Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL236093323M
Compliance #: HL236095355C

Date Concluded: March 13, 2023

Name, Address, and County of Licensee Investigated:
Diamond Willow of Proctor Assisted Living
913 Old Highway 2
Proctor MN, 55810
St Louis County

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

Evaluator's Name: Carol Moroney RN, Special Investigator

Finding: Substantiated, facility responsibility

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

Initial Investigation Allegation(s):
The facility neglected a resident when they did not prevent resident falls.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The resident had multiple falls with injury and the facility failed to investigate the cause, reassess the resident and implement new fall interventions after each fall. In addition, during the investigation, it was determined the resident eloped from the facility and the event was not documented. The facility failed to investigate the incident, assess the resident, and implement elopement interventions. After the resident's fourth documented fall, the resident died three weeks later due to falls, rib fractures and dementia.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the home care agency, the hospice agency, the local police department, and the case worker. The investigation included a review of the resident record, hospital records, ambulance records, police record, and home care records. The investigation also included review of pertinent facility policies and procedures.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Lewy bodies dementia, closed head injury, traumatic brain hemorrhage, multiple compression fractures, and acute metabolic encephalopathy (brain swelling).

The resident had a history of falls and her fall risk assessment determined she was a fall risk. The resident previously was independent with walking. After a fall with fracture, the resident's service plan was updated to include assistance with medication administration, assistance with toileting, transferring, bed mobility, walking/locomotion, grooming, dressing, and bathing. The resident's post hospitalization assessment indicated the resident had a fall resulting in bruising to her left eye, hip, and fracture to her right thumb. The resident required a sling upon discharge. The resident's change in assistance included assist of one for showers, dressing/grooming, toileting every two-three hours, and assist with walking with a walker. R1's gait balance changed to unsteady with standing and walking. New fall interventions included initiation of chair and bed pressure alarms. Previous fall interventions included decluttering her room twice a day and reminder to use her call pendant. The resident also started physical therapy (PT).

Approximately one month later, a progress note indicated the resident had a right-hand X-ray, which showed a fracture to her right finger, suggesting a subacute injury. The facility failed to include documentation about how the resident fractured her finger, lacked an incident report, and lacked a registered nurse (RN) assessment. The facility also failed to report suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC).

After another month, a progress noted indicated the resident was sent to the emergency room (ER) for altered mental status. CT (computed tomography) imaging showed no acute abnormalities and no sign of stroke. The resident had labs completed to determine a urinary tract infection and received one dose of intravenous antibiotics. The nurse wrote, [unlicensed] staff reported upon return to the facility, the resident was independent and at her baseline. The facility failed to have documentation of the resident's presentation of altered mental status which resulted in sending her to the ER and lacked a RN assessment upon her return.

The resident had a routine 90-day RN assessment completed six weeks later, however the assessment had the same language as the previous post hospitalization assessment including the skin findings of a bruise to the left eye, hip, and fracture to the right thumb.

Ten days later, a progress note indicated the resident fell in her room at 5:00 p.m., hit her shoulders and head. Initially, the resident did not report pain or other complaints. At 2:00 a.m., the resident had cognitive changes with fixed open eyes and staff sent her to the ER. The resident had CT imaging that was negative. The resident's record lacked a RN assessment regarding the resident's cognitive changes and follow up from the ER visit. No new fall interventions were implemented.

A week later, the resident's ER record indicated she had a fall in her room while putting on shoes and hit the back of her head on a television tray. The resident had CT imaging which were negative for fracture and sent back to the facility with a diagnosis of a closed head injury. The resident's record lacked any documentation of the resident's fall, incident report and a RN assessment. No new fall interventions were implemented.

Approximately three weeks later, a progress note indicated the resident fell again in her room, tripped over her bedside table, and had a bloody nose and abrasion to her forehead. Staff sent the resident to the ER. The ER record indicated the resident sustained a nasal fracture. The resident's record lacked a RN assessment and new fall interventions.

About 10 days later, a law enforcement report indicated local police were called to assist with encouraging the resident to the return to the facility after she was found on a local highway. The officers returned the resident to the facility. The resident's record lacked an incident report for the elopement, and a RN assessment regarding the elopement. The a facility RN failed to update to the resident's individual abuse prevention plan to assess the resident's elopement risks and implementation interventions to prevent reoccurrence. The facility failed to complete a MAARC report.

Although another 90-day assessment was completed five weeks later, the assessment failed to include the resident's elopement, her elopement risk and failed to include her three falls during the quarter. The assessment failed to include the injuries the resident had due to falls and any new implementation fall interventions or elopement interventions.

Eleven days later, the resident had a fourth fall. The resident fell in her shower onto her left side. Staff sent the resident to the hospital and imaging results showed multiple left rib fractures and a small hemothorax (a collection of blood in the space between the chest wall and the lung). The resident admitted to the intensive care unit and discharged back to the facility four days later with new medication orders. The resident's record failed to include any documentation regarding the fall, the hospital stay, a RN assessment upon return and any new fall interventions. The facility failed to complete a MAARC report.

Approximately two week later, the resident admitted to hospice and passed away five days later.

The resident's death record indicated the cause of death was rib fractures and falls. The secondary cause was Lewy body's dementia and hypertension.

The facility policy regarding falls indicated with each fall, the staff will complete an incident report, the nurse will conduct a post fall analysis, conduct an assessment and implement new interventions to prevent reoccurrence.

During an interview unlicensed personnel stated the resident wanted to shower by herself, and sometimes certain staff allowed her to do it alone. The resident also turned off the alarms on her own because she did not like the sound it made and said she did not need help. Staff stated the day she eloped from the facility, they let her outside. When they found her on the highway she would not return, and they called law enforcement.

During investigative interviews, multiple staff members stated the facility's fall reduction was to provide a motion pad for the staff to know when the resident moves. Some staff mentioned the resident would turn off the pad herself because it made too much noise. Leadership and nursing staff stated they had not reassessed the resident for the cause of the falls or reassess the effectiveness of the interventions used by the facility to prevent further falls. Leadership and nursing staff stated they did not monitor if the staff provided the ordered interventions for the resident to prevent falls.

During an interview with a nurse, she stated she started the month prior to the resident passing away. The nurse stated she identified many training needs.

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

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

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means:
(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.

Vulnerable Adult interviewed: No, the resident is deceased.

Family/Responsible Party interviewed: No, attempts were made to contact the family but unable to interview.

Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility staff sent the resident to the hospital following falls with injury and contacted law enforcement when the resident eloped. The nurse identified training needs.

Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4890 to receive a copy via mail or email

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
St Louis County Attorney
Proctor City Attorney
Proctor Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23609	A. BUILDING: _____ B. WING _____	C 01/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMOND WILLOW OF PROCTOR	913 OLD HIGHWAY 2 PROCTOR, MN 55810

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL236095355C/#HL236093323M and HL236095986C, HL236093644M On January 10, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 30 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL236095355C/#HL236093323M, tag identification 0580, 0620, 0630, 0730, 1620, 2310, 2360, and 3000. The following correction orders are issued for #/HL236095986C, HL236093644M tag identification, 2360, and 2410.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	

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0 580	Continued From page 1	0 580		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation of quality management activity appropriate to the size and relevant to the type of services provided by the assisted living. This had the potential to affect all 30 residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on January 10, 2023, p.m., the surveyor asked licensed assisted	0 580		

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0 580	Continued From page 2 living director (LALD)-A for the documentation of the licensee's quality management activities. On January 18, 2023, at 11:00 a.m., registered nurse (RN)-A stated the licensee did not have a current ongoing quality management plan or program. RN-A stated the facility was planning to start that program next week. On January 23, 2023, at 10:30 a.m., assistant executive director, RN-B confirmed the facility had not developed an ongoing quality management program or plan. The licensee planned to begin this process next week. The licensee did not provide a quality management plan when requested. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580		
0 620 SS=F	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to comply with requirements to immediately report suspected maltreatment to Minnesota Adult Abuse Reporting Center (MAARC) for one of one resident (R1) reviewed. R1 had multiple falls with injury and fractures and	0 620		

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0 620	Continued From page 3 an elopement. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's medical record indicated R1 diagnoses that included Lewy bodies dementia, closed head injury, traumatic brain hemorrhage, multiple compression fractures, and acute metabolic encephalopathy (brain swelling). R1's service plan dated February 4, 2021, indicated R1 received services which included medication administration assistance with toileting, transfer, bed mobility walking/locomotion, grooming, dressing, bed motility, and bathing. R1's fall risk assessment undated, indicated R1 was at risk for falls. R1's Individual Abuse Prevention Plan (IAPP) dated July 1, 2022, indicated R1 was vulnerable with weighing advice and had impaired judgement. R1 was disoriented occasionally, had memory problems, and moderate impairment which included poor decision making. R1 was at risk for falls. The risk for elopement was not addressed. R1's registered nurse (RN) post hospitalization	0 620		

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0 620	Continued From page 4 assessment dated March 30, 2022, indicated R1 had a fall with fracture to her right thumb. R1's change in need included assist of one for showers, dressing/grooming, toileting every two-three hours, walking with a walker. R1's gait balance changed to unsteady with standing and walking. R1's skin included bruising to her left eye, hip and right thumb. R1 required a sling. R1's new fall intervention included initiation of chair and bed pressure alarms. R1's previous fall interventions included decluttering her room twice a day and reminder to use her call pendant. R1's progress note dated April 28, 2022, indicated R1 had a right hand X-ray which showed a fracture of the 1st finger, suggesting subacute injury. R1's record lack any documentation how R1 fractured her right first finger and failed to make a MAARC report. R1's progress noted dated July 22, 2022, at 5:05 p.m., indicated staff contacted the RN to report R1 had a fall in her room. R1 reported she hit her shoulders and head but did not report any pain or other complaints following the fall. At 2:00 a.m. on July 23, 2022, R1 had a cognitive change and went to the ER. R1 had CT imaging of the head and C-spine, which were negative. R1's record lacked documentation regarding the fall, whether staff followed fall interventions and care plan. The licensee failed to make a MAARC report. R1's ER record dated July 30, 2022, undated R1 had a fall in her room while putting on shoes and hit the back of her head on a television tray. R1 had a CT of the head and neck were negative for	0 620		

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0 620	Continued From page 5 fracture. R1's discharge note included closed head injury. R1's record lacked documentation regarding the fall, whether staff followed fall interventions and care plan. The licensee failed to make a MAARC report. R1's progress note dated August 19, 2022, indicated R1 fell in the morning. R1 stated she tripped over her side table at bedside. She had a bloody nose and an abrasion along her forehead. R1 was sent to the hospital for evaluation. R1's ER record dated August 19, 2022, indicated R1 had a nasal fracture, but no medical intervention was required. R1's record lacked documentation regarding the fall, whether staff followed fall interventions and care plan. The licensee failed to make a MAARC report. A law enforcement report dated August 30, 2022, indicated local police were called to assist in encouraging R1 to return to the facility. R1 had been let out of the facility by the staff. The report indicated R1 had significant cognitive and psychological impairment due to Lewy body dementia. The police officer talked R1 into returning to the facility. R1's record lacked documentation regarding the elopement, whether staff provided supervision and evaluation of how the elopement occurred. The licensee failed to make a MAARC report. R1's hospital record dated October 16, 2022, indicated R1 had a fall in the shower and fell on her left side. Imaging results showed multiple left	0 620		

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0 620	Continued From page 6 rib fractures and a small hemothorax. In addition, imaging noted a change in the colon, concern for possible cancer. R1 admitted to the intensive care unit. R1 discharged back to the facility on October 20, 2022, with new medication orders. R1's record lacked documentation regarding the fall, whether staff followed fall interventions and care plan. The licensee failed to make a MAARC report. During an interview on January 17, 2023, at 11:00 a.m., RN-A confirmed R1 did not have an assessment completed for her following each fall. RN-A confirmed there was not new intervention or reassessment of the effectiveness of the interventions after each fall. During an interview on January 20, 2023, at 1:35 p.m., unlicensed personnel (ULP)-C stated the staff have been instructed to allow R1 to go outside for 10 minutes when she wasn't confused. ULP-C stated one day when R1 was outside she decided to walk away from the facility. The staff found R1 walking down the highway. R1 would not return with the staff, so they called the police. The police officer was able to get R1 to return to the facility. An interview on January 23, 2023, RN-A stated R1 was found on highway 2. R1 had not left the facility prior to this. R1 had a delusion and was looking of her attorney. The staff member working would let her out alone when she wanted to go out to go for a walk. The staff member had to let her out because the building was a dementia care unit, and the residents could not leave on their own. When re-entering the dementia unit, a person needed to push the green bottom located outside near the door. R1 would just push the	0 620		

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0 620	Continued From page 7 green button when she wanted to enter again. The licensees Vulnerable Adults and Maltreatment-Communication, Prevention, and Reporting policy reviewed and revised June 14, 2022, indicated all staff are provide training regarding internal reporting of suspected maltreatment and their obligations to report suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). TIME PERIOD TO CORRECT: Seven (7) Days	0 620		
0 630 SS=G	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to update the individual abuse prevention plan (IAPP) with content related risk of elopement and interventions following an elopement for one of one resident (R1) with records reviewed. This practice resulted in a level three violation (a	0 630		

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0 630	Continued From page 8 violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's medical record indicated R1's diagnoses included Lewy bodies dementia, closed head injury, traumatic brain hemorrhage, and acute metabolic encephalopathy (brain swelling). R1's service plan dated February 4, 2021, indicated R1 received services which included medication administration assistance with toileting, transfer, bed mobility walking/locomotion, grooming, dressing, bed motility, and bathing. R1's IAPP dated July 12, 2022, identified R1 was vulnerable with weighing advice and had impaired judgement. R1 was disoriented occasionally, had memory problems, and moderately impairment which included poor decision making. The IAPP did not address R1's risk of being abused by other residents. The risk for elopement was not addressed. R1's registered nurse (RN) 90-day assessment dated July 12, 2022, indicated R1 had no elopement history or risk to elope. A law enforcement report dated August 30, 2022, indicated local police were called to assist in encouraging R1 to return to the facility. R1 had been let out of the facility by the staff. The report	0 630		

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0 630	Continued From page 9 indicated R1 had significant cognitive and psychological impairment due to Lewy body dementia. The police officer talked R1 into returning to the facility. R1's record lacked an update to her IAPP and failed to include interventions to prevent elopements. R1's IAPP dated November 9, 2022, remained unchanged from the previous IAPP completed on July 12, 2022. During an interview on January 20, 2023, at 1:35 p.m., unlicensed personnel (ULP)-C stated the staff were instructed to allow R1 to go outside for 10 minutes when she wasn't confused. ULP-C stated one day when R1 was outside she decided to walk away from the facility. The staff found R1 walking down the highway. R1 would not return with the staff, so they called the police. The police officer was able to get R1 to return to the facility. During an interview on January 23, 2023, RN-A stated R1 was found on highway 2. R1 had not left the facility prior to this. R1 had a delusion and was looking of her attorney. The staff member working would let her out when she wanted to go out to go for a walk. The staff member had to let her out because the building was a dementia care unit, and the residents could not leave on their own. When re-entering the dementia unit, a person needed to push the green bottom located outside near the door or R1 would just push the green button when she wanted to enter again. The licensee's Elopement policy Individual Abuse Prevention Plan policy dated December 6, 2021, noted the licensee would complete an elopement risk assessment on admission and every 90 days	0 630		

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0 630	Continued From page 10 as needed and with change of condition. The elopement risk questions are incorporated into the assessment. If a resident is at risk for elopement and elopes the staff must complete an incident report. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 730 SS=G	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to	0 730		

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0 730	Continued From page 11 the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to include documentation of significant changes in the resident's status, including incidents, actions taken in response, and communication pertinent to the resident's services for one of one residents (R1) reviewed. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	0 730		

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0 730	Continued From page 12 R1's medical record indicated R1's diagnoses included Lewy bodies dementia, closed head injury, traumatic brain hemorrhage, multiple compression fractures, and acute metabolic encephalopathy (brain swelling). R1's service plan dated February 4, 2021, indicated R1 received services which included medication administration assistance with toileting, transfer, bed mobility walking/locomotion, grooming, dressing, bed motility, and bathing. R1's progress note dated April 28, 2022, indicated R1 had a right hand X-ray which showed a fracture of the 1st finger, suggesting subacute injury. R1's record lacked an incident or progress note that explained how R1 had a fracture of the finger, follow up with her physician, and documentation on follow up of R1's healing of her fracture. R1's progress noted dated May 31, 2022, indicated registered nurse (RN) called the emergency room (ER) for update regarding resident's condition. R1 was worked up for altered mental status, head CT was completed with "no acute abnormalities, no stroke." R1 also had labs for a urinary tract infection and received one dose of intravenous antibiotics. No new medications were ordered and R1 returned to the facility. The RN wrote, staff reported R1 was independent with her walker and at her baseline. R1's record lacked an incident or progress note that explained R1's mental status that resulted in requiring hospitalization for evaluation. R1's	0 730		

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0 730	Continued From page 13 record lacked documention of communication with her physician, and failed to follow up on R1's status post ER visit. R1's progress noted dated July 22, 2022, at 5:05 p.m., indicated staff contacted the RN to report R1 had a fall in her room. R1 reported she hit her shoulders and head but did not report any pain or other complaints following the fall. At 2:00 a.m. on July 23, 2022, R1 had a cognitive change and went to the ER. R1 had CT imaging of the head and C-spine, which were negative. R1's record lacked any follow up regarding her July 23, 2022, ER visit. R1's ER record dated July 30, 2022, undated R1 had a fall in her room while putting on shoes and hit the back of her head on a television tray. R1 had a CT of the head and neck were negative for fracture. R1's discharge note included closed head injury. R1's record lacked any documentation regarding R1's fall on July 30, 2022, an incident report, follow up from the ER visit and communication to her physician. R1's progress note dated August 15, 2022, indicated the note was a post ER visit note. The progress note failed to include the date of the ER visit the follow up was for, an assessment of R1's physical and mental status. The progress note included instructions from the discharge summary. R1's progress note dated August 19, 2022, indicated R1 fell in the morning. R1 stated she tripped over her side table at bedside. She had a bloody nose and an abrasion along her forehead.	0 730		

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0 730	Continued From page 14 R1 was sent to the hospital for evaluation. R1's ER record dated August 19, 2022, indicated R1 had a nasal fracture, but no medical intervention was required. R1's record lacked progress notes indicating R1 returned from the hospital, communication to her physician and status of healing of her nasal fracture. A law enforcement report dated August 30, 2022, indicated local police were called to assist in encouraging R1 to return to the facility. R1 had been let out of the facility by the staff. The report indicated R1 had significant cognitive and psychological impairment due to Lewy body dementia. The police officer talked R1 into returning to the facility. R1's lacked any documention of R1's elopement on August 30, 2022, including an incident report, communication with R1's physician and family, R1's wandering status post elopement. R1's hospital record dated October 16, 2022, indicated R1 had a fall in the shower and fell on her left side. Imaging results showed multiple left rib fractures and a small hemothorax. In addition, imaging noted a change in the colon, concern for possible cancer. R1 admitted to the intensive care unit. R1 discharged back to the facility on October 20, 2022, with new medication orders. R1's record lacked any documentation of R1's fall that led to hospitalization on October 16 through October 20, 2022. R1's record lacked an incident report, documentation of communication with R1's physician and family, R1's return to the facility and R1's follow up on medication orders	0 730		

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0 730	Continued From page 15 and healing of fractures. During an interview on January 20, 2023, at 1:35 p.m., unlicensed personnel (ULP)-C stated R1 wanted to shower by herself, and sometime certain staff let her do that. R1 also turned off the alarms on her own. She didn't like the sound it made and said she didn't need help. An interview on January 23, 2023, at 11:00 a.m., RN-A stated R1 was found on highway 2. R1 had not left the facility before. R1 had a delusion and was looking of her attorney. RN-A confirmed an assessment was not done specifically related to the elopement, following the elopement. R1 was not assessed prior to the event to ensure R1 was capable to push the green for re-entry. During an interview on January 23, 2023, at 10:50 a.m., RN-B stated she started in October 2022 and identified training needs. RN-B stated assessments should be completed after each fall and after elopements. The licensee's policy titled Elopement, reviewed September 4, 2022, indicated an incident report needs to be completed with an elopement. The licensee's policy titled Fall Prevention and Management, reviewed September 4, 2022, indicated staff will complete an incident report after a fall, nursing staff will document and follow up on the report for three days for clinical monitoring and effects related to the fall. TIME PERIOD TO CORRECT: Seven (7) days.	0 730		

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01620	Continued From page 16	01620		
01620 SS=G	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted assessments after each incident and completed a new comprehensive assessment every 90-days for one of one resident (R1) reviewed. As a result, the licensee failed to identify and implement interventions related to fall which resulted in subsequent falls for R1 with injuries.	01620		

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01620	Continued From page 17 This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's medical record indicated R1's diagnoses included Lewy bodies dementia, closed head injury, traumatic brain hemorrhage, multiple compression fractures, and acute metabolic encephalopathy (brain swelling). R1's service plan dated February 4, 2021, indicated R1 received services which included medication administration assistance with toileting, transfer, bed mobility walking/locomotion, grooming, dressing, bed motility, and bathing. R1's fall risk assessment undated, indicated R1 was at risk for falls. R1's RN post hospitalization assessment dated March 30, 2022, indicated R1 had a fall with fracture to her right thumb. R1's change in need included assist of one for showers, dressing/grooming, toileting every two-three hours, walking with a walker. R1's gait balance changed to unsteady with standing and walking. R1's skin included bruising to her left eye, hip and right thumb. R1 required a sling. R1's new fall intervention included initiation of chair and bed pressure alarms. R1's previous fall interventions included decluttering her room twice a day and	01620		

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01620	Continued From page 18 reminder to use her call pendant. R1's progress note dated March 31, 2022, indicated a referral was sent for home care services. On April 1, 2022, a progress note by home care indicated physical therapy (PT) was started. R1's progress note dated April 28, 2022, indicated R1 had a right hand X-ray which showed a fracture of the 1st finger, suggesting subacute injury. R1's record lacked an RN assessment. R1's progress noted dated May 31, 2022, indicated registered nurse (RN) called the emergency room (ER) for update regarding resident's condition. R1 was worked up for altered mental status, head CT was completed with "no acute abnormalities, no stroke." R1 also had labs for a urinary tract infection and received one dose of intravenous antibiotics. No new medications were ordered and R1 returned to the facility. The RN wrote, staff reported R1 was independent with her walker and at her baseline. R1's record lacked an RN assessment for change in mental status. R1's RN 90-day assessment dated July 12, 2022, indicated no changes from the previous assessment dated March 30, 2022 post hospitalization, The July 12, 2022 90-day assessment also had the same skin findings found on the March 30, 2022 assessment including bruising to the left eye, left hip and right thumb due to fracture. R1's progress noted dated July 22, 2022, at 5:05	01620		

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01620	Continued From page 19 p.m., indicated staff contacted the RN to report R1 had a fall in her room. R1 reported she hit her shoulders and head but did not report any pain or other complaints following the fall. At 2:00 a.m. on July 23, 2022, R1 had a cognitive change and went to the ER. R1 had CT imaging of the head and C-spine, which were negative. R1's record lacked any follow up regarding her July 23, 2022, ER visit. R1's record lacked an RN assessment regarding cognitive changes. R1's ER record dated July 30, 2022, undated R1 had a fall in her room while putting on shoes and hit the back of her head on a television tray. R1 had a CT of the head and neck were negative for fracture. R1's discharge note included closed head injury. R1's record lacked a RN assessment following her fall on July 30, 2022. R1's progress note dated August 15, 2022, indicated the note was a post ER visit note. The progress note failed to include the date of the ER visit the follow up was for, an assessment of R1's physical and mental status. The progress note included instructions from the discharge summary. R1's progress note dated August 19, 2022, indicated R1 fell in the morning. R1 stated she tripped over her side table at bedside. She had a bloody nose and an abrasion along her forehead. R1 was sent to the hospital for evaluation. R1's ER record dated August 19, 2022, indicated R1 had a nasal fracture, but no medical intervention was required.	01620		

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01620	Continued From page 20 R1's record lacked a RN assessment following after her fall and ER visit. A law enforcement report dated August 30, 2022, indicated local police were called to assist in encouraging R1 to return to the facility. R1 had been let out of the facility by the staff. The report indicated R1 had significant cognitive and psychological impairment due to Lewy body dementia. The police officer talked R1 into returning to the facility. R1's record lacked a RN assessment for R1's elopement. R1's RN 90-day assessment dated October 5, 2022, indicated updates to correct skin status and removal of brace. The assessment failed to include R1's elopement on August 30, 2022, and indicated R1 was not at elopement risk and did not have any elopements. R1's assessment also failed to include R1's nasal bone fracture on August 19, 2022. R1's hospital record dated October 16, 2022, indicated R1 had a fall in the shower and fell on her left side. Imaging results showed multiple left rib fractures and a small hemothorax. In addition, imaging noted a change in the colon, concern for possible cancer. R1 admitted to the intensive care unit. R1 discharged back to the facility on October 20, 2022, with new medication orders. R1's record failed to include an RN assessment after R1's hospitalization. R1's progress note dated November 2, 2022, indicated R1 started on hospice. R1's record failed to include a RN assessment for	01620		

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01620	Continued From page 21 a change in condition due to enrolling in hospice. During an interview on January 20, 2023, at 1:35 p.m., unlicensed personnel (ULP)-C stated R1 wanted to shower by herself, and sometime certain staff let her do that. R1 also turned off the alarms on her own. She didn't like the sound it made and said she didn't need help. An interview on January 23, 2023, at 11:00 a.m., RN-A stated R1 was found on highway 2. R1 had not left the facility before. R1 had a delusion and was looking of her attorney. RN-A confirmed an assessment was not done specifically related to the elopement, following the elopement. R1 was not assessed prior to the event to ensure R1 was capable to push the green for re-entry. During an interview on January 23, 2023, at 10:50 a.m., RN-B stated she started in October 2022 and identified training needs. RN-B stated assessments should be completed after each fall and after elopements. The licensee's policy entitled Nursing Assessments, Delegated Nursing Services and Supervision policy reviewed July 25, 2021, indicated a RN will reassess the client any time the client returns from a hospital or nursing home stay, has a change in condition, experiences an incident such as a fall, or experiences any unusual symptoms or possible side effects from medications. TIME PERIOD TO CORRECT: Seven (7) days.	01620		
02310 SS=J	144G.91 Subd. 4 (a) Appropriate care and services	02310		

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02310	Continued From page 22 (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure new fall interventions were implemented following falls for one of one resident (R1) reviewed. R1 had several falls with injuries and required hospital visits. R1's primary cause of death was falls and rib fracture. This practice resulted in a level four violation (a violation that results in serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's medical record indicated R1's diagnoses included Lewy bodies dementia, closed head injury, traumatic brain hemorrhage, multiple compression fractures, and acute metabolic encephalopathy (brain swelling). R1's service plan dated February 4, 2021, indicated R1 received services which included medication administration assistance with toileting, transfer, bed mobility walking/locomotion, grooming, dressing, bed motility, and bathing. R1's fall risk assessment undated, indicated R1	02310		

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DIAMOND WILLOW OF PROCTOR	913 OLD HIGHWAY 2 PROCTOR, MN 55810

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 23 was at risk for falls. R1's RN post hospitalization assessment dated March 30, 2022, indicated R1 had a fall with fracture to her right thumb. R1's change in need included assist of one for showers, dressing/grooming, toileting every two-three hours, walking with a walker. R1's gait balance changed to unsteady with standing and walking. R1's skin included bruising to her left eye, hip and right thumb. R1 required a sling. R1's new fall intervention included initiation of chair and bed pressure alarms. R1's previous fall interventions included decluttering her room twice a day and reminder to use her call pendant. R1's progress note dated March 31, 2022, indicated a referral was sent for home care services. On April 1, 2022, a progress note by home care indicated physical therapy (PT) was started. R1's RN 90-day assessment dated July 12, 2022, indicated no changes from the previous assessment dated March 30, 2022 post hospitalization, The July 12, 2022 90-day assessment also had the same skin findings found on the March 30, 2022 assessment including bruising to the left eye, left hip and right thumb due to fracture. R1's progress noted dated July 22, 2022, at 5:05 p.m., indicated staff contacted the RN to report R1 had a fall in her room. R1 reported she hit her shoulders and head but did not report any pain or other complaints following the fall. At 2:00 a.m. on July 23, 2022, R1 had a cognitive change and went to the emergency room (ER). R1 had CT imaging of the head and C-spine, which were negative.	02310		

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02310	Continued From page 24 R1's record lacked any follow up regarding her July 23, 2022, ER visit. R1's record lacked an registered nurse (RN) assessment with new fall interventions. R1's ER record dated July 30, 2022, indicated R1 had a fall in her room while putting on shoes and hit the back of her head on a television tray. R1 had a CT of the head and neck were negative for fracture. R1's discharge note included closed head injury. R1's record lacked a RN assessment following her fall on July 30, 2022 with new fall interventions. R1's progress note dated August 2, 2022, indicated a new order for PT to evaluate. R1's record lacked any notes when R1's previous PT that was initiated April 1, 2022, discharged services. R1's progress note dated August 15, 2022, indicated the note was a post ER visit note. The progress note failed to include the date of the ER visit the follow up was for, an assessment of R1's physical and mental status. The progress note included instructions from the discharge summary. The progress note failed to include any new fall interventions. R1's progress note dated August 19, 2022, indicated R1 fell in the morning. R1 stated she tripped over her side table at bedside. She had a bloody nose and an abrasion along her forehead. R1 was sent to the hospital for evaluation. R1's ER record dated August 19, 2022, indicated	02310		

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02310	Continued From page 25 R1 had a nasal fracture, but no medical intervention was required. R1's record lacked a RN assessment with new fall interventions. R1's RN 90-day assessment dated October 5, 2022, indicated updates to correct skin status and removal of brace. The assessment failed to include any new fall interventions. R1's hospital record dated October 16, 2022, indicated R1 had a fall in the shower and fell on her left side. Imaging results showed multiple left rib fractures and a small hemothorax. In addition, imaging noted a change in the colon, concern for possible cancer. R1 admitted to the intensive care unit. R1 discharged back to the facility on October 20, 2022, with new medication orders. R1's record failed to include a RN assessment with new fall interventions. R1's progress note dated November 2, 2022, indicated R1 started on hospice. R1's death record dated November 7, 2022, indicated the primary cause of death was rib fractures and falls. The secondary cause was Lewy body's dementia and hypertension. During an interview on January 17, 2023, at 11:00 a.m., RN-A reviewed the interventions to prevent falls with the surveyor. On March 30, 2022, the facility initiated a pressure alarm in R1's bed and in her chair. R1 had a pendant call light. The resident used a 4-wheel walker but needed reminders to use it. RN-A confirmed R1 did not have an assessment completed for her following each fall. RN-A confirmed there was not new	02310		

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02310	Continued From page 26 intervention or reassessment of the effectiveness of the interventions after each fall. During an interview on January 20, 2023, at 1:35 p.m., unlicensed personnel (ULP)-C stated R1 wanted to shower by herself, and sometime certain staff let her do that. R1 also turned off the alarms on her own. She didn't like the sound it made and said she didn't need help. During an interview on January 23, 2023, at 10:50 a.m., RN-B stated she started in October 2022 and identified training needs. RN-B stated assessments should be completed after each fall and after elopements. The licensee's policy titled Fall Prevention and Management, reviewed September 4, 2022, indicated if a fall occurs, staff will conduct a root cause anaylsis for any trends and interventions to prevent falls. TIME PERIOD TO CORRECT: Seven (7) days.	02310		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: Based on interviews and document review the facility failed to ensure two of two residents (R1, R2) reviewed were free from maltreatment. R1 was neglected. R2 was abused.	02360	No plan of correction required for tag 2360. Please refer to the public maltreatment report (sent separately) for details.	

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02360	Continued From page 27 Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for maltreatment of R1 and an individual staff person was responsible for the maltreatment of R2, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		
02410 SS=G	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance.	02410		

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02410	Continued From page 28 This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to conduct cares discreetly with privacy and maintain confidentiality for one of one resident (R2) reviewed. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 admitted to the licensee on October 27, 2022, with metastatic cancer and a blood infection. R2 admitted with hospice services for end of life care. R2's signed service plan dated October 27, 2022, indicated R2 received services including medication administration, total assist of all activities of daily living, total assist of transferring and does not ambulate. R2's admission assessment dated November 2, 2022, indicated R2 required routine incontinent brief changes from staff. While R2 was lying in bed, employee unlicensed personnel (ULP)-E took a picture of R2 using her personal phone. R2 did not have a blanket, was wearing only a sweatshirt and a brief. R2's face and legs were exposed. R2 and the family were unaware this picture had been taken. ULP-E	02410		

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02410	Continued From page 29 texted the picture to a unrelated 3rd party. During an interview on January 10, 2023, at 10:10 a.m., executive director (ED)-D stated she sent an email to all staff to remind them not to take pictures and verbally told staff. During an interview on January 17, 2023, at 12:55 a.m., registered nurse (RN)-A stated she completed an investigation on incident and ULP-E was no longer employed. During an interview on January 18, 2023, ULP-F stated she saw a picture of R2 on ULP-E personal phone and reported it to the facility administrator. During an interview on January 18, 2023, at 10:11 a.m., R2's family was interviewed who stated they were very upset ULP-E took a picture of R2 and sent it to someone unrelated to the resident or the facility. R2 was unresponsive and R2's family said R2 couldn't protect himself and couldn't even lift his head. The facility called the police and reported the breach. ULP-E's personnel file included a statement dated September 28, 2022, which indicated staff are not to take a pictures of a resident with a private phone was not allowed. The licensees Video and Photography reviewed September 5, 2022, indicated all photographs and/ or video taping of tenants, clients, and/ or staff are not permitted. TIME PERIOD FOR CORRECTION: Seven (7) Days	02410		

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03000	Continued From page 30	03000		
03000 SS=F	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should	03000		

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03000	Continued From page 31 determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to comply with requirements to immediately report suspected maltreatment to Minnesota Adult Abuse Reporting Center (MAARC) for one of one resident (R1) reviewed. R1 had multiple falls with injury and fractures and an elopement. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's medical record indicated R1 diagnoses that included Lewy bodies dementia, closed head injury, traumatic brain hemorrhage, multiple compression fractures, and acute metabolic encephalopathy (brain swelling).	03000		

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03000	Continued From page 32 R1's service plan dated February 4, 2021, indicated R1 received services which included medication administration assistance with toileting, transfer, bed mobility walking/locomotion, grooming, dressing, bed motility, and bathing. R1's fall risk assessment undated, indicated R1 was at risk for falls. R1's Individual Abuse Prevention Plan (IAPP) dated July 1, 2022, indicated R1 was vulnerable with weighing advice and had impaired judgement. R1 was disoriented occasionally, had memory problems, and moderate impairment which included poor decision making. R1 was at risk for falls. The risk for elopement was not addressed. R1's registered nurse (RN) post hospitalization assessment dated March 30, 2022, indicated R1 had a fall with fracture to her right thumb. R1's change in need included assist of one for showers, dressing/grooming, toileting every two-three hours, walking with a walker. R1's gait balance changed to unsteady with standing and walking. R1's skin included bruising to her left eye, hip and right thumb. R1 required a sling. R1's new fall intervention included initiation of chair and bed pressure alarms. R1's previous fall interventions included decluttering her room twice a day and reminder to use her call pendant. R1's progress note dated April 28, 2022, indicated R1 had a right hand X-ray which showed a fracture of the 1st finger, suggesting subacute injury. R1's record lack any documentation how R1 fractured her right first finger and failed to make a	03000		

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03000	Continued From page 33 MAARC report. R1's progress noted dated July 22, 2022, at 5:05 p.m., indicated staff contacted the RN to report R1 had a fall in her room. R1 reported she hit her shoulders and head but did not report any pain or other complaints following the fall. At 2:00 a.m. on July 23, 2022, R1 had a cognitive change and went to the ER. R1 had CT imaging of the head and C-spine, which were negative. R1's record lacked documentation regarding the fall, whether staff followed fall interventions and care plan. The licensee failed to make a MAARC report. R1's ER record dated July 30, 2022, undated R1 had a fall in her room while putting on shoes and hit the back of her head on a television tray. R1 had a CT of the head and neck were negative for fracture. R1's discharge note included closed head injury. R1's record lacked documentation regarding the fall, whether staff followed fall interventions and care plan. The licensee failed to make a MAARC report. R1's progress note dated August 19, 2022, indicated R1 fell in the morning. R1 stated she tripped over her side table at bedside. She had a bloody nose and an abrasion along her forehead. R1 was sent to the hospital for evaluation. R1's ER record dated August 19, 2022, indicated R1 had a nasal fracture, but no medical intervention was required. R1's record lacked documentation regarding the fall, whether staff followed fall interventions and	03000		

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03000	Continued From page 34 care plan. The licensee failed to make a MAARC report. A law enforcement report dated August 30, 2022, indicated local police were called to assist in encouraging R1 to return to the facility. R1 had been let out of the facility by the staff. The report indicated R1 had significant cognitive and psychological impairment due to Lewy body dementia. The police officer talked R1 into returning to the facility. R1's record lacked documentation regarding the elopement, whether staff provided supervision and evaluation of how the elopement occurred. The licensee failed to make a MAARC report. R1's hospital record dated October 16, 2022, indicated R1 had a fall in the shower and fell on her left side. Imaging results showed multiple left rib fractures and a small hemothorax. In addition, imaging noted a change in the colon, concern for possible cancer. R1 admitted to the intensive care unit. R1 discharged back to the facility on October 20, 2022, with new medication orders. R1's record lacked documentation regarding the fall, whether staff followed fall interventions and care plan. The licensee failed to make a MAARC report. During an interview on January 17, 2023, at 11:00 a.m., RN-A confirmed R1 did not have an assessment completed for her following each fall. RN-A confirmed there was not new intervention or reassessment of the effectiveness of the interventions after each fall. During an interview on January 20, 2023, at 1:35 p.m., unlicensed personnel (ULP)-C stated the	03000		

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03000	Continued From page 35 staff have been instructed to allow R1 to go outside for 10 minutes when she wasn't confused. ULP-C stated one day when R1 was outside she decided to walk away from the facility. The staff found R1 walking down the highway. R1 would not return with the staff, so they called the police. The police officer was able to get R1 to return to the facility. An interview on January 23, 2023, RN-A stated R1 was found on highway 2. R1 had not left the facility prior to this. R1 had a delusion and was looking of her attorney. The staff member working would let her out alone when she wanted to go out to go for a walk. The staff member had to let her out because the building was a dementia care unit, and the residents could not leave on their own. When re-entering the dementia unit, a person needed to push the green bottom located outside near the door. R1 would just push the green button when she wanted to enter again. The licensees Vulnerable Adults and Maltreatment-Communication, Prevention, and Reporting policy reviewed and revised June 14, 2022, indicated all staff are provide training regarding internal reporting of suspected maltreatment and their obligations to report suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). TIME PERIOD TO CORRECT: Seven (7) Days	03000		