Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL236269406M
Compliance #: HL236267202C

Date Concluded: February 23, 2024

Name, Address, and County of Licensee Investigated:
Apple Ridge Assisted Living
Appleton Area Health
100 South Barduson street
Appleton, MN 56208
Swift County

Facility Type: Assisted Living Facility (ALF)

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

Finding: Substantiated, facility responsibility

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

Initial Investigation Allegation(s):
The facility neglected a resident when the resident fell, sustained a bump on the forehead and facility staff failed to notify a registered nurse (RN) for direction. The next day the resident was hospitalized with a subdural hematoma (brain bleed) and orbital fracture.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. Facility staff were aware of a change in the resident's condition and did not contact a registered nurse (RN) or send the resident to the emergency room for further evaluation, resulting in a delay in care. The resident was later diagnosed with a subdural hematoma (brain bleed) and orbital (surrounding the eye) fracture.

The investigator conducted interviews with facility staff members, including administrative staff and unlicensed staff. The investigation included review of resident, facility, and hospital records.

The resident resided in an assisted living facility. The resident had a diagnosis of dementia. The resident's care plan included assistance with dressing, reminders for meals, medication administration, and every two-hour safety checks during the night. The resident's assessment indicated the resident had a noted increase in cognitive decline and forgetfulness and was independent with ambulation with the use of a walker. The assessment also noted the resident had no recent falls.

Facility documentation indicated the resident contacted his family and told them he fell but got himself back into bed. The family contacted the facility around 11:00 a.m. to inform staff about the fall and asked staff to check on the resident. Unlicensed personnel (ULP) #1 checked on the resident and noted a bump on the resident's forehead. ULP #1 did not follow-up with the family and did not contact the nurse about the fall or observed injury.

Staff documented that the resident refused medications and did not go to the dining room to eat later that day. However, the resident's record contained no additional documentation of the resident's condition or further monitoring of the resident's injury.

The next morning, a day shift staff member (ULP #3) checked on the resident and noticed the resident had a large bump on his head and a black and blue right eye. ULP #3 contacted the clinic and scheduled an appointment to have the resident evaluated.

Clinic records indicated the resident fell the day prior to the appointment. The resident reported he did not know how he fell but thought he hit his head and face on the toilet. The resident complained of a headache and nausea and staff documented purple bruising present on the resident's head, right eye, and forehead. A CT (computerized tomography) scan (detailed x-ray imaging) indicated evidence of an intracranial bleed (brain bleed) and the resident was transferred to the emergency room.

Emergency room records indicated the resident was admitted with a subdural hematoma (brain bleed), concussion, and a closed right orbital (bone surrounding the eye) fracture. The notes identified the following injuries: purple bruising around the right eye, four centimeters of purple bruising with a lump above the right eye with three to four abrasions (cuts or scrapes), an area of bruising to the top of the resident's head, and an eight-centimeter bruise to the resident's lower back. The resident was hospitalized and discharged to a skilled nursing facility eight days later due to the need for a higher level of care.

During an interview, ULP #1 stated around 10:00 a.m., she noticed a little bump on the resident's forehead, but the resident could not tell her what happened. ULP#1 gave the resident ice and text the housing director about the bump. ULP #1 stated ULP #2 told her not to worry about the bump. There was not a facility registered nurse (RN) at that time, so she did not know who to contact.

During an interview, ULP #2 stated around 10:30 a.m., ULP #1 told her the resident had a large bump on his forehead. ULP #2 told ULP #1 to have the resident seen for further evaluation. ULP #2 did not check on the resident after the discussion with ULP #1 and did not follow up to see if the resident was sent to the clinic.

During an interview, ULP #3 stated that the next morning ULP #1 informed her the resident had a bump on his head but had not been seen in the clinic. ULP #3 checked on the resident around 6:30 a.m., and noticed the resident had a large bump on his head and a black and blue right eye. ULP #3 contacted the clinic at 8:00 a.m. and set-up a 10:30 a.m. appointment. ULP #3 stated she did not contact the nurse but should have.

During an interview, the housing director stated she received a text message around 11:30 a.m. the day the resident fell. The text message indicated that the resident had a bump on his forehead and the resident did not know what happened. The housing director replied to staff later that day and asked if the nurse was contacted but staff did not respond. The housing director indicated ULP should have contacted the hospital nurse for direction since there was no facility RN.

During an interview, the resident's family member stated they spoke to the resident around 2:30 p.m., the day of the fall. The resident told the family he fell, hurt his shoulder, and could not get out of bed or walk. The resident's family called the facility to have staff check on him. The family stated they were not aware of the bump on the resident's forehead until the next morning. One family member who visited the resident the day he was admitted to the hospital, did not recognize the resident due to the severity of his injuries.

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

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

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

Vulnerable Adult interviewed: No, per family (POA) request
Family/Responsible Party interviewed: Yes

Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility filed a MAARC report with the state agency.

Action taken by the Minnesota Department of Health:

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

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

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

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

You may also call 651-201-4200 to receive a copy via mail or email

cc:

The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Swift County Attorney
Appleton City Attorney
Appleton Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23626	A. BUILDING: _____ B. WING _____	C 01/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLETON AREA HEALTH	100 SOUTH BARDUSON STREET APPLETON, MN 56208

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL236267202C/#HL236269406M On January 2, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were residents 19 receiving services under the provider's Assisted Living license. The following correction order is issued/orders are issued for #HL236267202C/#HL236269406M, tag identifications 0620, 0730, 1330, 2320, and 2360.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL	

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0 000	Continued From page 1	0 000	ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 620 SS=D	144G.42 Subd. 6 (a) / 626.557, Subd. 3 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. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (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	0 620		

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0 620	Continued From page 2 known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to report to the Minnesota Adult Abuse Reporting Center (MAARC)within 24 hours for one of one resident (R1) reviewed. 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 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	0 620	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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	

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0 620	Continued From page 3 situation has occurred only occasionally). The findings include: R1's diagnoses included dementia and chronic kidney disease. R1's care plan dated July 19, 2021, indicated R1 required assistance with dressing, reminders for meals, medication administration, and every two hour safety checks at night. R1's assessment dated July 24, 2023, indicated R1 was independent with walking using a 4 wheeled walker but at times would need reminders to use the walker. R1 had no recent falls and had an increase in cognitive decline and forgetfulness. R1's progress notes dated October 24, 2023, at 1:17 p.m., indicated R1 refused to take medications or come down to eat. An incident report, dated October 24, 2023, at 12:00 p.m., completed by unlicensed personnel (ULP)-A indicated R1 fell, got himself back up, and had a quarter sized lump on his forehead. The document indicated ULP-C informed her there was nothing to worry about, so ULP-A brought R1 ice to apply to his forehead. A second incident report, dated October 24, 2023, completed by ULP-C identified ULP-A told her R1 had a bump on his forehead and did not know how it happened. ULP-C told ULP-A to make a clinic appointment incase R1 had a concussion. ULP-C did not check on R1 since she was working in the kitchen that day. R1's clinic records dated October 25, 2023, indicated R1 fell yesterday but the time or cause	0 620	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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0 620	Continued From page 4 of the fall was unknown. R1 could not report to clinic staff if he got up independently or received assistance. R1 was complaining of a headache a nausea. The clinic notes indicated the housing manager received a text message at 11:30 a.m., that R1 had a "goose egg" on his head but was not sure how it happened. Later in the day, the housing manager responded to staff to have R1 evaluated. R1 was not seen in the clinic on October 24, 2023. R1's emergency room and hospital records, dated October 25, 2023, indicated R1 was admitted to the hospital with diagnoses including; subdural hematoma (brain bleed) with increase in confusion, concussion and underlying dementia, closed right orbital fracture and chronic dementia, worsened by a concussion and subdural hematoma. The ER notes indicated R1 had a black right eye, several abrasions on the scalp, and a bump on the right side of the forehead. R1's hospital discharge record dated November 2, 2023, indicated R1 would not be able to return to the assisted living as he now required more assistance. R1 was discharged to a skilled nursing facility. The licensee's MAARC report was received on October 31, 2023, seven days after the incident occurred. On January 2, 2024, at 1:30 p.m., housing director (HD)-B stated she did not report the incident to MAARC within 24 hours as she did not know that was required. HD-B stated it was reported days later. No further information was provided.	0 620		

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0 620	Continued From page 5 TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
0 730 SS=D	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 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;	0 730		

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0 730	Continued From page 6 (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 provide a discharge summary with required content for one of one resident (R1) discharged from the licensee. 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 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 was admitted to the licensee on July 19, 2021, and discharged on October 25, 2023. R3's record lacked a discharge summary to include: - diagnoses - course of illnesses - allergies - treatments and therapies	0 730		

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0 730	Continued From page 7 - pertinent lab, radiology, and consultation results; and - a final summary of the resident's status from the latest assessment or review including baseline and current mental, behavioral, and functional status. On January 2, 2024 at 2:00 p.m., Director of Nursing (DON)-H acknowledged R1's medical record did not include a discharge summary as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
01330 SS=D	144G.60 Subd. 4 (b) Unlicensed personnel (b) Unlicensed personnel performing delegated nursing tasks in an assisted living facility must: (1) have successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform; (2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or 484.36; or (3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner.	01330		

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01330	Continued From page 8 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed in all the required areas prior to providing assisted living services for one of two unlicensed personnel (ULP)-A with records reviewed. 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 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: ULP-A's personnel file was reviewed. ULP-A was hired April 21, 2023, to provide direct care services to residents under the licensee's assisted living with dementia care license. ULP-A's employee training records lacked evidence of training and demonstrated competency or practical skills test as required in the following areas: -documentation requirements for all services provided - reports of changes in the resident's condition to the supervisor designated by the facility -appropriate and safe techniques in personal hygiene and grooming, including: -hair care and bathing -care of teeth, gums, and oral prosthetic devices -dressing and assisting with toileting -standby assistance techniques and how to	01330		

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01330	Continued From page 9 perform them -medication, exercise, and treatment reminders -communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family -awareness of confidentiality and privacy -procedures to use in handling various emergency situations -awareness of commonly used health technology equipment and assuasive devices -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel - recognizing physical, emotional, cognitive, and developmental needs of the resident On January 2, at 2:30 p.m., Director of Nursing (DON)-H stated her and the housing director were responsible to ensure all training and competencies were completed as required. DON-H acknowledged ULP-A did not have the documentation in their personnel file of all required training and stated the licensee was currently working with a consultant company to ensure compliance. The licensee policy titled Assisted Living Annual Training, revised October 5, 2021, indicated newly hired unlicensed personnel will receive orientation and training on topics required by Minnesota statutes and rules for assisted living organizations. No Further Information was Provided. TIME PERIOD TO CORRECT: Twenty-one (21) days.	01330		

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(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
02320	Continued From page 10	02320		
02320 SS=G	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to report a resident's change in condition to the appropriate supervisor or health care professional for one of one residents (R1) reviewed following a fall. 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 diagnoses included dementia and chronic kidney disease. R1's care plan dated July 19, 2021, indicated R1 required assistance with dressing, reminders for meals, medication administration and safety checks every two hours at night. R1's assessment dated July 24, 2023, indicated	02320		

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	23626	A. BUILDING: _____ B. WING _____	C 01/02/2024

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02320	Continued From page 11 R1 was independent with walking using a 4 wheeled walker but at times would need reminders to use the walker. R1 had no recent falls and had an increase in cognitive decline and forgetfulness. R1's progress notes dated October 24, 2023, at 1:17 p.m., indicated R1 refused to take medications or come down to eat. An incident report completed October 24, 2023, at 12:00 p.m., completed by unlicensed personnel (ULP)-A indicated R1 fell, got himself back up, and had a quarter sized "goose egg" on his forehead. The document indicated ULP-C informed her there was nothing to worry about so ULP-A brought R1 ice to apply to his forehead. A second incident report completed October 26, 2023, at 9:30 a..m., completed by ULP-C, identified ULP-A told her R1 had a bump on his forehead and did not know how it happened. ULP-C told ULP-A to make a clinic appointment in case R1 had a concussion. ULP-C did not check on R1 since she was working in the kitchen that day. R1's clinic records dated October 25, 2023, indicated R1 fell yesterday but the time or cause of the fall was unknown. R1 could not report to clinic staff if he got up independently or received assistance. R1 complained of a headache and nausea. The clinic notes indicated the facility housing manager received a text message on October 24, 2023, at 11:30 a.m., which indicated R1 had a "goose egg" on his forehead but was not sure how it happened. Later in the day, the housing manager responded to have R1 evaluated, however, R1 was not seen in the clinic on October 24, 2023. Clinic records noted results	02320		

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02320	Continued From page 12 of a CT scan displayed an intracranial bleed and the R1 was sent to the emergency room for further evaluation. R1's emergency room (ER) and hospital records dated October 25, 2023, indicated R1 was admitted to the hospital with diagnoses including; subdural hematoma (brain bleed) with increased confusion, concussion underlying dementia, and a closed right orbital fracture. The ER notes indicated R1 had purple bruising around the right eye, 4 centimeter (cm) of purple bruising with a lump above the right eye with three to four linear abrasions, an area of bruising to top of the head, and an approximately 8 cm purple bruise to R1's lower back. R1 was hospitalized for eight days. R1's hospital discharge record dated November 2, 2023, indicated R1 would not be able to return to the assisted living since he required more assistance. R1 was discharged to a skilled nursing facility. The licensee's investigation report completed October 30, 2023, indicated the resident had an unwitnessed fall and proper procedures were not followed. On January 2, 2024, at 1:00 p.m., ULP-A was interviewed and stated on October 24, 2023, at around 10:00 a.m., ULP-A noticed a little bump on R1's forehead and R1 did not know what happened. ULP-A gave R1 ice and texted the housing manager. ULP-A did not remember if the housing manger responded to the text. ULP-A stated at that time the facility did not have a registered nurse (RN) so she didn't know who to call about the incident. ULP-A stated there was no RN on call and no procedure to follow.	02320		

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02320	Continued From page 13 On January 5, 2024, at 9:00 a.m., ULP-D was interviewed and stated on October 24, 2023, at 10:30 a.m., ULP-D completed R1's safety check around 6:40 a.m., and R1 did not have a bump on his head. Around 10:30 a.m., ULP-A told her R1 had a large bump on his forehead and R1 did not know what happed. ULP-D stated she told ULP-A to contact the family, housing manager, and to have R1 seen in the clinic in case R1 had a concussion. ULP-D stated she did not see R1 after that and did not follow up with ULP-A to see if the instructions were followed. ULP-D stated she worked in the kitchen that day was not responsible for health care needs of the residents. On January 4, 2024, at 12:00 p.m., ULP-C stated she worked at 6:00 a.m., on October 25, 2023, and ULP-A reported R1 had a bump on his head and had not been to the clinic. At 6:30 a.m., ULP-C went and checked on R1 and noticed R1 had a black and blue eye and a large bump on his head. ULP-C stated she waited until 8:00 a.m., and then made R1 a clinic appointment around 10:30 a.m. ULP-C stated she did not contact the nurse at that time, but should have. ULP-C also stated the night shift staff also mentioned R1 had a bump on his head. On January 2, 2024, at 1:30 p.m., housing director (HD)-B stated on October 24, 2023, she worked the night shift and checked on R1 around 5:00 a.m., and R1 was in bed. HD-B stated she received a text message on October 24, 2023, at 11:33 a.m., which indicated R1 had a goose egg (bump) on his forehead and did not know what happened. HD-B responded to ULP-A later in the day asking if ULP-A contacted the nurse. HD-B did not receive a response from ULP-A and did not follow up with ULP-A. HD-B stated there was	02320		

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02320	Continued From page 14 not a RN at this time and staff were directed to call the hospital nurse. HD-B stated ULP-A should have completed an incident report and contacted a nurse on the day of the incident. On January 5, 20234, at 12:00 p.m., Family member (FM)-G stated she called R1 on October 24, 2023, at 2:30 p.m. R1 told her he could not get out of bed or walk and stated that he fell and hurt his shoulder, but did not remember the details of the fall or what time he fell. FM-G stated she called the facility around 3:00 p.m., to have staff check on R1. None of R1's family was notified by the licensee regarding the fall or the bump on R1's forehead on October 24, 2024. FM-E stated she received a call on October 25, 2024, at 7:15 a.m., which indicated R1 had hurt himself and his face was black and blue and staff wanted to make R1 a clinic appointment. FM-F stated he arrived to the hospital on October 25, 2023, and at first did not recognize R1 due to the injuries. FM-F stated it looked like R1 had been through a traumatic event. FM-G stated R1 was not able to return to the licensee and was admitted to a skilled nursing facility. The licensee's Reporting, Documenting, and Reviewing Incidents Involving Residents, dated March 7, 2023, indicated a staff discovering an incident involving a resident will ensure the resident is safe and then contact a nurse. If a no nurse was available on site, staff will update the on call RN and follow direction from the nurse. Staff will complete an incident report. The RN will complete an assessment of the resident and will document in the resident's chart. The physician, resident representative and the clinical nurse supervisor will be notified of the incident and notifications documented.	02320		

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02320	Continued From page 15 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No plan of correction is required for this tag.	