level of 9 out of 10 at 2:33 p.m. on November 23, 2023. R1 received two 500 mg tablets of Tylenol at each administration. R1's MAR dated November 2023, indicated R1 complained of pain at a level of 9 out of 10 at 1:11 p.m. on November 24, 2023, and received two 500 mg tablets of Tylenol. The record indicated the medication was not effective. Medical provider portal notes dated November 24, 2023, at 1:48 p.m., indicated the medical	01620		

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01620	Continued From page 15 provider ordered an x-ray of right hip and x-ray of chest with attention to right ribs. At 2:30 p.m., the note indicated the provider spoke with RN-C via phone, x-rays were ordered earlier, will order another x-ray STAT (immediately) and previous message had orders for x-ray of hip and ribs. The STAT order was for a STAT x-ray of the right hip. R1's progress noted dated November 24, 2023, at 7:09 p.m., RN-I indicated R1 experienced increased pain to right hip and advised for non-emergency transport to hospital to prevent further injury if family transported. RN-I wrote R1 had not had portable imaging completed yet. At 7:15 p.m., RN-I documented 911 called and R1 transported to the hospital. R1's progress notes dated November 24, 2023, at 8:48 p.m., RN-C indicated she received a call from the ULP on November 22, 2023, R1 had an unwitnessed fall and had complained of right hip and ribs pain. The progress notes indicated R1's doctor was notified, and x-ray was ordered. The note did not indicate a nurse completed an assessment for R1 following the fall with injury. Mobile x-ray company orders dated November 24, 2023, indicated orders received for x-ray of hip with two to three views that was completed on November 25, 2023, at 8:45 a.m. The order lacked indication of x-ray of chest with attention to right ribs. R1's MAR dated November 2023, indicated R1 complained of pain at a level of 7 out of 10 on November 25, 2023, at 8:58 a.m. R1 received two 500 mg tablets of Tylenol. Medical provider portal note dated November 25, 2023, at 9:28 a.m., indicated the medical provider	01620		

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01620	Continued From page 16 wrote to the facility they were notified R1 was seen at the hospital emergency room (ER) on November 24, 2023 at 7:51 p.m. and discharged from the ER on November 25, 2023, at 12:12 a.m. The medical provider requested the facility nursing staff to provide an update on R1. Medical provider portal note dated November 26, 2023, at 4:29 p.m., the medical provider nurse sent a message to the facility nursing staff indicating it was noted R1 was discharged from the hospital. Again requested an update on R1's status. The medical provider nurse notified the facility nursing staff R1 was scheduled to be seen by the medical provider on Tuesday (November 28, 2023). R1's MAR dated November 2023, indicated R1 complained of pain at a level of 4 out of 10 at 9:29 a.m. on November 27, 2023. R1 received two 500 mg tablets of Tylenol. R1's progress note dated November 27, 2023, at 10:31 a.m., RN-G indicated she spoke on the phone with R1's family member regarding concerns of communication, fall assessments, resident identification and some other concerns. RN-G indicated she explained the assessment process and on-call nurse process to R1's family member. Medical provider portal notes dated November 27, 2023, indicated licensed practical nurse (LPN)-F faxed the x-ray results of R1's hip completed on November 25, 2023. The medical provider asked if R1 was seen at the hospital for the hip pain or another issue. LPN-F replied R1 was seen for the hip pain after the fall. R1's record lacked progress notes dated	01620		

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01620	Continued From page 17 November 28, 2023, the day R1 was scheduled to be seen by her medical provider. R1's MAR dated November 2023, indicated R1 complained of pain at a level of 5 out of 10 on November 29, 2023, at 9:27 a.m. R1 received two 500 mg tablets of Tylenol. R1's progress notes dated November 29, 2023, at 12:00 p.m., LPN-F indicated physical therapy reported R1's oxygen saturation was low, between 82-85% on room air. LPN-F wrote a chest x-ray, urine analysis and culture and antibiotics were ordered. LPN-F spoke with R1's family member and would send R1 to the hospital for evaluation. At 12:27 p.m., LPN-F documented R1 transported to the hospital. R1's progress notes dated November 22, 2023, through November 29, 2023, lacked documented evidence of a nursing assessment completed by a RN on R1. R1's medical record lacked documentation of a nursing assessment completed by a RN on R1 following a fall with injury, pain and post ER visit. A photograph dated November 29, 2023, at 8:15 p.m., showed R1 in a hospital bed with a oxygen mask. R1's right side was exposed and showed dark purple bruising from her armpit to her hip. The purple bruising covered her entire rib area. R1's right breast had purple bruising and some faded yellow bruising. R1's hospital record dated November 29, 2023, indicated imaging reports revealed R1 had five broken ribs on her right side with a large hemothorax and bilateral pulmonary emboli. R1 required placement of a chest tube, blood transfusion, medication for blood clots and	01620		

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01620	Continued From page 18 oxygen. R1 had a second chest tube place on December 4, 2023 and R1 required intensive care unit during her hospitalization. R1 had chest tubes removed on December 6 and 7, 2023. R1 discharged from the hospital on December 12, 2023. A photograph dated November 29, 2023, at 8:15 p.m., showed R1 in a hospital bed with a oxygen mask. R1's right side was exposed and showed dark purple bruising from her armpit to her hip. The purple bruising covered her entire rib area. R1's right breast had purple bruising and some faded yellow bruising. During an interview on November 19, 2024, at 1:00 p.m., family member (FM)-A stated if she knew of the fall right away, she would have had R1 evaluated in the emergency room. FM-A stated R1 had complained of pain on the right side of her body and had noticeable pain and discomfort the days following the fall. FM-A stated she never saw any documentation of an assessment or additional monitoring of R1 following the fall. FM-A stated R1 became very tired and declined to go to meals due to pain following the fall, which was not R1's baseline. During an interview on November 19, 2024, at 3:00 p.m., FM-B stated she expected a full head to toe assessment of R1, but it never happened. FM-B stated she noted R1 had declined during a visit with R1 after the fall. FM-B did not believe the facility had checked R1 over after the fall or perform any additional monitoring. During an interview on November 25, 2024, at 9:00 a.m., RN-C stated she received a call about a resident fall. RN-C stated she heard the staff tell her a different resident name, not the name of	01620		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING OF RAMSEY	7007 139TH LANE NW RAMSEY, MN 55303

(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 19 R1. Two days later when RN-C returned to work, she realized the mistake of reporting a fall to the family and medical provider of a resident other than R1. RN-C stated she then updated R1's family and medical provider of the fall with no injuries. RN-C stated she did not recall if she saw R1 after the fall to assess her but stated it would be shocking if she did not go see her. During an interview on November 25, 2024, at 11:05 a.m., RN-D stated an assessment should be completed on a resident after a change in condition and should accurately reflect the resident's needs. RN-D stated she would expect staff to monitor resident's skin while assisting with bathing and dressing and report any skin concerns to the nurse. RN-D stated the nurse would see a resident for assessment after a fall to look for any latent bruising or injury, check for range of motion, and to make sure the resident remained cognitively intact and at baseline. During an interview on November 27, 2024, at 2:30 p.m., LPN-F stated if a resident had a fall after regular business hours, the nurse would make a follow up the next time they were in. The licensee-provided policy titled Resident Change in Condition or Need dated July 20, 2021, indicated change of condition assessments will be initiated after every resident readmission to the facility from the hospital, emergency department or other medical/treatment stay. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
02360	144G.91 Subd. 8 Freedom from maltreatment	02360		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36601	A. BUILDING: _____ B. WING _____	C 11/12/2024

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02360	Continued From page 20 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.	