

Protecting, Maintaining and Improving the Health of All Minnesotans

# Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL23224007M Date Concluded: March 23, 2021

Compliance #: HL23224008C

Name, Address, and County of Licensee

**Investigated:** 

Minnesota Greenleaf 1006 Greenwood Street East Thief River Falls, MN 56701 Pennington County

Facility Type: Home Care Provider Investigator's Name: Angela Vatalaro, 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 the client was unresponsive for approximately 28 hours before transferring to the hospital. The client diagnosed with a subdural hematoma (brain bleed), hip fracture, and bruising on her right side.

## **Investigative Findings and Conclusion:**

Neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to assess the client's change in needs, implement required assistance with walking and implement fall interventions after repeated falls. The client had five falls within three weeks and sustained a right eye bruise and cut, bleeding lip, bump on head, bruises, and skin tears. Ten days after the last fall, the hospital diagnosed the client's subdual hematoma and right femoral neck (hip) fracture. She died five days later.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, unlicensed staff, and the client's family. The investigation included review of the client's medical record, hospital record, incident reports, internal investigation, death record,

policy and procedures related to maltreatment, nursing assessments, service plans, care plans, and falls.

The client's diagnoses included dementia, atrial fibrillation, and macular degeneration. The clients signed service plan indicated she required assistance with medication administration, bathing, cues for dressing and grooming, and safety checks every two-hours. The service plan indicated the client was independent with toileting, transfers/walking, and repositioning.

A nursing assessment indicated the client had disorientation, had history of falls, and used a walker. The assessment indicated the client required assistance of one person for bathing, dressing, grooming, transfers and the client depended on staff for escorts. The client had physical aggression towards staff and would sometimes hit out during cares. The assessment indicated the client had not wandered. The client's service plan was not updated to include the client's required assistance.

Six days after the completed nursing assessment, the client was found on the floor of another client's room after being awake all night. She hit her right check and eye, which resulted in bruising and a six inch long skin tear. The next day, the client's progress note indicated she was "very sleepy" since the fall.

The facility failed to implement any new interventions or monitoring after a fall, change in sleep status and newly documented wandering.

Approximately two weeks later, the client fell twice during the same day. The second fall shehit her head. The facility updated the client's medical provider regarding the client's two falls, refusal to use the walker and indicated concerns over consistency of falls. The facility requested a urine analysis due to increased behaviors and falls. However, the facility failed to implement any new interventions, monitoring or services to address an increase in falls and unidentified behaviors. The client's service plan remained independent with transfers and mobility.

The next day, the medical provider evaluated the client for increased falls, agitation and hypotension (low blood pressure). The client's blood pressure medication was reduced and staff were instructed to hold medication if the blood pressure was below 100/60. The provider noted a left side limp and gait instability. Orders included to check the client's blood pressure twice a day, changed the blood pressure medication to extended release form, started an antipsychotic medication at bedtime and collect a urine analysis. The provider also ordered occupational therapy (OT) and physical therapy (PT) evaluations for safety, strengthening and cognitive assessment.

Three days later, PT and OT completed their evaluations of the client. Both therapies recommended one-staff assist using a gait belt for all transfers, mobility, and activities of daily

living (ADL's). Neither therapy however was able to add to the client to services due to her inability to follow commands due to cognition.

The facility failed to conduct a change in needs assessment related to repetitive falls, change in mental status, increased behaviors and new medications. The facility also failed to update the clients service plan with assistance with transfers as ordered by therapy and found on evaluation. The facility also failed to implement any new safety measures for increased falls and behaviors.

Four days later, the client experienced a fourth fall in her room with no visible injury. The fall documentation indicated, therapy was unable to provide services, but failed to include any new interventions. Early the next morning, the client was found on the floor (fifth fall) and had bruising and a skin tear to her right side. Staff assisted the client back into bed after obtaining vitals. The facility failed to implement any new interventions nor update the service plan with needed assistance with transfers and mobility.

Two days later, staff obtained a straight catheter urine sample for the urine analysis that was ordered nine days prior. The urine analysis results indicated a urinary tract infection and the client started on an antibiotic.

Nine days following the fifth fall, at 1:45 p.m. the client had a change in status with decreased oxygen saturation and lethargy. The next day at about 9:45 a.m., the client's oxygen saturation decreased further below normal with labored breathing. Staff updated the client's family and sent the client to the hospital.

Hospital records indicated the client had a brain bleed and right hip/leg fracture with bruising to the right side of the body. The client discharged the following day back to the facility on hospice services.

The client died four days later. The client's death record indicated cause of death was traumatic subdural hemorrhage (brain bleed), fall, and other significant conditions contributed to death included right femur (hip/leg) fracture.

A review of the client's service flow sheet indicated she was independent with transfers and mobility. In addition, the flow sheet indicated safety checks were provided as needed on each shift, although the service plan indicated every two hours.

During an interview with a family member, she stated the client had falls. She said the facility would notify family of falls and at other times, they would not. She stated the facility did not discuss fall interventions to reduce the risk of falls. She also stated the facility did not discuss adding additional services to the client's care plan. She stated the day the client diagnosed with a subdural hematoma and hip fracture the client had a black eye and a bruised cheek.

During an interview registered nurse (RN)-A stated after the client's falls she conducted an assessment, checked for injury, assessed ambulation, transfers, and checked neuros. She said she did not document her assessment. She said she did not recall the client's functional status or observations after falls. She stated the care plan should have indicated the client's needs to include one-staff assist using a gait belt for transfers, mobility, ADL's, and should have indicated two-hour safety checks.

During an interview, RN-B who identified as the administrator stated a nurse should have conducted and documented an assessment after the client's falls. She stated it is an expectation a nurse conducts a face-to-face assessment within 24 hours. She also said a nurse should have implemented PT/OT recommendations and this should have reflected in the care plan.

During an interview director of nursing (DON)-C stated it is an expectation that the client's care plan accurately reflects assessed needs. She stated it is an expectation that a nurse conducts and documents an assessment after falls. She added the assessment includes the client's range of motion, leg length discrepancies, level of consciousness, neuros, vital signs, full skin assessment, transfers, and mobility. The nursing assessment indicates services necessary to take care of the client. She said the client had a change in status and a nurse should have conducted an assessment. DON-C stated if a nurse would have conducted assessments, implemented PT/OT recommendations, and updated the service plan the client may not have sustained significant injuries that led to her death.

In conclusion, neglect was substantiated.

# 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, the client was deceased.

Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: Not Applicable.

### Action taken by facility:

The facility updated the medical provider of the client's falls and implemented orders. The facility sent the client to the hospital for evaluation.

#### 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.

The responsible party will be notified of their right to appeal the maltreatment finding.

cc:

The Office of Ombudsman for Long-Term Care Pennington County Attorney Thief River Falls City Attorney Thief River Falls Police Department The MN Board of Nursing

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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		H23224	B. WING		02/05/2021
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	
MINNES	OTA GREENLEAF	4445 2ND FARGO, N	AVE SOUTI ID 58103	<b>-1</b>	
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0 000	Initial Comments		0 000		
	In accordance with 144A.43 to 144A.43 to 144A.43 of Health issued a ca survey.  Determination of what requires compliance provided at the state When a Minnesota items, failure to combe considered lack  INITIAL COMMENTO On February 5, 202 of Health initiated a #HL23224008C/#H the survey, there we services under the complex of the following correct #HL23224008C/#H	VIDER LICENSING DER  Minnesota Statutes, section 32, the Minnesota Department correction order(s) pursuant to  nether a violation is corrected with all requirements ute number indicated below. Statute contains several apply with any of the items will of compliance.  TS:  11, the Minnesota Department in investigation of complaint L23224007M. At the time of the ere # 40 clients receiving comprehensive license.  Ction orders are issued for		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal so Tag numbers have been assigned Minnesota State Statutes for Hom Providers. The assigned tag numappears in the far left column entity Prefix Tag." The state Statute number the corresponding text of the state out of compliance is listed in the "Summary Statement of Deficience column. This column also includes findings which are in violation of the requirement after the statement, "Minnesota requirement is not met evidenced by." Following the surve findings is the Time Period for Correction." THIS APPLIES THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES THE FOERAL DEFICIENCIES ONLY. WILL APPEAR ON EACH PAGE.  THERE IS NO REQUIREMENT THE SUBMIT A PLAN OF CORRECTIONS OF MINNESOTA STATUTES.  THE LETTER IN THE LEFT COLUMN C	oftware. to e Care ber led "ID ber and Statute ies" s the e state This as eyors' rection. DING OF TO THIS ON FOR TATE JMN IS ES AND VEL
SS=J	144A.44, Subd. 1(a Plan/Accepted Star		0 265	SUBDIVISION 11 (b)(1)(2).	
Junnesota D	epartment of Health				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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0 265	receives home care in an assisted living chapter 144G has to (2) receive care an suitable and up-to-caccepted health care standards and pers	ment of rights. (a) A client who services in the community or facility licensed under hese rights: d services according to a date plan, and subject to re, medical or nursing on-centered care, to take an oping, modifying, and	0 265			
	This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed implement fall interventions for one of three clients (C1) reviewed. C1 had five falls between August 25, 2020, and September 16, 2020. The last fall resulted in serious injury and as a result, C1 died a short time later.					
	violation that results or death) and was is (when one or a limit affected or one or a	ed in a level four violation (a s in serious injury, impairment, ssued at an isolated scope ted number of clients are limited number of staff are ation has occurred only				
	The findings include	<b>ə</b> :				
		d was reviewed. C1's dementia, atrial fibrillation, eration.				
	included assistance administration, bath	plan dated April 26, 2019, with medication ing, cues for dressing and ty checks every two-hours. C1				

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AND DIAN OF CORRECTION INTERCATION NUMBER:	•	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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was independent with toileting, transfers and repositioning.  C1's nursing assessment dated August 19, 2020, indicated C1 was disoriented and a history of falls. The same document indicated C1 required assistance with bathing, dressing, grooming, one-staff assist with transfers, used a walker, and dependent on staff for escorts. C1 had physical aggression and would sometimes hit out at caregivers. C1 had not wandered.  C1's Supervisory Visit dated August 25, 2020, indicated no change to the service plan or care plan.  C1's Post Fall Progress Note and Fall Risk Tool dated August 25, 2020, indicated a score of 10, high risk for falls. C1 was found on the floor of another client's room without her walker after being awake all night. She hit her right cheek and eye. C1 sustained a bruise and cut.  C1's progress notes dated August 26, 2020, at 10:30 a.m., indicated C1 was "very sleepy" since fall and bruising on face had spread.  C1's record lacked any interventions or monitoring after a change in sleep status and newly documented wandering.  C1's progress notes dated August 27, 2020, at 1:40 p.m., indicated C1 had a skin tear that measured six inches long by a half inch wide to her right forearm.  C1's Post Fall Progress Note and Fall Risk Tool dated September 7, 2020, at 3:30 p.m., indicated C1 had fall in her room without injury. Additional	0 265		

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0 265	Continued From pa	ige 3	0 265			
	due to increased be	ehaviors and falls.				
	dated September 7 fall in her room, her C1's record lacked	ress Note and Fall Risk Tool , 2020, at 9:00 p.m., C1 had a r lip bled, and she hit her head. an new fall interventions				
	unidentified behavior	navior monitoring for increased ors.				
	C1's update to the medical provider dated September 7, 2020, signed by unlicensed staff indicated C1's falls, C1's refusal to use walker, and indicated concerns over consistency of falls.					
	C1's medical provider visit dated September 8, 2020, indicated C1 was seen for two falls, increased agitation and hypotension (low blood pressure). C1's blood pressure medication was reduced and staff instructed to hold medication if blood pressure was below 100/60. The provider noted a left sided limp and gait instability. Orders included: check blood pressure twice a day, changed blood pressure medication to extended release form, start antipsychotic medication for two weeks at bedtime and then increase dose. Orders also included consult with Occupational Therapy (OT) for safety evaluation, strengthening and cognitive assessment.					
	11:00 a.m., indicate and falls. The nurse	dated September 9, 2020 at ed C1 had increased behaviors requested a urine analysis ic records, indicated the UA ptember 9, 2020.				
		s dated September 10, 2020, d orders to obtain urine for				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ,	CONSTRUCTION	l ` ′	E SURVEY PLETED	
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0 265	September 11, 2020 of one-staff assist used and during ADL's for physical cues to use indicated C1 would to C1's inability to to C1's Physical Thera 11, 2020, indicated for all mobility and to use. The same door receive PT services decreased ability to C1's record lacked increased monitoring was not updated to assistance with am commands with apprecord also lacked infection symptoms.  C1's progress notes at 4:24 p.m., indicated infection symptoms.  C1's progress notes at 4:24 p.m., indicated to C1's behavior straight catheter.  C1's record lacked monitoring or nursing redirect behaviors.  C1's Post Fall Progress and the commands with appreciated to C1's behavior straight catheter.	herapy notes dated 0, indicated recommendations using a gait belt for all transfers or safety and verbal and e walker. The same document not receive OT services, due olerate therapy.  Appy notes dated September C1 required one-staff assist transfers and cues for walker transf	0 265			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
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0 265	to right elbow. Unlice to bed.  C1's progress note: at 10:02 a.m., indice via straight cath. At urine was positive for started nitrofuranto daily for five days.  C1's record lacked increased monitoring was not updated to assistance with am commands with apprecord also lacked infection symptoms.  C1's progress note: at 1:44 p.m., indicated attempted to rouse C1's vital signs included 135/70, temperature 81, Respirations (Respirations) (Re	d two bruises and a skin tear censed staff assisted C1 back is dated September 18, 2020, ated nursing obtained a urine 4:11 p.m., indicated C1's for urinary tract infection and in (antibiotic) 100 mg twice in (antibiotic) 100 mg twice in (antibiotic) 100 mg twice reflect the need for staff bulation and inability to follow propriate interventions. C1's monitoring for a urinary tract in the control of the cont				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
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0 265	Continued From pa	ge 6	0 265			
	sending C1 to the e	mergency room.				
	at 2:39 p.m., indicated subdural hematomated with poor prognosis	ds dated September 26, 2020, ted C1 diagnosed with a, right femoral neck fracture, s. The same records also the right side of C1's face, cks.				
	at 7:52 a.m., indicated bleed and right hip provider recommen	s dated September 27, 2020, ted C1 diagnosed with a brain fracture and the medical ided comfort measures. C1 ity and admitted to hospice				
		s dated October 1, 2020 at I C1 passed away at 9:50 a.m.				
	was traumatic subd	ndicated the cause of death ural hemorrhage, fall, and nditions contributed to death r fracture.				
	a.m., RN-A stated stalls that occurred of September 15, 202 assessment, check ambulation, transfer RN-A stated she did assessment. She stan assessment of Cobservations after to September 7, 2020 on C1's falls that occurred to 2020 and September 2020. She said she assessment. She stated she assessment.	on March 5, 2020, at 11:04 she followed up on C1's two on September 7, 2020, on 0. She said she conducted an ed for injury, assessed rs, and checked neuro's. It do not document her aid nursing did not document C1's functional status or he two falls that occurred on RN-A said she followed up ccurred on September 15, er 16, 2020 on September 22, did not document her aid she did not recall C1's rany observations. She said a				

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MINNESOTA GREENLEAF FARGO, ND 58103	
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O 265  Continued From page 7  nurse seen C1 on September 18, 2020, and collected a urine sample using a straight catheter. She said nursing did not document an assessment of C1's functional status or observations after falls that occurred on September 7, 15, and 16. She said C1's subdural hematoma and right femur fracture were sustained when C1 fell. RN-A stated assessments should have been conducted and documented.  During an interview on March 9, 2021, at 12:48 p.m., RN-B who identified as the administrator stated a nurse should have conducted and documented an assessment of C1's functional status after falls that occurred on August 25, September 7, September 15, and September 16, 2020. She stated it is an expectation a nurse conducts a face-to-face assessment within 24 hours of a fall that includes any observations, injuries, and functional status. She stated it is an expectation that PT/OT recommendations implement and this should have reflected in C1's care plan.  During an interview on March 10, 2021, at 2:26 p.m., director of nursing (DON)-C stated it is an expectation that a nurse conducts and documents an assessment after falls. She stated the assessment includes range of motion, leg length discrepancies, level of consciousness, neuro's, vital signs, full skin assessment, transfers, and mobility. She stated the nursing assessment includes range of motion, leg length discrepancies, level of consciousness, neuro's, vital signs, full skin assessment, transfers, and mobility. She stated the nursing assessment includes range of motion, leg length discrepancies, level of consciousness, neuro's, vital signs, full skin assessment, transfers, and mobility. She stated the nursing assessment includes assessment after falls. She stated if the licensee would have conducted assessments, implemented PT/OT recommendations, and	

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		<b>`</b>	E CONSTRUCTION	COMPLETED	
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MINNES	OTA GREENLEAF	FARGO, N	AVE SOUTH ID 58103	1	
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0 265	Continued From pa	ge 8	0 265		
	sustained significan	t injury that led to her death.			
	1, 2015, indicated Cactivities of daily living ambulation policy indicated "oth as necessary or appannually or if the clippreferences change	titled "Care Plan" dated May Care Plans will included ing needs and preferences, in and physical needs. The ner areas" would be included propriate and updated ent's condition, needs or extend of the condition o			
0 325	144A.44, Subd. 1(a	)(14) Free From Maltreatment	0 325		
	receives home care in an assisted living chapter 144G has to (14) be free from planed extended in altreatment cover	ment of rights. (a) A client who e services in the community or facility licensed under hese rights: hysical and verbal abuse, eploitation, and all forms of ed under the Vulnerable Maltreatment of Minors Act;			
	by: Based on interviews facility failed to ensire reviewed (C1) was was neglected.  Findings include:	ent is not met as evidenced and document review, the ure one of three clients free from maltreatment. C1		No plan of correction is required for 325. Please refer to public maltreateport for details.	
	The state of the s	ed a determination that neglect			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		<b>l</b> ` ´	CONSTRUCTION	(X3) DATE COMP		
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				DEFICIENCY)		
0 325	Continued From pa	ge 9	0 325			
	the maltreatment, in which occurred at the	the facility was responsible for connection with an incident he facility. The MDH is a preponderance of eatment occurred.				
	144A.479, Subd. 6( Vulnerable Adults/M	a) Reporting Maltrx of Iinors	0 805			
	adults and minors. must comply with reof maltreatment of the requirements for maltreatment of vul 626.557. Each home and implement a with the requirement of the requ	maltreatment of vulnerable (a) All home care providers equirements for the reporting minors in section 626.556 and or the reporting of nerable adults in section le care provider must establish ritten procedure to ensure that ted maltreatment are reported.				
	by: Based on interview licensee failed to reto the Minnesota Ad (MAARC) immediate hours for one of thrediagnosed with a subleed) and a right feet.	and record review, the port suspected maltreatment dult Abuse Reporting Center tely, but no longer than 24 ee clients (C1) reviewed. C1 ubdural hematoma (brain emoral neck fracture (hip) at essed away five days later.				
	violation that did no safety but had the parties of client's health or safety cause serious injury was issued at an isolamited number of cliented	ed in a level two violation (a t harm a client's health or otential to have harmed a fety, but was not likely to y, impairment, or death;) and olated scope (when one or a lients are affected or one or a taff are involved or the				

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Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′	E CONSTRUCTION	(X3) DATE	SURVEY PLETED
		H23224	B. WING		<b>I</b>	C <b>05/2021</b>
	PROVIDER OR SUPPLIER  OTA GREENLEAF	4445 2ND	DRESS, CITY, S AVE SOUTH ND 58103	TATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC)	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
0 805	Continued From pa	ge 10	0 805			
	situation has occurr	ed only occasionally)				
	The findings include	e:				
		d was reviewed. C1's dementia, atrial fibrillation, eration.				
	included assistance administration, bath	plan dated April 26, 2019, with medication ing, cues for dressing and ty checks every two-hours.				
		ssessment dated October 22, was unable to report abuse, s.				
	indicated C1 was different falls. The same doc assistance with bat	sment dated August 19, 2020, soriented and a history of cument indicated C1 required hing, dressing, grooming, transfers, used a walker, and for escorts.				
	indicated C1 walked	s dated August 25, 2020, d without her walker, fell face or. She hit her right cheek and a bruise and cut.				
		sment dated August 25, 2020, e to the service plan or care				
	dated August 25, 20 high risk for falls. T	ress Note and Fall Risk Tool 20, indicated a score of 10, he same document did not ent of C1's functional status.				
		s dated August 26, 2020, at ed C1, was "very sleepy" since				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′	CONSTRUCTION	(X3) DATE	E SURVEY PLETED	
		H23224	B. WING			C <b>05/2021</b>
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, S	TATE, ZIP CODE		
MINNES	OTA GREENLEAF		AVE SOUTH			
		•	ND 58103			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
0 805	Continued From pa	ge 11	0 805			
	fall and bruising on	face had spread.				
	1:40 p.m., indicated	s dated August 27, 2020, at I C1 had skin tear that es long by a half inch wide to				
		ress Note and Fall Risk Tool , 2020, at 3:30 p.m., indicated oom without injury.				
	dated September 7	ress Note and Fall Risk Tool , 2020, at 9:00 p.m., C1 had a lip bled, and she hit her head.				
	September 7, 2020 indicated C1's falls,	medical provider dated , signed by unlicensed staff C1's refusal to use walker, erns over consistency of falls.				
	increased agitation pressure). C1's bloreduced and staff in blood pressure was noted a left sided liningluded: check blochanged blood pressure two weeks at bedting Orders also included.	ler visit dated September 8, was seen for two falls, and hypotension (low blood od pressure medication was astructed to hold medication if a below 100/60. The provider and gait instability. Orders od pressure twice a day, saure medication to extended antipsychotic medication for the and then increase dose. It does not be consult with Occupational afety evaluation, strengthening asment.				
		s dated September 10, 2020, I orders to obtain urine for				
	C1' Occupational T	herapy notes dated				

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	DIAN OF CORRECTION IN TOENTIFICATION NUMBER:		` ,	X2) MULTIPLE CONSTRUCTION  (X3) DATE COM		SURVEY LETED
		H23224	B. WING		02/0	; 5/2021
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MINNES	OTA GREENLEAF	4445 2ND FARGO, N	AVE SOUTH D 58103			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
0 805	Continued From pa	ge 12	0 805			
	of one-staff assist used and during ADL's for physical cues to use indicated C1 would to C1's inability to to C1's Physical There 11, 2020, indicated	O, indicated recommendations ising a gait belt for all transfers or safety and verbal and walker. The same document not receive OT services, due blerate therapy.  Apy notes dated September C1 required one-staff assist ransfers and cues for walker				
	use. The same doc	ument indicated C1 would not due to cognitive status and				
	at 4:24 p.m., indicated updated on staff's in	s dated September 15, 2020, ted the medical provider nability to obtain urine sample ors and requested an order for				
		s dated September 15, 2020, ted C1 did not admit to PT/OT				
	dated September 1	ress Note and Fall Risk Tool 5, 2020, at 5:20 p.m., fall in her room without injury.				
	dated September 1 indicated C1 had a two bruises and a s	ress Note and Fall Risk Tool 6, 2020, at 3:10 a.m., fall in her room, and sustained kin tear to right elbow. sisted C1 back to bed.				
	at 10:02 a.m., indication via straight cath. The	ated September 18, 2020, ated nursing obtained a urine same progress notes diductional status after falls or by the nurse.				

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PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION)  (Continued From page 13  C1's progress notes dated September 18, 2020, at 4:11 p.m., indicated C1's urine was positive for urinary tract infection and started nitrofurantoin (antibiotic) 100 mg twice daily for five days.  C1's medication administration record indicated on September 24, 2020, indicated C1 received risperdal 0.5 mg.  C1's progress notes dated September 25, 2020, at 1:44 p.m., indicated C1 slept all shift. Staff attempted to rouse C1 and she did not wake up. C1's vital signs included blood pressure (B/P) 135/70, temperature 96.8 Fahrenheit, pulse (P) 81, Respirations (R) 18, oxygen saturation (Sp02) 91-94%. At 7:10 p.m., indicated C1 slept all day, was unable to get out of bed and was drowsy. At 8:13 p.m., indicated the nurse spoke to the medical provider and risperdal put on hold until September 29, 2020. At 8:33 p.m., indicated C1 was lethargic, sleepy, had not got out of bed, and had no oral intake. C1's vital signs included BP 150/76, P 81, Sp02 93 %.  C1's progress notes dated September 26, 2020, at 9:43 a.m., indicated nursing received a phone	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	l \ '	E SURVEY PLETED	
MINNESOTA GREENLEAF  A445 2ND AVE SOUTH FARGO, ND 58103  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  0 805  Continued From page 13  C1's progress notes dated September 18, 2020, at 4:11 p.m., indicated C1's urine was positive for urinary tract infection and started nitrofurantoin (antibiotic) 100 mg twice daily for five days.  C1's medication administration record indicated on September 24, 2020, indicated C1 received risperdal 0.5 mg.  C1's progress notes dated September 25, 2020, at 1:44 p.m., indicated C1 slept all shift. Staff attempted to rouse C1 and she did not wake up. C1's vital signs included blood pressure (B/P) 135/70, temperature 96.8 Fahrenheit, pulse (P) 81, Respirations (R) 18, oxygen saturation (Sp02) 91-94%. At 7:10 p.m., indicated C1 slept all day, was unable to get out of bed and was drowsy. At 8:13 p.m., indicated the nurse spoke to the medical provider and risperdal put on hold until September 29, 2020. At 8:33 p.m., indicated C1 was lethargic, sleepy, had not got out of bed, and had no oral intake. C1's vital signs included BP 150/76, P 81, Sp02 93 %.  C1's progress notes dated September 26, 2020, at 9:43 a.m., indicated to nursing received a phone			H23224	B. WING		l	
(24) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY) WIST BE PRECEDED BY FULL TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  0 805  Continued From page 13  C1's progress notes dated September 18, 2020, at 4:11 p.m., indicated C1's urine was positive for urinary tract infection and started nitrofurantoin (antibiotic) 100 mg twice daily for five days.  C1's medication administration record indicated on September 24, 2020, indicated C1 received risperdal 0.5 mg.  C1's progress notes dated September 25, 2020, at 1:44 p.m., indicated C1 slept all shift. Staff attempted to rouse C1 and she did not wake up. C1's vital signs included blood pressure (B/P) 135/70, temperature 96.8 Fahrenheit, pulse (P) 81, Respirations (R) 18, oxygen saturation (Sp02) 91-94%. At 7:10 p.m., indicated C1 slept all day, was unable to get out of bed and was drowsy. At 8:13 p.m., indicated the nurse spoke to the medical provider and risperdal put on hold until September 29, 2020. At 8:33 p.m., indicated C1 was lethargic, sleepy, had not got out of bed, and had no oral intake. C1's vital signs included BP 150/76, P 81, SpO2 93 %.  C1's progress notes dated September 26, 2020, at 9:43 a.m., indicated nursing received a phone	NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
SUMMARY STATEMENT OF DEFICIENCIES   PREFIX TAG   SUMMARY STATEMENT OF DEFICIENCIES   PREFIX TAG   REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION (COMPLIFICATION AND COMPLIFY IN TAG   PROVIDER'S PLAN OF CORRECTION (COMPLIFICATION AND COMPLIFY IN TAG   PROVIDER'S PLAN OF CORRECTION (COMPLIFY IN TAG   PROVIDER'S PLAN OF CORRECTIVE TAG   PROVIDER'S PROVIDER'S PLAN OF CORRECTIVE TAG   PROVIDER'S PLAN OF CORRECTIVE TO THE APPROPER TO THE APPROPENT OF COMPLIANCE OF COMPLET TAG   PROVIDER'S PLAN OF CORRECTIVE TAG   PROVIDER'S PLAN OF CORRECTIVE TAG   PROVIDER'S PROVIDER'S PROVIDER'S PLAN OF CORRECTIVE TAG   PROVIDER'S P	MINNES	OTA GREENLEAF					
C1's progress notes dated September 18, 2020, at 4:11 p.m., indicated C1's urine was positive for urinary tract infection and started nitrofurantoin (antibiotic) 100 mg twice daily for five days.  C1's medication administration record indicated on September 24, 2020, indicated C1 received risperdal 0.5 mg.  C1's progress notes dated September 25, 2020, at 1:44 p.m., indicated C1 slept all shift. Staff attempted to rouse C1 and she did not wake up. C1's vital signs included blood pressure (B/P) 135/70, temperature 96.8 Fahrenheit, pulse (P) 81, Respirations (R) 18, oxygen saturation (Sp02) 91-94%. At 7:10 p.m., indicated C1 slept all day, was unable to get out of bed and was drowsy. At 8:13 p.m., indicated the nurse spoke to the medical provider and risperdal put on hold until September 29, 2020. At 8:33 p.m., indicated C1 was lethargic, sleepy, had not got out of bed, and had no oral intake. C1's vital signs included BP 150/76, P 81, SpO2 93 %.  C1's progress notes dated September 26, 2020, at 9:43 a.m., indicated nursing received a phone	PRÉFIX	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	SHOULD BE	(X5) COMPLETE DATE
call that C1 was still lethargic, not talking, and not getting out of bed. C1's vital signs included SpO2 low in the 80's and labored breathing. Staff received instruction to call family to see about sending C1 to the emergency room.  C1's hospital records dated September 26, 2020, at 2:39 p.m., indicated C1 diagnosed with subdural hematoma, right femoral neck fracture, with poor prognosis. The same records also indicated bruising to the right side of C1's face, shoulder, and buttocks.  C1's progress notes dated September 27, 2020,	0 805	C1's progress notes at 4:11 p.m., indicate urinary tract infection (antibiotic) 100 mg C1's medication ad on September 24, 2 risperdal 0.5 mg. C1's progress notes at 1:44 p.m., indicated attempted to rouse C1's vital signs including 135/70, temperatur 81, Respirations (R 91-94%. At 7:10 p.m. was unable to get on 8:13 p.m., indicated medical provider and September 29, 202 was lethargic, sleep had no oral intake. 150/76, P 81, SpO2 C1's progress notes at 9:43 a.m., indicated lithat C1 was still getting out of bed. C1's progress notes at 9:43 a.m., indicated lithat C1 was still getting out of bed. C1's hospital record at 2:39 p.m., indicated lithat C1 was still getting C1 to the except of the second control of the secon	s dated September 18, 2020, ted C1's urine was positive for on and started nitrofurantoin twice daily for five days.  ministration record indicated 2020, indicated C1 received  s dated September 25, 2020, ted C1 slept all shift. Staff C1 and she did not wake up. uded blood pressure (B/P) e 96.8 Fahrenheit, pulse (P) 18, oxygen saturation (Sp02) m., indicated C1 slept all day, but of bed and was drowsy. At the nurse spoke to the nd risperdal put on hold until 0. At 8:33 p.m., indicated C1 by, had not got out of bed, and C1's vital signs included BP 2 93 %.  Is dated September 26, 2020, ted nursing received a phone I lethargic, not talking, and not C1's vital signs included SpO2 labored breathing. Staff to call family to see about emergency room.  Is dated September 26, 2020, ted C1 diagnosed with a, right femoral neck fracture, is. The same records also the right side of C1's face, cks.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	CONSTRUCTION	l \ '	E SURVEY PLETED	
		H23224	B. WING			C <b>05/2021</b>
	PROVIDER OR SUPPLIER OTA GREENLEAF		DRESS, CITY, ST AVE SOUTH ID 58103	TATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE
0 805	bleed and right hip provider recommer returned to the facilist services.  C1's progress note: 4:27 p.m., indicated the continuous traumatic substituted as traumatic substituted right femu.  During an interview a.m., RN-A stated sfalls that occurred of September 15, 202 assessment, check ambulation, transfer RN-A stated she did assessment. She san assessment of Cobservations after the September 7, 2020 on C1's falls that occurred the compact of the comp	ted C1 diagnosed with a brain fracture and the medical ided comfort measures. C1 lity and admitted to hospice is dated October 1, 2020 at a C1 passed away at 9:50 a.m. Indicated the cause of death fural hemorrhage, fall, and inditions contributed to death in fracture.  If on March 5, 2020, at 11:04 she followed up on C1's two on September 7, 2020, on 0. She said she conducted an ited for injury, assessed instantial indicates and checked neuro's indicated the cause of death in fracture.  If on March 5, 2020, at 11:04 she followed up on C1's two on September 7, 2020, on in the followed in the control of the control of the control of the control of the two falls that occurred on in the two falls that occurred on in the control of the	0 805			
	p.m., RN-B who ide stated a nurse show documented an ass	entified as the administrator all land and sessment of C1's functional at occurred on August 25,				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING: (X3) DATE S  COMPL				
		H23224	B. WING		02/0	; 5/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MINNES	OTA GREENLEAF	4445 2ND FARGO, N	AVE SOUTH ID 58103			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 805	Continued From pa	ge 15	0 805			
	September 7, Septe 2020. She stated it conducts a face-to-hours of a fall that it injuries, and function expectation that PT implement and this care plan.  During an interview p.m., director of nurexpectation that a redocuments an asset the assessment inclength discrepancies neuro's, vital signs, transfers, and mobin assessment indicate take care of the clies change in status it is nurse conducts and the licensee would implemented PT/O updated the services sustained significant She stated once the significant injuries to MAARC.  The licensee policy dated January 1, 20 would be reported to Reporting Center (Name of reporting Center (Na	ember 15, and September 16, is an expectation a nurse face assessment within 24 includes any observations, anal status. She stated it is an include any observations and status. She stated it is an include any observations should have reflected in C1's on March 10, 2021, at 2:26 and considered in C1's on March 10, 2021, at 2:26 and considered it is an increase conducts and essment after falls. She stated ludes range of motion, leg is, level of consciousness, full skin assessment, lity. She stated the nursing est he services necessary to ent. She stated with C1's was an expectation that a conducted assessments, it is an expectation and explan, C1 may not have it injury that led to her death. It is facility learned of C1's his should have reported to titled "Mandated Reporting" of indicated maltreatment of the Minnesota Adult Abuse MAARC). The policy did not				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '		(X3) DATE COMP	SURVEY
	H23224	B. WING		02/0	) 5/2021
NAME OF PROVIDER OR SUPPLIER MINNESOTA GREENLEAF	4445 2ND	AVE SOUTH	TATE, ZIP CODE		
	FARGO, N	ID 58103			
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 860 Continued From p	age 16	0 860			
0 860 144A.4791, Subd. SS=G and Monitoring	8 Comprehensive Assessment	0 860			
Subd. 8.Comprehended and reassessment provided are companied in individualized in conducted in personal the services are professionals, the conducted by the This initial assess five days after the are first provided.  (b) Client monitoriconducted in the oddays after the date first provided.  (c) Ongoing client must be conducted in the needs of the days from the last monitoring and reat the client's residual to the cli	ensive assessment, monitoring, t. (a) When the services being prehensive home care services, nitial assessment must be on by a registered nurse. When rovided by other licensed health assessment must be appropriate health professional, ment must be completed within date that home care services are monitoring and reassessment must be that home care services are monitoring and reassessment das needed based on changes a client and cannot exceed 90 date of the assessment. The assessment may be conducted dence or through the utilization tion methods based on practice et the individual client's needs.				
licensee failed to described assessment for or reviewed. C1 had 2020, and Septem	v and document review, the conduct a change in needs ne of three clients (C1) five falls between August 25, aber 16, 2020, required nce with ambulation and had e decline.				
This practice resu	Ited in a level three violation (a				

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	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		COMPLETED	
			D WING		C	
		H23224	B. WING		02/0	5/2021
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MINNESOTA GREENI FAF		4445 2ND FARGO, N	AVE SOUTH ID 58103			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
0 860	Continued From pa	ge 17	0 860			
	not including serious or a violation that has serious injury, impairs used at an isolate limited number of collimited number of situation has occurred to the findings included and macular degendand macular degendant macular degendant included assistance administration, bath grooming, and safe	d was reviewed. C1's dementia, atrial fibrillation, eration. e plan dated April 26, 2019,				
	indicated C1 was difalls. The same doc assistance with bath one-staff assist with dependent on staff aggression and work caregivers. C1 had C1's Supervisory Vindicated no change plan.  C1's Post Fall Prog dated August 25, 20	sment dated August 19, 2020, isoriented and a history of cument indicated C1 required hing, dressing, grooming, a transfers, used a walker, and for escorts. C1 had physical uld sometimes hit out at not wandered.  isit dated August 25, 2020, e to the service plan or care  ress Note and Fall Risk Tool 20, indicated a score of 10, 1 was found on the floor of				
	another client's roo	m without her walker after ht. She hit her right cheek and				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY	
		H23224	B. WING		02/0	) 5/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
MINNES	OTA GREENLEAF		AVE SOUTH ND 58103			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 860	10:30 a.m., indicate fall and bruising on C1's progress notes 1:40 p.m., indicated measured six inches her right forearm.  C1's Post Fall Progress actions indicated a due to increased be C1's Post Fall Progress and indicated to the respective of	a bruise and cut.  s dated August 26, 2020, at ed C1 was "very sleepy" since face had spread.  s dated August 27, 2020, at I C1 had a skin tear that es long by a half inch wide to ress Note and Fall Risk Tool, 2020, at 3:30 p.m., indicated from without injury. Additional urine analysis was requested	0 860	DETICIENCY)		
		ed consult with Occupational afety evaluation, strengthening ssment.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		<b> </b> ` ′	CONSTRUCTION	` ′	E SURVEY PLETED	
		H23224	B. WING		1	C <b>05/2021</b>
	PROVIDER OR SUPPLIER		DRESS, CITY, ST	TATE, ZIP CODE		
MIININES	OTA GREENLEAF	FARGO, N	ND 58103			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
0 860	Continued From pa	ige 19	0 860			
	11:00 a.m., indicate and falls. The nurse (UA) lab order. Clin was ordered on Se	s dated September 10, 2020,				
	3:24 p.m., indicated analysis.	d orders to obtain urine for				
	C1' Occupational Therapy notes dated September 11, 2020, indicated recommendations of one-staff assist using a gait belt for all transfers and during ADL's for safety and verbal and physical cues to use walker. The same document indicated C1 would not receive OT services, due to C1's inability to tolerate therapy.					
	11, 2020, indicated for all mobility and to use. The same doc	apy notes dated September C1 required one-staff assist transfers and cues for walker ument indicated C1 would not be due to cognitive status and follow commands.				
	(RN) after C1 expe wandering, walking evaluations which is assistance of one punable to follow cor	eted by a registered nurse rienced several repeated falls, without her walker and OT/PT ndicated she required erson for walking and was mmands due to cognition. C1 behaviors and concerns about				
	at 4:24 p.m., indica updated on staff's i	s dated September 15, 2020, ted the medical provider nability to obtain urine sample ors and requested an order for				

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		H23224	B. WING			C <b>05/2021</b>
	PROVIDER OR SUPPLIER	4445 2ND	DRESS, CITY, Some of the second secon	TATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
	dated September 1 indicated C1 had a PT evaluated but co C1's post fall asses 2020, at 3:10 a.m.,	ress Note and Fall Risk Tool 5, 2020, at 5:20 p.m., fall in her room without injury. ould not add to services.  sment dated September 16, indicated C1 had a fall in her	0 860			
	to right elbow. Unlice to bed.  C1's progress notes at 10:02 a.m., indicate via straight cath. The not include C1's fur observations made.  C1's progress notes at 4:11 p.m., indicate urinary tract infections.	d two bruises and a skin tear censed staff assisted C1 back is dated September 18, 2020, ated nursing obtained a urine ne same progress notes diductional status after falls or by the nurse.  Is dated September 18, 2020, ted C1's urine was positive for and started nitrofurantoin twice daily for five days.				
	(RN) after C1 expensions wandering, walking evaluations which is assistance of one punable to follow cor	eted by a registered nurse rienced several repeated falls, without her walker and OT/PT ndicated she required erson for walking and was mmands due to cognition. C1 behaviors and concerns about				
	a.m., RN-A stated stalls that occurred of September 15, 202 assessment, check	on March 5, 2020, at 11:04 she followed up on C1's two on September 7, 2020, on 0. She said she conducted an ed for injury, assessed rs, and checked neuro's.				

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	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  O PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION  IDENTIFICATION NUMBER:  A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		H23224	B. WING		02/0	5/2021
	PROVIDER OR SUPPLIER	4445 2ND	DRESS, CITY, S AVE SOUTH ND 58103	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
0 860	an assessment of Cobservations after to September 7, 2020 on C1's falls that of 2020 and September 2020. She said she assessment. She safunctional status, or nurse seen C1 on Scollected a urine sa RN-A stated assess conducted and doctor During an interview p.m., RN-B who idestated a nurse should documented an assistatus after falls that september 7, September 7, September 7, September 3, Sept	d not document her aid nursing did not document C1's functional status or he two falls that occurred on RN-A said she followed up curred on September 15, er 16, 2020 on September 22, did not document her aid she did not recall C1's any observations. She said a September 18, 2020, and mple using a straight catheter. Sments should have been umented.  On March 9, 2021, at 12:48 antified as the administrator ald have conducted and sessment of C1's functional at occurred on August 25, ember 15, and September 16, is an expectation a nurse face assessment within 24 includes any observations, nal status. She stated it is an AOT recommendations should have reflected in C1's	0 860			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		` ′	(X3) DATE SURVEY COMPLETED	
		H23224	B. WING		1	C <b>05/2021</b>
	PROVIDER OR SUPPLIER	4445 2ND	DRESS, CITY, S AVE SOUTH ND 58103	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
0 865	Continued From pa	ge 22	0 865			
	144A.4791, Subd. 9 Implementation & F	,	0 865			
	revisions to service days after the date first provided, a hor a current written se (b) The service plant include a signature home care provider client's representation the services to be must be revised, if review or reassessing. The provider must client about change	n and any revisions must or other authentication by the and by the client or the ive documenting agreement be provided. The service plan needed, based on client ment under subdivisions 7 and st provide information to the es to the provider's fee for contact the Office of the				
		provider must implement and required by the current				
	must be entered int	n and revised service plan to the client's record, including in a client's fees when				
		nome care services must be rent written service plan.				
	by: Based on interview licensee failed imple one of three clients falls between Augus	ent is not met as evidenced and document review, the ement fall interventions for (C1) reviewed. C1 had five st 25, 2020, and September fall resulted in serious injury				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUP AND PLAN OF CORRECTION IDENTIFICATION	INHMRED:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING: (X3) D. CO	
H23224	B. WING		C 02/05/2021
NAME OF PROVIDER OR SUPPLIER  MINNESOTA GREENLEAF	STREET ADDRESS, CITY, 4445 2ND AVE SOUT FARGO, ND 58103		
(X4) ID  PREFIX  TAG  SUMMARY STATEMENT OF DEFICIEN  SUMMARY STATEMENT OF DEFICIEN  SUMMARY STATEMENT OF DEFICIEN  SUMMARY STATEMENT OF DEFICIEN  (EACH DEFICIENCY MUST BE PRECEDED  REGULATORY OR LSC IDENTIFYING INFO	BY FULL PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETE
and as a result, C1 died a short time  The practice resulted in a level four wiolation that results in serious injury, or death) and was issued at an isolat (when one or a limited number of clie affected or one or a limited number of cirovolved or the situation has occurred occasionally)  The findings include:  C1's medical record was reviewed. C diagnoses included dementia, atrial find macular degeneration.  C1's signed service plan dated April 2 included assistance with medication administration, bathing, cues for drest grooming, and safety checks every to was independent with toileting, transform repositioning.  C1's nursing assessment dated Auguindicated C1 was disoriented and a hing falls. The same document indicated assistance with bathing, dressing, groone-staff assist with transfers, used a dependent on staff for escorts. C1 has aggression and would sometimes hit caregivers. C1 had not wandered.  The licensee failed to update C1's seinclude services to assist with dressing grooming, transfers and escorts.  C1's Supervisory Visit dated August 2 indicated no change to the service pliplan.	violation (a impairment, led scope ents are of staff are donly  21's fibrillation,  26, 2019,  ssing and wo-hours. C1 fers and  ust 19, 2020, history of C1 required coming, a walker, and ad physical cout at ervice plan tong,  25, 2020,		

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AND DIAN OF CORRECTION INTERPRETATION NUMBERS	,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
H23224	3. WING		0 <b>2/0</b>	; 5/2021
NAME OF PROVIDER OR SUPPLIER  MINNESOTA GREENLEAF  STREET ADDRES  4445 2ND AV FARGO, ND	VE SOUTH	TATE, ZIP CODE		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE	(X5) COMPLETE DATE
C1's Post Fall Progress Note and Fall Risk Tool dated August 25, 2020, indicated a score of 10, high risk for falls. C1 was found on the floor of another client's room without her walker after being awake all night. She hit her right cheek and eye. C1 sustained a bruise and cut.  C1's progress notes dated August 26, 2020, at 10:30 a.m., indicated C1 was "very sleepy" since fall and bruising on face had spread.  C1's progress notes dated August 27, 2020, at 1:40 p.m., indicated C1 had a skin tear that measured six inches long by a half inch wide to her right forearm.  C1's Post Fall Progress Note and Fall Risk Tool dated September 7, 2020, at 3:30 p.m., indicated C1 had fall in her room without injury. Additional actions indicated a urine analysis was requested due to increased behaviors and falls.  C1's Post Fall Progress Note and Fall Risk Tool dated September 7, 2020, at 9:00 p.m., C1 had a fall in her room, her lip bled, and she hit her head.  C1's update to the medical provider dated September 7, 2020, signed by unlicensed staff indicated C1's falls, C1's refusal to use walker, and indicated concerns over consistency of falls.  C1's medical provider visit dated September 8, 2020, indicated C1 was seen for two falls, increased agitation and hypotension (low blood pressure). C1's blood pressure medication was reduced and staff instructed to hold medication if blood pressure was below 100/60. The provider noted a left sided limp and gait instability. Orders included: check blood pressure twice a day, changed blood pressure medication to extended	0 865			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	<b> </b> ` ´	CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
	H23224	B. WING		02/0	5/2021
NAME OF PROVIDER OR SUPPLIER  MINNESOTA GREENLEAF		AVE SOUTH	TATE, ZIP CODE		
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
two weeks at bedting Orders also include Therapy (OT) for stand cognitive assess and cognitive assess and cognitive assess and cognitive assess and falls. The nurse (UA) lab order. Clirally was ordered on Section 2:24 p.m., indicated analysis.  C1' Occupational Tour September 11, 2020 of one-staff assist and during ADL's for physical cues to us indicated C1 would to C1's inability to the C1's Physical Theraphysical Theraphysical Theraphysical Theraphysical Theraphysical Theraphysical Theraphysical Theraphysical Theraphysical The same door receive PT services decreased ability to the company of the physical transport of the company of the compa	antipsychotic medication for me and then increase dose. ed consult with Occupational afety evaluation, strengthening ssment.  dated September 9, 2020 at ed C1 had increased behaviors e requested a urine analysis nic records, indicated the UA eptember 9, 2020.  Stated September 10, 2020, et al. orders to obtain urine for the commendations using a gait belt for all transfers or safety and verbal and se walker. The same document I not receive OT services, due	0 865			

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
		H23224	B. WING			C <b>05/2021</b>	
	PROVIDER OR SUPPLIER	4445 2ND	DRESS, CITY, S AVE SOUTH ND 58103	TATE, ZIP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
0 865	dated September 1 indicated C1 had a PT evaluated but co C1's Post Fall Progress and a story bruises and a	ress Note and Fall Risk Tool 5, 2020, at 5:20 p.m., fall in her room without injury. buld not add to services.  ress Note and Fall Risk Tool 6, 2020, at 3:10 a.m., fall in her room, and sustained skin tear to right elbow. sisted C1 back to bed.  s dated September 18, 2020, ated nursing obtained a urine 4:11 p.m., indicated C1's for urinary tract infection and in (antibiotic) 100 mg twice s dated September 25, 2020, ated C1 slept all shift. Staff C1 and she did not wake upuded blood pressure (B/P) e 96.8 Fahrenheit, pulse (P) 18, oxygen saturation (Sp02) m., indicated C1 slept all day, but of bed and was drowsy. At the nurse spoke to the indirected C1 slept all until 0. At 8:33 p.m., indicated C1					
	had no oral intake. 150/76, P 81, SpO2 C1's progress notes at 9:43 a.m., indicated call that C1 was still getting out of bed. (	by, had not got out of bed, and C1's vital signs included BP 2 93 %.  Is dated September 26, 2020, ted nursing received a phone I lethargic, not talking, and not C1's vital signs included SpO2 labored breathing. Staff					

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	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	<b>l</b> ` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		H23224	B. WING	_	02/0	) 5/2021
	PROVIDER OR SUPPLIER		AVE SOUTH	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 865	C1's hospital record at 2:39 p.m., indicate subdural hematoms with poor prognosis indicated bruising to shoulder, and butto. C1's progress notes at 7:52 a.m., indicate bleed and right hip provider recommenter returned to the faciliservices. C1's service Flow Sindicated C1 was in repositioning and sa "PRN (as needed)" C1's progress notes 4:27 p.m., indicated C1's death record in was traumatic subdother significant conincluded right femula. During an interview a.m., RN-A stated seals that occurred of September 15, 202 assessment, check ambulation, transfer RN-A stated she did assessment of C1's services.	to call family to see about emergency room.  ds dated September 26, 2020, ted C1 diagnosed with a, right femoral neck fracture, a. The same records also the right side of C1's face, cks.  ds dated September 27, 2020, ted C1 diagnosed with a brain fracture and the medical ided comfort measures. C1 ity and admitted to hospice sheet dated September 2020, idependent with transfer, afety checks were deemed throughout shift.  Is dated October 1, 2020 at a C1 passed away at 9:50 a.m. indicated the cause of death lural hemorrhage, fall, and inditions contributed to death in fracture.  In March 5, 2020, at 11:04 she followed up on C1's two on September 7, 2020, on 0. She said she conducted an ited for injury, assessed rs, and checked neuro's.	0 865			

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	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	<b>l</b> `´	E CONSTRUCTION	(X3) DATE COMP	E SURVEY PLETED	
		H23224	B. WING		02/0	) 5/2021	
	PROVIDER OR SUPPLIER		AVE SOUTH	STATE, ZIP CODE	•		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
0 865	on C1's falls that of 2020 and September 2020. She said she assessment. She significant functional status, or nurse seen C1 on Scollected a urine satisfies said nursing diassessment of C1's observations after for September 7, 15, and hematoma and right sustained when C1 assessments should documented.  During an interview p.m., RN-B who idense status after falls that september 7, September 3 fall that injuries, and function expectation that PT implement and this care plan.  During an interview p.m., director of nure expectation that a redocuments an asset the assessment inclength discrepancies neuro's, vital signs, transfers, and mobiles.	curred on September 15, er 16, 2020 on September 22, did not document her aid she did not recall C1's any observations. She said a September 18, 2020, and ample using a straight catheter of not document an affunctional status or falls that occurred on and 16. She said C1's subdural at femur fracture were fell. RN-A stated of have been conducted and sessment of C1's functional at occurred on August 25, ember 15, and September 16, is an expectation a nurse face assessment within 24 includes any observations, anal status. She stated it is an analytic for March 10, 2021, at 2:26 resing (DON)-C stated it is an analytic for March 10, 2021, at 2:26 resing (DON)-C stated it is an analytic for March 10, 2021, at 2:26 resing (DON)-C stated it is an analytic for March 10, 2021, at 2:26 resing (DON)-C stated it is an analytic for March 10, 2021, at 2:26 resing (DON)-C stated it is an analytic for March 10, 2021, at 2:26 resing (DON)-C stated it is an analytic for March 10, 2021, at 2:26 resing (DON)-C stated it is an analytic for March 10, 2021, at 2:26 resing (DON)-C stated it is an analytic for March 10, 2021, at 2:26 resing (DON)-C stated it is an analytic for March 10, 2021, at 2:26 resing (DON)-C stated it is an analytic for March 10, 2021, at 2:26 resing (DON)-C stated it is an analytic for March 10, 2021, at 2:26 resing (DON)-C stated it is an analytic for March 10, 2021, at 2:26 resing (DON)-C stated it is an analytic for March 10, 2021, at 2:26 resing (DON)-C stated it is an analytic for March 10, 2021, at 2:26 resing (DON)-C stated it is an analytic for March 10, 2021, at 2:26 resing (DON)-C stated it is an analytic for March 10, 2021, at 2:26 resing (DON)-C stated it is an analytic for March 10, 2021, at 2:26 resing (DON)-C stated it is an analytic for March 10, 2021, at 2:26 resing (DON)-C stated it is an analytic for March 10, 2021, at 2:26 resing (DON)-C stated it is an analytic for March 10, 2021, at 2:26 resing (DON)-C stated it is an analytic for March 10, 2021, at 2:26 resing (DON)-C stated it is an analy	0 865				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING: (X3) DATE S  COMPL			
		H23224	B. WING		02/0	) 5/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
MINNES	OTA GREENLEAF	4445 2ND FARGO, N	AVE SOUTH ID 58103			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
0 865	change in status it values conducts and the licensee would implemented PT/O updated the service sustained significant.  The licensee policy May 1, 2015, indicated the change in the client plan would be compositely client or responsibly.	ent. She stated with C1's was an expectation that a assessment. DON-C stated if have conducted assessments, T recommendations, and plan, C1 may not have it injury that led to her death.  It titled "Service Plans," dated the service plan must be ange in prescriber's orders or a d's needs. The updated service pleted and reviewed with the	0 865			
02015 SS=D	who has reason to lis being or has been knowledge that a vul a physical injury where explained shall improve the common entrought of the common entrought admitted to a facility required to report strindividual that occur unless:  (1) the individual was another facility and believe the vulneral previous facility; or	eport. (a) A mandated reporter believe that a vulnerable adult in maltreated, or who has ulnerable adult has sustained ich is not reasonably rediately report the information by point. If an individual is a ely because the individual is a ely because the individual is a not uspected maltreatment of the red prior to admission,	02015			

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	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		H23224	B. WING		02/0	) 5/2021
		ПЕЗЕЕ			02/0	13/2UZ I
NAME OF I	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
MINNES	OTA GREENLEAF	4445 2ND FARGO, N	AVE SOUTH ID 58103			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
02015	Continued From pa		02015			
		a vulnerable adult as defined , subdivision 21, paragraph				
		quired to report under the ection may voluntarily report as				
	known or suspected	ection requires a report of maltreatment, if the reporter on to know that a report has ommon entry point.				
	_ ` ,	ection shall preclude a eporting to a law enforcement				
	reason to believe the 626.5572, subdivision (5), occurred must be subdivision. If the rebelieves that an invitative agency determine that the reaccording to the critical subdivision 17, para reporter or facility mentry point or direct agency information meets the criteria usubdivision 17, para lead investigative agency agency agency information meets the criteria usubdivision 17, para lead investigative agency agency agency agency information meets the criteria usubdivision 17, para lead investigative agency agency agency agency information meets the criteria usubdivision 17, para lead investigative agency agency agency agency information meets the criteria usubdivision 17, para lead investigative agency ag	orter who knows or has lat an error under section on 17, paragraph (c), clause make a report under this eporter or a facility, at any time estigation by a lead y will determine or should reported error was not neglect teria under section 626.5572, agraph (c), clause (5), the hay provide to the common ly to the lead investigative explaining how the event explaining how the event nder section 626.5572, agraph (c), clause (5). The gency shall consider this haking an initial disposition of bdivision 9c.				
	by:	ent is not met as evidenced and record review, the				

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MANE OF PROVIDER OR SUPPLIER   STREET ADDRESS, CITY, STATE, ZIP CODE		NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	<b>l</b> ` ′	E CONSTRUCTION		
MINNESOTA GREENLEAF  ### A445 ZND AVE SOUTH FARGO, ND \$8103    CAUMARY STATEMENT OF DEFICIENCES   CAUMARY STATEMENT OF DE			H23224	B. WING			
CALCAPTION   CAL	NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	1 0 = 10	
PRÉFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  PRÉGULATORY OR LSC IDENTIFYING INFORMATION)  PRÉGULATORY OR LSC IDENTIFYING INFORMATION)  Deficience (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  O2015  Continued From page 31  Ilicensee failed to report suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC) immediately, but no longer than 24 hours for one of three clients (Cf) reviewed. C1 diagnosed with a subdural hematoma (brain bleed) and a right femoral neck fracture (hip) at the hospital and passed away five days later.  The practice resulted in a level two violation (a violation that did not harm 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 clients are affected or one or a limited number of clients are affected or one or a limited number of clients are affected or one or a limited number of clients are affected or one or a limited number of clients are affected or one or a limited number of clients are affected or 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 medical record was reviewed. C1's diagnoses included dementia, atrial fibrillation, and macular degeneration.  C1's signed service plan dated April 26, 2019, included assistance with medication administration, bathing, cues for dressing and grooming, and safety checks every two-hours.  C1's vulnerability assessment dated October 22, 2019, indicated C1 was unable to report abuse, neglect, or concerns.  C1's nursing assessment dated August 19, 2020, indicated C1 was disoriented and a history of falls. The same document indicated C1 required assistance with bathing, dressing, grooming, one-staff assist with transfers, used a walker, and	MINNES	OTA GREENLEAF			•		
licensee failed to report suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC) immediately, but no longer than 24 hours for one of three clients (C1) reviewed. C1 diagnosed with a subdural hematorna (brain bleed) and a right femoral neck fracture (hip) at the hospital and passed away five days later.  The 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:  C1's medical record was reviewed. C1's diagnoses included dementia, atrial fibrillation, and macular degeneration.  C1's signed service plan dated April 26, 2019, included assistance with medication administration, bathing, cues for dressing and grooming, and safety checks every two-hours.  C1's vulnerability assessment dated October 22, 2019, indicated C1 was unable to report abuse, neglect, or concerns.  C1's nursing assessment dated August 19, 2020, indicated C1 was disoriented and a history of falls. The same document indicated C1 required assistance with bathing, dressing, grooming, one-staff assists with transfers, used a walker, and	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETE
dependent on staff for escorts.	02015	licensee failed to reto the Minnesota Ad (MAARC) immediate hours for one of three diagnosed with a subleed) and a right fethe hospital and past. The practice results violation that did no safety but had the policent's health or sa cause serious injury was issued at an isolimited number of colimited number of situation has occurred included and macular degen. C1's medical record diagnoses included and macular degen. C1's signed service included assistance administration, bath grooming, and safe. C1's vulnerability as 2019, indicated C1 neglect, or concern. C1's nursing assessindicated C1 was diffalls. The same docassistance with bath one-staff assist with	eport suspected maltreatment dult Abuse Reporting Center tely, but no longer than 24 ee clients (C1) reviewed. C1 ubdural hematoma (brain emoral neck fracture (hip) at ssed away five days later.  ed in a level two violation (a tharm a client's health or potential to have harmed a fety, but was not likely to by, impairment, or death;) and colated scope (when one or a lients are affected or one or a taff are involved or the red only occasionally)  e:  d was reviewed. C1's dementia, atrial fibrillation, eration.  e plan dated April 26, 2019, ewith medication hing, cues for dressing and thy checks every two-hours.  essessment dated October 22, was unable to report abuse, s.  sment dated August 19, 2020, isoriented and a history of cument indicated C1 required hing, dressing, grooming, in transfers, used a walker, and		DETICITY		

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	. ,	(X3) DATE SURVEY COMPLETED		
		H23224	B. WING			C <b>05/2021</b>		
	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE				
MINNES	OTA GREENLEAF	FARGO, N						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE		
02015	Continued From pa	ge 32	02015					
	indicated C1 walked	s dated August 25, 2020, d without her walker, fell face or. She hit her right cheek and a bruise and cut.						
		sment dated August 25, 2020, e to the service plan or care						
	dated August 25, 20 high risk for falls. T	ress Note and Fall Risk Tool 020, indicated a score of 10, he same document did not nent of C1's functional status.						
		s dated August 26, 2020, at ed C1, was "very sleepy" since face had spread.						
	1:40 p.m., indicated	s dated August 27, 2020, at d C1 had skin tear that es long by a half inch wide to						
		ress Note and Fall Risk Tool , 2020, at 3:30 p.m., indicated oom without injury.						
	dated September 7	ress Note and Fall Risk Tool , 2020, at 9:00 p.m., C1 had a lip bled, and she hit her head.						
	September 7, 2020 indicated C1's falls,	medical provider dated , signed by unlicensed staff C1's refusal to use walker, erns over consistency of falls.						
	2020, indicated C1 increased agitation	der visit dated September 8, was seen for two falls, and hypotension (low blood and pressure medication was						

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NAME OF PROVIDER OR SUPPLIER  MINNESOTA GREENLEAF  4445 2ND AVE SOUTH FARGO, ND 58103  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP		NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
MINNESOTA GREENLEAF  4445 2ND AVE SOUTH FARGO, ND 58103  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY) (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  02015  Continued From page 33  reduced and staff instructed to hold medication if blood pressure was below 100/60. The provider noted a left sided limp and gait instability. Orders included: check blood pressure twice a day, changed blood pressure medication to extended release form, start antipsychotic medication for two weeks at bedtime and then increase dose. Orders also included consult with Occupational Therapy (OT) for safety evaluation, strengthening and cognitive assessment.  C1's progress notes dated September 10, 2020, 3:24 p.m., indicated orders to obtain urine for analysis.  C1' Occupational Therapy notes dated September 11, 2020, indicated recommendations of one-staff assist using a gait belt for all transfers and during ADL's for safety and verbal and physical cues to use walker. The same document indicated C1 would not receive OT services, due			H23224	B. WING		C 02/05/2021	
(X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  02015  Continued From page 33  reduced and staff instructed to hold medication if blood pressure was below 100/60. The provider noted a left sided limp and gait instability. Orders included: check blood pressure twice a day, changed blood pressure medication to extended release form, start antipsychotic medication for two weeks at bedtime and then increase dose. Orders also included consult with Occupational Therapy (OT) for safety evaluation, strengthening and cognitive assessment.  C1's progress notes dated September 10, 2020, 3:24 p.m., indicated orders to obtain urine for analysis.  C1' Occupational Therapy notes dated September 11, 2020, indicated recommendations of one-staff assist using a gait belt for all transfers and during ADL's for safety and verbal and physical cues to use walker. The same document indicated C1 would not receive OT services, due			4445 2ND	AVE SOUTH			
PRÉFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (EACH DEFICIENCY)  D2015  Continued From page 33  reduced and staff instructed to hold medication if blood pressure was below 100/60. The provider noted a left sided limp and gait instability. Orders included: check blood pressure twice a day, changed blood pressure medication to extended release form, start antipsychotic medication for two weeks at bedtime and then increase dose. Orders also included consult with Occupational Therapy (OT) for safety evaluation, strengthening and cognitive assessment.  C1's progress notes dated September 10, 2020, 3:24 p.m., indicated orders to obtain urine for analysis.  C1' Occupational Therapy notes dated September 11, 2020, indicated recommendations of one-staff assist using a gait belt for all transfers and during ADL's for safety and verbal and physical cues to use walker. The same document indicated C1 would not receive OT services, due			FARGO, N	ND 58103			
reduced and staff instructed to hold medication if blood pressure was below 100/60. The provider noted a left sided limp and gait instability. Orders included: check blood pressure twice a day, changed blood pressure medication to extended release form, start antipsychotic medication for two weeks at bedtime and then increase dose. Orders also included consult with Occupational Therapy (OT) for safety evaluation, strengthening and cognitive assessment.  C1's progress notes dated September 10, 2020, 3:24 p.m., indicated orders to obtain urine for analysis.  C1' Occupational Therapy notes dated September 11, 2020, indicated recommendations of one-staff assist using a gait belt for all transfers and during ADL's for safety and verbal and physical cues to use walker. The same document indicated C1 would not receive OT services, due	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	LD BE	(X5) COMPLETE DATE
C1's Physical Therapy notes dated September 11, 2020, indicated C1 required one-staff assist for all mobility and transfers and cues for walker use. The same document indicated C1 would not receive PT services due to cognitive status and decreased ability to follow commands.  C1's progress notes dated September 15, 2020, at 4:24 p.m., indicated the medical provider updated on staff's inability to obtain urine sample due to C1's behaviors and requested an order for straight catheter.  C1's progress notes dated September 15, 2020, at 4:33 p.m., indicated C1 did not admit to PT/OT services.	02015	reduced and staff in blood pressure was noted a left sided lin included: check blo changed blood pressurelease form, start atwo weeks at bedtin Orders also include Therapy (OT) for sa and cognitive assess C1's progress notes 3:24 p.m., indicated analysis.  C1' Occupational T September 11, 2020 of one-staff assist us and during ADL's for physical cues to use indicated C1 would to C1's inability to to C1's Physical Thera 11, 2020, indicated for all mobility and to use. The same docreceive PT services decreased ability to C1's progress notes at 4:24 p.m., indicated to C1's behaviors traight catheter.  C1's progress notes at 4:33 p.m., indicated at 4:33 p.m.	estructed to hold medication if a below 100/60. The provider mp and gait instability. Orders od pressure twice a day, asure medication to extended antipsychotic medication for me and then increase dose. In deconsult with Occupational afety evaluation, strengthening asment.  It dated September 10, 2020, if orders to obtain urine for the safety and verbal and the walker. The same document not receive OT services, due to blerate therapy.  If approved the same document of required one-staff assist transfers and cues for walker ument indicated C1 would not a due to cognitive status and follow commands.  It dated September 15, 2020, the determination of the same document indicated C1 would not a due to cognitive status and follow commands.  It dated September 15, 2020, the determination of the same document indicated C1 would not a due to cognitive status and follow commands.  It dated September 15, 2020, the determination of the medical provider mability to obtain urine sample or and requested an order for the same document of the medical provider mability to obtain urine sample or and requested an order for the same document of the medical provider mability to obtain urine sample or and requested an order for the same document of th				

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	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		H23224	B. WING		02/0	) 5/2021
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MINNES	OTA GREENLEAF		AVE SOUTH			
		FARGO, N				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
02015	Continued From pa	ge 34	02015			
	dated September 1 indicated C1 had a	ress Note and Fall Risk Tool 5, 2020, at 5:20 p.m., fall in her room without injury.				
	dated September 1 indicated C1 had a two bruises and a s	6, 2020, at 3:10 a.m., fall in her room, and sustained kin tear to right elbow. sisted C1 back to bed.				
	at 10:02 a.m., indication via straight cath. Th	ated September 18, 2020, ated nursing obtained a urine ne same progress notes did actional status after falls or by the nurse.				
	at 4:11 p.m., indicat urinary tract infection	s dated September 18, 2020, ed C1's urine was positive for on and started nitrofurantoin twice daily for five days.				
		ministration record indicated 2020, indicated C1 received				
	at 1:44 p.m., indicated attempted to rouse C1's vital signs included 135/70, temperature 81, Respirations (R 91-94%. At 7:10 p.m. was unable to get of 8:13 p.m., indicated medical provider and September 29, 202 was lethargic, sleep	s dated September 25, 2020, ted C1 slept all shift. Staff C1 and she did not wake up. uded blood pressure (B/P) e 96.8 Fahrenheit, pulse (P) 18, oxygen saturation (Sp02) m., indicated C1 slept all day, but of bed and was drowsy. At I the nurse spoke to the drisperdal put on hold until 0. At 8:33 p.m., indicated C1 by, had not got out of bed, and C1's vital signs included BP 2 93 %.				

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	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		H23224	B. WING		02/0	5/2021
	PROVIDER OR SUPPLIER		AVE SOUTH	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
02015	at 9:43 a.m., indicate call that C1 was still getting out of bed. Clow in the 80's and received instruction sending C1 to the electric cat 2:39 p.m., indicate subdural hematoms with poor prognosis indicated bruising to shoulder, and butto C1's progress notes at 7:52 a.m., indicate bleed and right hip provider recommenter turned to the facilist services.  C1's progress notes 4:27 p.m., indicated to the facilist services.  C1's death record in was traumatic subduted right femula other significant continuity and interview a.m., RN-A stated stalls that occurred of September 15, 202 assessment, check ambulation, transfer RN-A stated she did assessment. She say an assessment of C1.	s dated September 26, 2020, sed nursing received a phone I lethargic, not talking, and not C1's vital signs included SpO2 labored breathing. Staff to call family to see about mergency room.  Is dated September 26, 2020, sed C1 diagnosed with a, right femoral neck fracture, so the right side of C1's face, cks.  Is dated September 27, 2020, sed C1 diagnosed with a brain fracture and the medical ded comfort measures. C1 sity and admitted to hospice as dated October 1, 2020 at I C1 passed away at 9:50 a.m. andicated the cause of death ural hemorrhage, fall, and anditions contributed to death of fracture.  In March 5, 2020, at 11:04 she followed up on C1's two on September 7, 2020, on C. She said she conducted an ed for injury, assessed rs, and checked neuro's.	02015			

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AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	<b>l</b> `´	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED					
		H23224	B. WING		02/0	) 5/2021				
NAME OF PROVIDER OR SUPPLIER  MINNESOTA GREENLEAF  STREET ADDRESS, CITY, STATE, ZIP CODE  4445 2ND AVE SOUTH  FARGO, ND 58103										
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	ROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD BE S-REFERENCED TO THE APPROPRIATE DEFICIENCY)					
02015	on C1's falls that of 2020 and September 2020. She said she assessment. She said status, or nurse seen C1 on Scollected a urine sa RN-A stated assess conducted and doc During an interview p.m., RN-B who ide stated a nurse should ocumented an assistatus after falls that September 7, September 7, September 7, September 7, September 3, Septembe	RN-A said she followed up curred on September 15, er 16, 2020 on September 22, did not document her aid she did not recall C1's any observations. She said a September 18, 2020, and mple using a straight catheter sments should have been	02015							
	p.m., director of numerous percentation that a reduction that a reduction that a reduction assessment included the assessment indicated take care of the client change in status it is nurse conducts and the licensee would implemented PT/O	on March 10, 2021, at 2:26 rsing (DON)-C stated it is an aurse conducts and essment after falls. She stated ludes range of motion, leg s, level of consciousness, full skin assessment, lity. She stated the nursing es the services necessary to ent. She stated with C1's was an expectation that a assessment. DON-C stated if have conducted assessments, T recommendations, and e plan. C1 may not have								

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED				
		H23224	B. WING		02/0	5/2021			
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  4445 2ND AVE SOUTH FARGO, ND 58103									
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE			
02015	She stated once the significant injuries to MAARC.  The licensee policy dated January 1, 20 would be reported to Reporting Center (National Center) include timing of respective contents.	titled "Mandated Reporting"  1016, indicated maltreatment to the Minnesota Adult Abuse MAARC). The policy did not	02015						

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