Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL20006019M
Compliance #: HL20006020C

Date Concluded: August 17, 2021

Name, Address, and County of Licensee Investigated:
Regina Assisted Living
1175 Nininger Road
Hastings, MN
55033

Facility Type: Home Care Provider

Investigator's Name: Erin Johnson-Crosby RN, Special investigator

Finding: Substantiated, facility responsibility

Nature of Visit:
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.

Allegation(s): It is alleged: The facility neglected the client when they failed to ensure the client had access to a call light system. The client was pushed into the middle of his room without access to a call light. The client attempted to self-transfer, fell, broke his hip, and died.

Investigative Findings and Conclusion:
Neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to assess the client's ability to use a pull cord and failed to provide access to a call light system.

The investigation included observation of staff and client interactions. The investigator conducted interviews with administrative staff, nursing staff, unlicensed staff, and the client's power of attorney (POA). The investigator reviewed facility documentation, including incident reports, grievances, policies and procedures, client records, and employee training records.

During an observation, another client did not have access to the call light. One time the call light was on the floor and another time the call light was wrapped around the side rail.

The client resided in memory care and had diagnoses including dementia, anxiety, and displaced fracture of left acetabulum (break in the socket portion of the ball and socket hip joint).

The client's service plan identified the client required assistance of two staff and a transfer belt for transfers and for staff to use a mechanical lift as needed for weakness. The service plan also identified the client was at risk for falls due to vision and hearing impairment, memory issues and deconditioning (functional loss following inactivity). The intervention included that staff were to meet the client's needs 24 hours per day. The service plan did not include specific individual fall interventions and did not include whether the client could be left alone in his room without access to a call light. The service plan also did not include if the client's foot pedals should be on his wheelchair.

The client's 90-day assessment indicated the client occasionally fell three to six times per year and staff were to report increasing evidence of unsteadiness or other safety concerns. Staff were to report all falls and any increase in falls. Another intervention included staff will meet the client's needs 24 hours per day.

The client's Resident Occurrence Management Project (ROMP) identified staff found the client lying on the floor on his left side. Unlicensed personnel (ULP) heard a cracking sound and observed the client had facial grimacing and displayed signs and symptoms of pain. The client's left leg was shorter than the right leg and rotated outward. Emergency services (EMS) transported the client to the hospital.

The facility's Minnesota Adult Abuse Reporting Center (MAARC) report identified the client fell after getting up from the wheelchair. The report indicated client's family was upset and claimed if staff would not have left him alone in his room the client would not have fallen. The client had a history of impaired mobility, multiple falls, and dementia. The client had poor safety awareness and would attempt to self-transfer. The MAARC report identified staff were not able to be with every client all the time and the clients were allowed to be in their apartment unsupervised. The MAARC report identified the client's fall interventions included: staff will respond promptly to the clients call for assistance; call light within reach of the client when he is in bed; footwear will fit properly; keep curtain open when personal care is not being done; keep paths clear of clutter; move trash can, shoes or other personal items out of the way and leave the door open with the bathroom light on. The MAARC report indicated the ULP assisted to the client to his room to get the client ready for bed. The ULP said she was called to assist another ULP with a client transfer in another room and left the client for about five minutes. When the ULP returned, the client was on the floor. The nurse was notified, and the client was sent to the emergency department (ED) via ambulance.

The client's fall interventions were not included on the client's service plan, daily service schedule or nursing assessments.

The facility progress notes call summary (documentation from an on-call provider group) identified the client fell while trying to stand up and walk to his bed. When staff tried to get the client up the staff heard a cracking sound. EMS was called and transferred the client to the hospital.

The client's progress note authored by the Registered Nurse (RN) identified the client must have stood up from his wheelchair and self-transferred, took a few steps lost his balance. The progress notes also identified the unlicensed personnel (ULP) heard a cracking noise and the client was kept still until the resident was taken by stretcher to the Emergency room (ER) for signs and symptoms of a possible left hip fracture.

The client's hospital records identified the client was admitted to the hospital with a displaced left acetabular fracture and nondisplaced fracture of left inferior pubic ramus (hip bone). It was noted the client's family preferred non-surgical management of the injuries. The client was discharged back to the facility on hospice services three days after the fall.

The client's death record indicated the client died six days later with an immediate cause of death noted as complications of left hip and pelvis fractures from a fall.

The facility did not have any documentation regarding recent staff education that pertained to client falls and call lights. The facility also did not have client assessments for ability to use the pull cord or documentation of a discussion of the call light system upon admission or with nursing assessments that were completed.

Employee records were reviewed and did not contain training records regarding call lights. The facility did not have a policy related to assessing the client's ability to use the call system.

When interviewed, the family member said the facility called after the client had fallen and the facility nurse said the client must have broken something because they heard a snap. The nurse asked the family member if the ambulance should be called. When the client returned to his room following the hospital stay the wheelchair was sitting where staff left the client in the middle of the room without foot pedals on. The family member said if the client had his foot pedals on the wheelchair, the fall would not have happened. The family member said she had told staff several times the client needed to have his foot pedals on. The family member also said a client that is not able to reach the pull cord to call for help should not be left alone in their room as the pull cord was not long enough to reach the middle of the room. The family member also said she had never been offered a different call light system.

When interviewed, the registered nurse (RN) said when she works in the client's unit, she has all clients in the lobby until staff can get them ready for bed. The RN said it is not safe to leave them in their room unattended. The RN said there is a pull cord by the client's bed, but no other call light system was available. The call light system lights up outside of the room when the cord is pulled but does not make a sound to alert staff that a client has called for assistance.

The RN did not know if the client needed to have foot pedals on his wheelchair and said staff did not move the client before calling EMS.

When interviewed, two ULPs said if a client was not in their bed by the pull cord, the client would not be able to call for help and did not know if the client could be left alone in their room without access to a call light. When interviewed, the licensed practical nurse (LPN) said if the clients are not by the pull cord, they would not be able to call for help. Staff would have to walk by and hear the client yelling. The LPN also said the client should have had his foot pedals on, but it was not in the service plan. The LPN did not know if the clients could be left alone in their rooms without access to a call light.

When interviewed, the Housing Director said the call light system on the client's unit only lights up and does not make a sound and it was a pull cord system. The Housing Director said clients on the unit would not know how to operate a pendant and the pendants would be lost within seconds. The Housing Director said the pendant call system was not working during the onsite visit. The Housing Director did not know if assessments were completed to see if the clients could use the current call system. The Housing Director said the facility has been talking about a new call light system for two years.

When interviewed, ULP#1 said she worked the evening the client fell. ULP#1 said ULP#2 brought the client to his room, but ULP#1 needed assistance with another client's transfer, so ULP#2 came to assist her. ULP#1 said ULP#2 left the client for only two to three minutes and then returned to the client's room and found the client on the floor. ULP#1 said the RN and ULP#2 attempted to get the client off the floor without a mechanical lift until ULP#1 stopped them. ULP#1 said when they rolled the client over, they heard a crack. ULP#1 also said the client should always have foot pedals on the wheelchair and should not be left alone in his room. ULP#1 also said she did not know how the client would call for help if the client was in the middle of the room.

The investigator attempted to reach ULP#2 multiple times for an interview. ULP#2 did not respond to the requests.

When interviewed, the Director of Nursing (DON) said she was not the DON at the time of the incident and did not complete the MAARC report. The DON said the Housing Director discusses call lights with client family members upon client admission but was unsure if that discussion was documented anywhere. The DON said there was no assessment completed to determine if clients could use the pull cord. The DON also said the facility should have had communication with the client's family about the call light system. The DON said the facility should have made sure the client could use the pull cord or a pendant and if the client could not, there should have been another fall intervention besides having the call light within in reach when the client is in bed, which was listed as a fall intervention on the MAARC report. The DON also said progress notes were lacking detail to be able to complete a root cause analysis regarding falls and nursing staff would need to be re-educated. The DON also said she was not aware if falls

were tracked and trended and also indicated the facility could do a more thorough job on client assessments. The DON said falls were reviewed weekly.

An email was sent to the DON by the investigator requesting contact information for the cooperate nurse to discuss this incident. The DON did not reply to the email.

In conclusion, neglect was substantiated. The facility did not assess the client's individual needs regarding the ability to use the call light system. The service plan did not include fall interventions or did not include if the client was able to be in his room alone without access to a call light. The facility did not identify and take corrective action or implement measures to reduce the risk for further occurrence of this error and/or similar errors.

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:
(a) 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.
(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

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

Action taken by facility:
No action was taken by the facility to prevent re-occurrence.

Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:
https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html, or call

651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

cc:
The Office of Ombudsman for Long-Term Care
County Attorney Dakota County
City Attorney for Hastings, MN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H20006	A. BUILDING: _____ B. WING _____	C 06/22/2021

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REGINA ASSISTED LIVING	1175 NININGER ROAD HASTINGS, MN 55033

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0 000	Initial Comments ******ATTENTION****** HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: On June 22, 2021, a complaint investigation was initiated to investigate complaints #HL20006018M/HL20006017C, #HL20006019M/HL20006020C and #HL20006021M/HL20006022C. The following correction order is re-issued related to #HL20006018M/HL20006017C, #HL20006019M/HL20006020C and #HL20006021M/HL20006022C, tag identification 0645. The following new correction orders are issued for the aforementioned complaints, tag identification 0265, 0715, 1210, and 1252. The following new correction orders are issued related to complaint #HL20006019M/HL20006020C, tag identification 0805 and 2015. The following new correction orders are issued	0 000	The Minnesota Department of Health documents the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the investigators ' findings is the Time Period for Correction. Per Minnesota Statute § 144A.474, Subd. 8(c), the home care provider must document any action taken to comply with the correction order. A copy of the provider ' s records documenting those actions may be requested for licensing order follow-ups. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states " Provider ' s Plan of Correction." The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144A.474, Subd. 11 (b).	

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0 000	Continued From page 1 for complaints #HL20006021M/HL20006022C and #HL20006018M/HL20006017C, tag identification 0865 and 0935.	0 000		
0 265 SS=J	144A.44, Subd. 1(a)(2) Up-To-Date Plan/Accepted Standards Practice Subdivision 1.Statement of rights. (a) A client who receives home care services in the community or in an assisted living facility licensed under chapter 144G has these rights: (2) receive care and services according to a suitable and up-to-date plan, and subject to accepted health care, medical or nursing standards and person-centered care, to take an active part in developing, modifying, and evaluating the plan and services; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide services according to accepted standards of medical, nursing, and health care practices for falls for two of two clients (C1, C2) reviewed. C1 fell 33 times in approximately four months. C2 fell, fractured his left hip and pelvis, and later died of complications due to his fractures. Licensee nursing staff failed to conduct appropriate post-fall assessments to determine causative factors and implement specific interventions to minimize the risk of future falls and potential injury following C1 and C2's falls. This practice resulted in a level four violation (a violation that results in serious injury, impairment, or death), and was issued at an isolated scope	0 265		

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0 265	Continued From page 2 (when one or a limited number of clients are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: C1 The American Journal of Nursing article titled, "When a Fall Occurs," dated November 2007, volume 107, number 11, indicated fall analysis should be completed to identify the underlying causes and risk factors of the fall. Immediate follow-up will help identify and enable staff to initiate preventative measures. C1's current face sheet identified C1 resided in the licensee's memory care unit. C1's physician order report identified C1 had diagnoses of vascular dementia, anxiety, and Parkinson's disease. C1's service plan dated June 7, 2021, identified C1 required extensive assistance of one to two staff members for activities of daily living (ADLs). C1 had greater than 6 falls per year so staff should report all falls and evidence of unsteadiness. C1's service plan identified C1 was at risk for falls due to Parkinson's disease. Interventions included staff instructions to keep the area free of obstructions to reduce C1's risk of falls or injury; remind C1 to use the emergency pull cord as needed; ensure C1's footwear fit properly with non-skid soles; keep curtains open; keep paths clear; and C1 should wear a helmet when he is walking. Staff were supposed to complete safety checks every two hours between toiletings. C1 was oriented to person and place; staff were to provide daily cueing. C1's toileting	0 265		

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0 265	Continued From page 3 schedule identified staff should toilet C1 according to the floor rounding schedule. On June 22, 2021, at 3:06 p.m., the evaluator observed C1's pull cord laying on the floor out of C1's reach to call for staff assistance. On June 23, 2021, at 10:47 a.m., the evaluator observed C1's pull cord wrapped around his side bedrail on his bed. C1's progress notes and ROMPS (Resident Occurrence Management Project) identified C1 experienced falls on: - February 23, 2021, at 10:48 p.m., staff found C1 lying on his back in front of the closet. C1 said he tripped on the wheelchair. C1 had an abrasion to the left thumb and shoulder. C1 said he was going to the bathroom. The ROMP was signed on March 5, 2021, did not include an assessment for causative factors or the intervention identified or fall precautions initiated. - February 28, 2021, at 3:00 p.m., staff found C1 lying on the floor in front of the bed with his head under his walker. C1 said he was going to the bathroom. There was no ROMP documentation completed for this fall. - March 5, 2021, nursing staff completed a change in condition assessment, and C1's service plan was reviewed. -March 7, 2021, at 4:50 a.m., staff found C1 sitting on the floor. C1 fell while attempted to go to the bathroom. C1 wore slippers, but no helmet or glasses. The bathroom light was on; C1 was not using his walker. Staff last checked C1 at 2:30 a.m. The ROMP was signed March 18, 2021 but did not include causative factors or post-fall	0 265		

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0 265	Continued From page 4 interventions. - March 7, 2021, at 3:20 p.m., C1 experienced an unwitnessed fall but there was no further description of the fall and no ROMP completed. - March 12, 2021, at 10:31 p.m., C1 self-transferred and ambulated to get to the bathroom, lost his balance, and fell. The incident report signed on March 18, 2021, identified the interdisciplinary team reviewed the fall. The ROMP did not include an assessment for causative factors or post-fall interventions. - March 15, 2021, at 8:10 a.m., staff found C1 on the floor in the television room. The ROMP signed on April 1, 2021, identified C1 and his family were educated, and the service plan reviewed. The report did not include an assessment for causative factors or post-fall interventions. - March 18, 2021, at 6:30 p.m., staff found C1 on floor and reminded him to wear his helmet and ask for help. There was no ROMP documentation completed for this fall. - March 21, 2021, at 11:30 p.m., staff found C1 on the floor with no injuries. There was no ROMP or assessment documentation for causative factors or post-fall interventions. - March 25, 2021, at 4:07 a.m., staff found C1 on the floor by his closet with no injuries. There was no ROMP or assessment documentation for causative factors or post-fall interventions. - March 31, 2021, at 3:15 p.m., staff found C1 on the floor in front of the bathroom. The ROMP signed on April 1, 2021, identified C1 was sitting	0 265		

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0 265	Continued From page 5 on the floor on his bottom in front of the doorway to the bathroom. C1 was wearing proper footwear and his walker was within reach. The post-fall interventions included educating C1 and his family, and the service plan reviewed. - April 1, 2021, nursing staff completed a change in condition due to C1's recent falls; current services were considered appropriate. - April 4, 2021, at 12:30 p.m., C1 fell, and staff assisted C1 to the bathroom. There was no ROMP or assessment documentation for causative factors or post-fall interventions. - April 4, 2021, at 3:54 a.m., staff found C1 lying on his back in front of his bed with no injuries. There was no ROMP or assessment documentation for causative factors or post-fall interventions. - April 6, 2021, at 11:45 p.m., staff found C1 on the floor to the right of the toilet. The ROMP signed April 12, 2021, identified staff found C1 sitting on the floor with his back against the wall. Post- fall interventions included fall precautions initiated, C1 and his family education, increased monitoring and supervision, and service plan review. - April 8, 2021, at 1:50 a.m., while staff walked C1 to the toilet, C1 fell. The fall scraped the top layer of skin off C1's right shoulder blade. There was no ROMP or assessment documentation for causative factors or post-fall interventions. - April 11, 2021, at 2:36 p.m., staff noted C1 fell during the early morning with no injury. The ROMP signed on April 12, 2021, identified C1 fell early morning with no injuries. The post-fall	0 265		

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0 265	Continued From page 6 interventions included fall precautions initiated, C1 and family educated, and increased resident monitoring. - April 12, 2021, nursing staff completed a change in condition assessment for C1 related to falls; C1's current services were determined to be appropriate. - April 13, 2021, at 9:30 p.m., staff found C1 in the hallway on the floor outside of the doorway to his room. C1 had an abrasion to the left side of his forehead. There was no ROMP or assessment documentation for causative factors or post-fall interventions. - April 15, 2021, at 1:15 a.m., staff found C1 on the floor in the hallway outside of the doorway. The ROMP signed on April 19, 2021, identified post-fall interventions included fall precautions initiated, family educated, and IDT reviewed. - April 27, 2021, at 8:30 a.m., staff found C1 on the dining room bathroom floor in front of the sink. The ROMP signed on May 18, 2021, identified C1 had 16 falls in six months and noted the majority of C1's falls occurred in C1's room, including the bathroom. The post-fall interventions included increase supervision and consideration of a toileting plan. - May 5, 2021, at 9:45 p.m., staff found C1 on floor. The ROMP signed May 18, 2021, identified C1 was found on the floor with no injury. The post-fall intervention was considering a toileting plan. - May 6, 2021, at 12:54 a.m., staff found C1 lying on his back on the floor at the foot of his bed trying to go to the bathroom. There was no	0 265		

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0 265	Continued From page 7 ROMP or assessment documentation for causative factors or post-fall interventions. - May 6, 2021, at 11:38 p.m., staff found C1 on the floor with his back against the wall. The ROMP signed on May 18, 2021, identified post-fall interventions for fall precautions and increase client monitoring and supervision. - May 8, 2021, at 1:00 a.m., staff found C1 on the floor lying on his back. There was no ROMP or assessment documentation for causative factors or post-fall interventions. - May 12, 2021, at 12:00 a.m., staff found C1 on the floor lying next to the couch; C1 said he heard people talking. The ROMP signed May 18, 2021, included post-fall interventions to remind C1 to use his emergency pull cord, fall precautions initiated, and increased supervision. - May 15, 2021, at 4:30 a.m., staff found C1 in the bathroom lying in front of the toilet with a right arm skin tear. The ROMP signed on May 18, 2021, included post-fall interventions to ensure C1's walker is by his bed, gripper socks are on, complete safety checks, and to keep the bathroom light on. - May 18, 2021, at 1:55 a.m., staff found C1 lying on the floor on right side with his walker tipped over. The ROMP was signed on May 19, 2021, noted C1 reported someone was talking and woke C1 up. - May 20, 2021, at 3:46 p.m., staff found C1 lying on his back on the floor. The ROMP signed May 25, 2021, identified C1 was trying to get out of his wheelchair in the dining room and fell. Post-fall interventions included to increase client	0 265		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA ASSISTED LIVING	1175 NININGER ROAD HASTINGS, MN 55033

(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
0 265	Continued From page 8 monitoring. - May 25, 2021, at 1:39 p.m., staff found C1 lying on the floor by his bed. The ROMP signed June 14, 2021, noted C1 was found lying on the floor at the foot of his bed. Post-fall interventions included staff rounding on C1 every two hours and offering toileting. The ROMP identified C1 had poor safety awareness related to his dementia. - May 30, 2021, at 7:15 a.m., staff saw C1 stumble and fall to the floor. C1 had a laceration and abrasion on his eyebrow. C1 was ambulating without his walker. The ROMP signed June 3, 2021, identified post-fall interventions as increased client monitoring and supervision. - June 4, 2021, at 9:30 p.m., staff found C1 sitting on his bathroom floor. The ROMP was signed on June 14, 2021, and did not include post-falls interventions to prevent future falls. - June 11, 2021, at 3:45 a.m., staff found C1 on the floor by the bedside; C1 did not have his helmet on. The ROMP signed on June 14, 2021, identified post-falls interventions as the service plan was reviewed and increased monitoring and supervision. - June 7, 2021, nursing staff completed a change in condition assessment; C1's services were updated to meet C1's care needs. - June 11, 2021, at 3:45 a.m., staff found C1 lying on floor by the bedside. The ROMP signed on June 14, 2021, identified the service plan was reviewed and to increase client supervision. - June 14, 2021, at 3:50 a.m., staff found C1 lying	0 265		

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0 265	Continued From page 9 in the middle of the floor of his room. C1's walker was found in the bathroom. There was no ROMP or assessment documentation for causative factors or post-fall interventions. - June 17, 2021, at 4:35 a.m., staff found C1 sitting on the floor. There was no ROMP or assessment for causative factors or post-fall interventions. On June 28, 2021, the evaluator received email correspondence from the Director of Nursing (DON) verifying she sent the evaluator all of C1's ROMP documentation to which she had access. On June 23, 2021, at 1:56 p.m., the DON said C1's progress notes were lacking detail to be able to complete a root cause analysis regarding falls and that licensee staff would need to be re-educated. On July 26, 2021, at 1:45 p.m., the DON could not articulate how the licensee tracked and trended client falls in the facility. C2 C2's current face sheet identified C2 resided in memory care with diagnoses including dementia, anxiety, and displaced fracture of left acetabulum. C2's service plan dated June 27, 2020, identified C2 required extensive assistance with activities of daily living (ADLs) and was toileted per the floor rounding schedule. C2 required the assistance of two staff members, a transfer belt and a mechanical lift for transfers, as needed, for weakness. C2's service plan identified C2 was at risk for falls due to vision/hearing impairment,	0 265		

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0 265	Continued From page 10 memory issues and deconditioning. The interventions noted instructed staff to meet C2's needs 24 hours per day. C2's ROMP dated April 12, 2021, at 7:00 p.m., identified staff found C2 found lying on the floor on his left side. Unlicensed personnel (ULP) heard a cracking sound and observed C2 had facial grimacing and was displaying signs and symptoms of pain. It was noted C2's left leg was shorter than the right leg and rotated outward. Emergency medical services (EMS) transported C2 to the hospital. Minnesota Adult Abuse Reporting Center (MAARC) report submitted April 14, 2021, at 9:33 a.m., identified C2 fell after getting himself up from his wheelchair into bed. C2's family was upset and claimed if staff would not have left him in his room alone. he would not have fallen. C2 had a history of impaired mobility, multiple falls, and dementia. C2 had poor safety awareness and would attempt to self-transfer. The MAARC report identified staff were not able to be with every client all the time, and clients were allowed to be in their apartment unsupervised. The MAARC report identified C2's fall interventions in place included: staff will respond promptly to C2's calls for assistance; put call light within reach of C2 when he is in bed; footwear will fit properly; keep curtain open when personal care is not being done; keep paths to the bathroom free from clutter; move trash cans, shoes, or other personal items out of the way and leave the door open with the bathroom light on. C2's fall interventions were not included on C2's service plan or assessment. The MAARC report indicated the staff member assigned to the client said she brought C2 to his room in his wheelchair at 6:45 p.m. the day of the fall to start getting him ready for bed. The staff	0 265		

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0 265	Continued From page 11 member was then called to assist another staff member with a client transfer and left C2 for five minutes. When the staff member returned, the staff member observed C2 on the floor. The nurse was notified, and C2 was sent to the emergency department (ED). The ED confirmed C2 had a minimally displaced left acetabular fracture and nondisplaced fracture of his left inferior pubic ramus. Facility progress note call summary dated April 12, 2021, identified in a fall report that C2 tried to independently stand up from a wheelchair and self-transferred and ambulated to bed. C2 lost his balance and fell on his left side. When staff tried to get the C2 up, they heard a cracking sound. Emergency medical services was called, and C2 was transferring to the hospital. C2's progress note dated April 12, 2021, identified C2 must have stood up from the wheelchair and self-transferred, took a few steps and lost his balance. The staff on duty heard a cracking noise. C2's hospital records identified C2 was admitted to the hospital on April 12, 2021, with a displaced left acetabular fracture and nondisplaced fracture of left inferior pubic ramus. It was noted C2's family preferred non-surgical management of C2's injuries; C2 was discharged to licensee on hospice services on April 15, 2021. C2's death record identified C2 died on April 18, 2021. The immediate cause of death was noted as complications of left hip and pelvis fractures from a fall. On July 8, 2021, at 10:21 a.m., family member (FM)-C said the licensee staff lacked knowledge	0 265		

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0 265	Continued From page 12 and training; staff did not know what to do to care for the clients. FM-C said she received a call from the licensee on April 12, 2021, at around 7:30 p.m. where FM-C learned C2 had fallen, and licensee's nurse said they thought he broke something because they heard a snap. FM-C said the nurse asked if she should call an ambulance. When C2 returned to his room on April 15, 2021, FM-C said his wheelchair was sitting where they left him which was in the middle of the room without the wheelchair foot pedals on. FM-C said if C2 would have had his foot pedals on the wheelchair, the fall would not have happened. FM-C said she had told staff members several times C2 needed foot pedals on. FM-C also said someone that is not able to reach the pull cord to call for help should not be left alone in their room as the pull cord was not long enough to reach the middle of the room. On July 8, 2021, at 1:30 p.m., registered nurse (RN)-A said all clients on C2's unit are out in the lobby until staff can get them ready for bed, as it is not safe to leave the clients in their room unattended. RN-A said there was a pull cord by the C2's bed, but no other call light system was available. RN-A said there is a light outside of the room that lights up when the pull cord is pulled, but the pull cord does not make a sound to alert staff that a client has called for assistance. RN-A said she was working on April 12, 2021, when C2 fell. RN-A said the staff member left C2 for a minute to get towels and washcloths and when she came back, C2 was lying on the floor. RN-A said the staff member did not attempt to move C2. RN-A said she did not know if C2's foot pedals should have been on when he was in the wheelchair. On July 9, 2021, at 4:33 p.m., ULP-C said if a	0 265		

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0 265	Continued From page 13 client was not in their bed by the pull cord, the client would not be able to call for help. On July 23, 2021, at 11:50 a.m., the Housing Director said the call light system on C2's unit only lights up but does not make a sound. The Housing Director said nobody (clients) on the unit would know how to operate a pendant, and they would be lost within seconds. The Housing Director said the licensee did have a call pendant system, but that system did not work on C2's unit. The Housing Director said there was a plan to get a new call system, and that the license had been talking about it for the last two years. On July 26, 2021, at 1:30 p.m., the Director of Nursing (DON) said the Housing Director discusses call lights with client family members upon a client's admission to the licensee, but she was unsure if that discussion was documented anywhere. The DON said there was no assessment completed to determine if clients could use the pull cord. The DON said the licensee should have had communication with C2's family about the call light system. The DON said she was not part of the investigation related to C2's April 12, 2021, fall because she was not the DON at that time. On July 27, 2021, at 8:34 p.m., the evaluator attempted to contact the ULP that was assigned to care for C2 on April 12, 2021, but the call was not returned. On July 27, 2021, at 3:30 p.m., ULP-I said on April 12, 2021, ULP-J brought C2 to his room, but ULP-I needed an assistance with another client's transfer, so ULP-J came to assist her. ULP-I said ULP-J assisted her for two to three minutes and when ULP-J got back to C2's room, C2 was on	0 265		

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0 265	Continued From page 14 the floor. ULP-I said RN-L and ULP-J attempted to get C2 off of the floor without a mechanical lift until she stopped them. ULP-I said when they rolled C2 over they heard a crack. ULP-I said C2 should have always had his foot pedals on his wheelchair. ULP-I also said C2 could be left in his room alone, she but did not know how C2 would call for help if he was pushed in the middle of his room. The evaluator requested licensee provided documentation related to staff education about client falls and call lights, but none was provided. Licensee's policy titled, Fall Prevention and Reeducation, identified an interdisciplinary falls prevention and reduction program will be implemented in coordination with the registered nurse (RN), housing manager, and resident home care associates to identify and implement appropriate interventions as needed to maintain resident safety, prevent falls and reduce injury from falls. No further information was provided. TIME PERIOD TO CORRECTION: Seven (7) days	0 265		
0 645 SS=F	144A.475, Subd. 1 Conditions Subdivision 1.Conditions. (a) The commissioner may refuse to grant a temporary license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the home care provider or owner or managerial official of the home care provider:	0 645		

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0 645	Continued From page 15 (1) is in violation of, or during the term of the license has violated, any of the requirements in sections 144A.471 to 144A.482; (2) permits, aids, or abets the commission of any illegal act in the provision of home care; (3) performs any act detrimental to the health, safety, and welfare of a client; (4) obtains the license by fraud or misrepresentation; (5) knowingly made or makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the home care provider's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the home care provider's clients; (8) interferes with or impedes a representative of the department in the enforcement of this chapter or has failed to fully cooperate with an inspection, survey, or investigation by the department; (9) destroys or makes unavailable any records or other evidence relating to the home care provider's compliance with this chapter; (10) refuses to initiate a background study under section 144.057 or 245A.04; (11) fails to timely pay any fines assessed by the	0 645		

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0 645	Continued From page 16 department; (12) violates any local, city, or township ordinance relating to home care services; (13) has repeated incidents of personnel performing services beyond their competency level; or (14) has operated beyond the scope of the home care provider's license level. (b) A violation by a contractor providing the home care services of the home care provider is a violation by the home care provider. This MN Requirement is not met as evidenced by: Based on interviews and document review, the licensee failed to provide access to all requested employee information, including information on temporary employees providing direct cares to clients. Failure to provide access to employee information as requested by the Minnesota Department of Health (MDH) evaluator impeded MDH's investigation into multiple vulnerable adult complaints at the licensee. This failure to provide access to this information had the potential to impact all clients receiving services. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 the clients).	0 645		

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0 645	Continued From page 17 The findings include: On July 8, 2021, the MDH evaluator received a staffing list from the temporary staffing agencies utilized by the licensee with the names of the temporary staff who worked at the licensee's facility, but the evaluator received no contact information for these temporary staff. The MDH evaluator had made multiple requests to the licensee for staff information, including temporary staff names and contact information, since the onsite inspection on June 22, 2021. On July 14, 2021, MDH issued a correction order under Minnesota Statute 144A with letter dated July 13, 2021, to the licensee due to license's failure to provide requested employee information to the MDH evaluator after multiple requests for the information by the evaluator since June 22, 2021. The temporary staff information was necessary for the MDH evaluator to continue to investigate vulnerable adult maltreatment complaints with clients cared for by the licensee. On July 26, 2021, the MDH evaluator received email correspondence on behalf of the licensee containing unlicensed personnel (ULP)-H, ULP-I and ULP-J employee records with names and contact information. The email correspondence did not include contact information for ULP-K as previously requested. No further information was provided.	0 645		
0 715 SS=F	144A.476, Subd. 2 Employees, Contractors, and Volunteers Subd. 2.Employees, contractors, and volunteers. (a) Employees, contractors, and volunteers of a	0 715		

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0 715	Continued From page 18 home care provider are subject to the background study required by section 144.057, and may be disqualified under chapter 245C. Nothing in this section shall be construed to prohibit a home care provider from requiring self-disclosure of criminal conviction information. (b) Termination of an employee in good faith reliance on information or records obtained under paragraph (a) or subdivision 1, regarding a confirmed conviction does not subject the home care provider to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was completed for one of one non-employees reviewed. Unlicensed personnel (ULP)-H asked her non-employee boyfriend to assist with client cares. The non-employee had direct access to clients for up to 10 minutes with no background study completed. This deficiency had the potential to impact all clients at the license. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 the clients). The findings include: Review of the staff schedule on June 6, 2021, showed two ULPs provided cares to 24 clients on	0 715		

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0 715	Continued From page 19 the licensee's memory care unit. On July 26, 2021, at 11:20 a.m., ULP-H said she asked her non-employee boyfriend to come help pass meal trays to clients for an "extra set of hands" while caring for clients. ULP-H said her boyfriend assisted with setting up trays for 10 minutes before she told him he had to leave. ULP-H stated she was not sure if she told the Director of Nursing (DON) her boyfriend was going to come in and assist with setting up trays. There was no further evidence of ULP-H's boyfriend having access to clients. On July 26, 2021, at 1:30 p.m., the DON said all staff and volunteers need a background check completed before assisting clients. The DON also said she was not aware ULP-H's boyfriend came in to assist with passing trays to clients. Review of ULP-H's employee record did not include any documentation that ULP-H was re-educated about vulnerable clients at the licensee and client contact with individuals in the faclity with no background study. The evaluator requested documentation of education for all staff regarding vulnerable adults and staff, volunteer, and non-employee contact, but documentation was provided. The evaluator requested the licensee's background study policy, but no policy was provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 715		

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0 805	Continued From page 20	0 805		
0 805 SS=D	144A.479, Subd. 6(a) Reporting Maltrx of Vulnerable Adults/Minors Subd. 6.Reporting maltreatment of vulnerable adults and minors. (a) All home care providers must comply with requirements for the reporting of maltreatment of minors in section 626.556 and the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. Each home care provider must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to report suspected maltreatment in a timely manner (immediately, but not to exceed 24 hours) for one of one client (C1) reviewed. C1 was hospitalized from the licensee with a left acetabular (socket of the hip) fracture after experiencing a fall. The licensee submitted a Minnesota Adult Abuse Reporting Center (MAARC) report to the State Agency (SA) regarding the C2's fall with injury more than 24 hours after the incident. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety) and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). Findings include:	0 805		

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0 805	Continued From page 21 C2's current face sheet identified C2 resided in memory care with diagnoses including dementia, anxiety, and displaced fracture of left acetabulum. C2's service plan dated June 27, 2020, identified C2 required extensive assistance with activities of daily living (ADLs) and was toileted per the floor rounding schedule. C2 required the assistance of two staff members and a transfer belt and mechanical lift for transfers, as needed, for weakness. C2's service plan identified C2 was at risk for falls due to vision/hearing impairment, memory issues and deconditioning. C2's interventions were instructions for staff to meet C2's needs 24 hours per day. C2's Resident Occurrence Management Report (ROMP) dated April 12, 2021, at 7:00 p.m., identified staff found C2 lying on the floor on his left side. C2's ROMP indicated an unlicensed personnel (ULP) heard a cracking sound, C2 had facial grimacing and displayed signs and symptoms of pain. C2's left leg was shorter than the right leg and rotated outward. Emergency Medical Services (EMS) brought C2 to the hospital. Review of a MAARC report dated April 14, 2021, at 9:33 a.m., indicated the licensee submitted a MAARC report to the SA regarding C2's fall with injury approximately 36 hours after the incident occurred. On July 26, 2021, the Director of Nursing (DON) said a MAARC report should be made immediately or within the first 24 hours after an incident. Licensee's policy titled, Vulnerable Adult Reporting Investigation Policy, dated May 2019,	0 805		

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0 805	Continued From page 22 identified the registered nurse (RN) or Housing Director shall immediately report the incident to MAARC as soon as possible, but no longer than 24 hours from the time the RN or Housing Director received knowledge that an incident occurred. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 805		
0 865 SS=G	144A.4791, Subd. 9(a-e) Service Plan, Implementation & Revisions Subd. 9.Service plan, implementation, and revisions to service plan. (a) No later than 14 days after the date that home care services are first provided, a home care provider shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the home care provider and by the client or the client's representative documenting agreement on the services to be provided. The service plan must be revised, if needed, based on client review or reassessment under subdivisions 7 and 8. The provider must provide information to the client about changes to the provider's fee for services and how to contact the Office of the Ombudsman for Long-Term Care. (c) The home care provider must implement and provide all services required by the current service plan. (d) The service plan and revised service plan must be entered into the client's record, including	0 865		

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0 865	Continued From page 23 notice of a change in a client's fees when applicable. (e) Staff providing home care services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to update client service plans after multiple falls and functional decline for one of two clients (C1) reviewed. C1's service plan was not updated until C1 fell twenty-nine (29) times. 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 limited number of staff are involved or the situation has occurred only occasionally) The findings include: C1's current face sheet identified C1 resided in the memory care unit. C1's physician order report identified C1's diagnoses as vascular dementia, anxiety, and Parkinson's disease. C1's service plan dated January 18, 2021, identified C1 required the extensive assistance of one to two staff members for activities of daily living (ADLs) and was assisted with toileting per the floor rounding schedule. C1's service plan identified C1 was at risk for falls and had frequent falls greater than six times per year. Staff were instructed to report if C1 had an increase of unsteadiness or other safety concerns.	0 865		

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0 865	Continued From page 24 Interventions included instructions for staff to keep the area free of obstructions to reduce C1's risk of falls or injury; remind C1 to use the emergency pull cord as needed; ensure C1's footwear fit properly with non-skid soles; keep curtains open; keep paths clear; and C1 should wear a helmet when he is walking. There appeared to be no changes or updates to C1's service plan regarding fall prevention. C1's progress notes and Resident Occurrence Management Project (ROMPs) from February 23, 2021, through June 22, 2021, showed C1 had thirty-three (33) falls during that time period. C1's change of condition assessment dated March 5, 2021, had the same information regarding falls and interventions as the previous assessment; no new interventions were added. C1's change of condition assessment dated April 1, 2021, had the same information regarding falls and interventions as the previous assessment; no new interventions were added. C1's service plan dated June 7, 2021, identified C1 required the extensive assistance of one to two staff members for ADLs. C1 had greater than 6 falls per year; staff were instructed to report all falls and evidence of unsteadiness. C1's service plan identified C1 was at risk for falls due to Parkinson's disease. Interventions included instructions for staff to keep the area free of obstructions to reduce C1's risk of falls or injury; remind C1 to use the emergency pull cord as needed; ensure C1's foot wear fit properly with non-skid soles; keep curtains open; keep paths clear; and C1 should wear a helmet when he is walking. C1 had safety checks every two hours between toileting. C1 was oriented to person and	0 865		

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0 865	Continued From page 25 place; staff were instructed to provide daily cueing. C1's toileting schedule identified staff should toilet C1 per the floor rounding schedule. There appeared to be no changes or updates to C1's service plan regarding fall prevention. C1's change of condition assessment dated June 7, 2021, had the same information regarding falls and interventions as the previous assessment; no new interventions were added. On June 23, 2021, at 1:34 p.m., the Director of Nursing (DON) said changes in service plans were not signed by the client or the client's representative unless there were point value/payment changes. The DON said the assessments are built into the service plan, and the information flows from the assessment to the service plan. The DON said she was aware the licensee could do a more thorough job on client assessments and that she was trying to fix too many things at one time. Licensee's undated policy titled, Service Plan Policy, identified the client service plan and any revisions must include a signature or other authentication by the DON and client. The client service plan must be revised, if needed, based on the results of the client monitoring or reassessments. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) Days	0 865		
0 935 SS=D	144A.4792, Subd. 8 Documentation of Administration of Medication	0 935		

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0 935	Continued From page 26 Subd. 8.Documentation of administration of medications. Each medication administered by comprehensive home care provider staff must be documented in the client's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the client's needs when medication was not administered as prescribed and in compliance with the client's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff administered scheduled medications to clients as prescribed and failed to ensure when scheduled medications were not administered that staff documented the reason why the medication was not administered and any follow-up procedures for three of four clients (C1, C3, C6) reviewed. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	0 935		

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0 935	Continued From page 27 C1 C1's current face sheet identified C1 resided in memory care with diagnoses of vascular dementia, Parkinson's disease, and glaucoma. C1's service plan dated June 9, 2021, identified C1 required staff assistance with medication administration. C1's June 2021 medication administration record (MAR) identified C1's refresh eye drops were not administered as prescribed (twice daily) from June 2 through June 5, 2021. C1's June 2021 MAR noted the drug was not available. C1's June 2021 MAR has indicated C1's prescribed debrox ear drops were not administered on June 21 and 22, 2021. C1's June 2021 MAR noted the drug was not available. C1's medical record did not include documentation the licensed nurse, provider or client's representitive were notified of the omitted medications. C3 C3's current face sheet identified C3 resided in memory care with diagnoses of chronic kidney disease, chronic obstructive pulmonary disease, and vitamin D deficiency. C3's May 2021 and June 2021 MARs identified C3's bumetanide 1 milligram (mg) was not administered as prescribed (twice daily) from June 3 through June 7, 2021. C3's May 2021 and June 2021 noted the drug was unavailable. C3's June 2021 MAR identified C3's vitamin D3 20,000 units were not administered as prescribed (daily) from May 23 through June 14, 2021. C3's	0 935		

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0 935	Continued From page 28 June 2021 MAR noted the drug was unavailable. C3's June 2021 MAR identified C3's pantoprazole 40 mg was not administered as prescribed (daily) from June 18 through June 20, 2021. C3's June 2021 MAR noted the drug was unavailable. C3's medical record did not include documentation the licensed nurse, provider or client's representitive were notified of the omitted medication. C6 C6's current face sheet identified C6 resided in memory care with diagnoses of Alzheimer's disease, right hip fracture, anxiety, and chronic pain. C6's service plan dated June 4, 2021, identified C6 required assistance with medication administration. C6's June 2021 MAR identified acetaminophen 500 mg was not administered as prescribed (three times daily) on June 14 through June 16, 2021, and not administered the mornings of June 22 and 23, 2021. C6's June 2021 MAR noted the drug was unavailable. C6's June 2021 MAR identified Zoloft 25 mg was not administered as prescribed (daily) June 5 and 6, 2021. C6's June 2021 MAR noted the drug was unavailable. C6's medical record did not include documentation the licensed nurse, provider or client's representitive were notified of the omitted medication. On June 23, 2021, at 8:30 a.m., licensed practical	0 935		

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0 935	Continued From page 29 nurse (LPN)-F said C6 was out of acetaminophen and had been out since Monday (June 21, 2021). On June 23, 2021, at 1:56 p.m., the Director of Nursing (DON) said the licensee had only one medication error in the past six months. The DON said she was aware there were many medications not administered to clients. The DON stated medication error reports should have been completed. Licensee's policy titled, Medication Error/Occurrence, dated 2018, identified medication errors included omitted medications. When a medication error is discovered, the licensed nurse is notified and the resident's condition is assessed. The provider and resident or resident representative is notified. The resident is monitored for 24 hours or as ordered by the physician. Action is then taken to prevent the medication error from reoccurring. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 935		
01210 SS=F	144A.4797, Subd. 1(b) Availability of Contact Person - Comp (b) A home care provider with a comprehensive home care license must have a registered nurse available for consultation to staff performing delegated nursing tasks and must have an appropriate licensed health professional available if performing other delegated services such as therapies. This MN Requirement is not met as evidenced	01210		

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01210	Continued From page 30 by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) was available for consultation to staff performing delegated nursing tasks, which had the potential to affect all of the licensee's staff and clients. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 the clients). The findings include On July 9, 2021, at 10:11 a.m., an unidentified staff member said if a client falls at night, the employee can get the client up and a nurse will follow-up with the client in the morning. On July 9, 2021, at 4:00 p.m., unlicensed personnel (ULP)-C said if a client falls at night, ULPs get their vital signs and let the nurse know the next day. ULP-C stated the Director of Nursing (DON) informed the employees the clients have the right to fall and nothing can be done about it so they do not need to call at night if someone falls. ULP-C said a lot of times, the DON does not answer the phone. ULP-C stated it may be three to four hours until the phone call is returned or they may not get a call back. On July 26, 2021 at 1:30 p.m., the DON said staff are aware she (the RN) has a 30 minute turnaround time before she has to call staff back. The DON also said the licensee's administrator	01210		

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01210	Continued From page 31 was her back up for staff to call for consultation until last week. The licensee's administrator is not an RN. The evaluator requested licensee's policy regarding RN availability to staff, but no policy was provided. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01210		
01252 SS=D	144A.4798, Subd. 3 Infection Control Program Subd. 3.Infection control program. A home care provider must establish and maintain an effective infection control program that complies with accepted health care, medical, and nursing standards for infection control. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to establish and maintain an effective infection control program that complies with accepted health care, medical and nursing standards for infection control related to medication administration and hand hygiene. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).	01252		

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01252	Continued From page 32 Findings include: C4's current face sheet identified C4 resided in memory care with diagnoses including dementia, anxiety, and polysosteoarthritis. C4's service plan dated April 7, 2021, identified C4 required staff assistance with medication administration. On June 22, 2021, at 3:20 p.m., the evaluator observed registered nurse (RN)-G don gloves, lock the medication cart, and proceed to apply diclofenac gel to C4's knee. RN-G then walked back to the medication cart with gloved hands and touched the the medication cart drawers with the same gloves. C5's current face sheet identified C5 resided in memory care with diagnoses including dementia, anxiety and vision loss. C5's service plan dated April 29, 2021, identified C5 required staff assistance with medication administration. On June 23, 2021, at 8:23 a.m., the evalutor observed licensed practical nurse (LPN)-F had long acrylic finger nails. The evaluator did not observe LPN-F perform hand hygiene before beginning to prepare C5's medications. LPN-F took two tablets of acetaminophen out of the medication cartridge and touched them with her un-gloved hands and put them in a medication cup. LPN-F then began touching the computer keyboard, the medication cart and other cartridges of medication. LPN-F then touched three metoprolol tablets with un-gloved hands. LPN-F said, "I should have gloves on." LPN-F	01252		

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01252	Continued From page 33 then applied gloves and finished the medication preparation. On June 23, 2021, at 8:42 a.m., the evaluator observed LPN-F digging in a client's medication cup with un-gloved hands when evaluator walked into the medication room to ask a question. On June 23, 2021, at approximately 1:56 p.m., the Director of Nursing (DON) said staff should apply topical medication with gloves, then remove the gloves and wash their hands. The DON also said staff should not touch medications with their bare hands. Licensee's policy titled, Hand Hygiene, dated June 2017, identified infection prevention begins with basic hand hygiene. Following proper hand hygiene practices will reduce spread of potentially deadly germs. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01252		
02015 SS=D	626.557, Subd. 3 Timing of Report Subd. 3.Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission,	02015		

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02015	Continued From page 34 unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572,	02015		

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REGINA ASSISTED LIVING	1175 NININGER ROAD HASTINGS, MN 55033

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02015	Continued From page 35 subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to report suspected maltreatment in a timely manner (immediately, but not to exceed 24 hours) for one of one client (C1) reviewed. C1 was hospitalized from the licensee with a left acetabular (socket of the hip) fracture after experiencing a fall. The licensee submitted a Minnesota Adult Abuse Reporting Center (MAARC) report to the State Agency (SA) regarding the C2's fall with injury more than 24 hours after the incident. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety) and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). Findings include: C2's current face sheet identified C2 resided in memory care with diagnoses including dementia, anxiety, and displaced fracture of left acetabulum. C2's service plan dated June 27, 2020, identified C2 required extensive assistance with activities of daily living (ADLs) and was toileted per the floor rounding schedule. C2 required the assistance of two staff members and a transfer belt and	02015		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H20006	A. BUILDING: _____ B. WING _____	C 06/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA ASSISTED LIVING	1175 NININGER ROAD HASTINGS, MN 55033

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02015	Continued From page 36 mechanical lift for transfers, as needed, for weakness. C2's service plan identified C2 was at risk for falls due to vision/hearing impairment, memory issues and deconditioning. C2's interventions were instructions for staff to meet C2's needs 24 hours per day. C2's Resident Occurrence Management Report (ROMP) dated April 12, 2021, at 7:00 p.m., identified staff found C2 lying on the floor on his left side. C2's ROMP indicated an unlicensed personnel (ULP) heard a cracking sound, C2 had facial grimacing and displayed signs and symptoms of pain. C2's left leg was shorter than the right leg and rotated outward. Emergency Medical Services (EMS) brought C2 to the hospital. Review of a MAARC report dated April 14, 2021, at 9:33 a.m., indicated the licensee submitted a MAARC report to the SA regarding C2's fall with injury approximately 36 hours after the incident occurred. On July 26, 2021, the Director of Nursing (DON) said a MAARC report should be made immediately or within the first 24 hours after an incident. Licensee's policy titled, Vulnerable Adult Reporting Investigation Policy, dated May 2019, identified the registered nurse (RN) or Housing Director shall immediately report the incident to MAARC as soon as possible, but no longer than 24 hours from the time the RN or Housing Director received knowledge that an incident occurred. No further information was provided.	02015		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02015	Continued From page 37 TIME PERIOD FOR CORRECTION: Seven (7) days	02015		