Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL247189888M
Compliance #: HL247188102C

Date Concluded: June 10, 2024

Name, Address, and County of Licensee Investigated:
New Perspective Mankato
100 Dublin Road
Mankato MN 56001
Blue Earth County

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

Evaluator's Name: Lena Gangestad, RN
Special Investigator

Finding: Substantiated, facility responsibility

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

Initial Investigation Allegation(s):
The facility neglected the resident when the facility did not call emergency medical services (EMS) after finding the resident fallen on the floor with a television set on top of her. Instead, the facility contacted the family and offered the family a choice of 911 or family-provided transport to urgent care.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility found the resident on the floor with a television set on top of her. The facility contacted the family and offered them a choice of 911 or family-transport to an urgent care. When family arrived, the resident was alone in her room and lethargic. The family took her to urgent care but was redirected to the emergency room where she was diagnosed with an intracranial hemorrhage (bleeding that occurs within the skull or brain). The resident died ten days later due to the injuries from the fall.

The investigator conducted interviews with facility staff members, including administrative staff, and nursing staff. The investigator contacted the resident's family member. The investigation included review of resident's records, facility's policies and procedures, incident reports, and the resident's external medical record. The investigation included an onsite visit, observations, and interactions between residents and facility staff.

The resident resided in an assisted living memory care unit. The resident’s diagnoses included dementia. The resident's service plan included four to seven toileting checks and four to six cues per day. The resident’s assessment indicated she had history of falls and confused.

The progress notes indicated the resident was found in another resident's room on the floor with a flat screen television on top of her. The same document indicated the resident had no bumps on her head but did have an injury to her left thumb and a skin tear on the back of her neck. The facility contacted the family and offered them a choice of 911 or family could take her to an urgent care.

While the resident did go to an urgent care clinic, she was transferred from there to a hospital for treatment.

The hospital records indicated diagnostic imaging showed scan intracranial hemorrhage and obtunded (a reduced level of alertness).

A review of the resident’s records did not identify documentation the facility contacted the resident’s medical provider regarding the fall on the day it occurred.

A further review of the records kept by the resident’s medical provider did not identify documentation that the facility notified the medical provider of the resident’s fall on the day it occurred.

According to the fall assessment, the resident wandered on the unit and went into another resident’s room. The same documented indicated there was no suspected impact to the head or face of the resident during the cognition test but stated in the root cause section that the TV fell onto the resident. In the referral section, it listed urgent care.

The resident’s death record indicated the resident passed away ten days later and the cause of death was complications from intracranial head injury resulting from a fall onto the floor and being struck by a falling television.

During an interview, a nurse stated she worked on the day the incident happened. She said the facility’s manager was rounding in the memory care unit and found the resident on the floor in another resident’s unit. The nurse stated the resident's family was notified but she could not remember whether the doctor was notified or not. She said she called the family, and they decided to take the resident to the emergency room (ER). The nurse also said she did an

assessment and remembered the resident had a couple of lacerations and her vital signs were normal. The nurse stated if there was an obvious wound, or the resident hit their head, was on blood thinners, had abnormal vital signs, pain, or anything not at their baseline, then the resident would be sent to the ER. She confirmed that staff did not have any specific time to check on the resident unless it was specified in their care plan.

During an interview, family member #1 stated he got a call from a nurse informing him that the resident had fallen, and a TV set had fallen on top of her. He inquired about her condition, to which the nurse said she had a cut on her fingers and complained of leg pain. When he asked if an ambulance was necessary, the nurse indicated she did not believe so but suggested taking the resident to urgent care. Family member #1 stated the decision to seek medical attention was left to family members. Being out of town, he had to contact his sister to arrange for the resident's urgent care visit. He noted that the call from the caregiver occurred around noon on the same day as the incident.

During an interview, family member #2 said she received a call from family member #1 around 1: 30 p.m. asked her to take the resident to urgent care after a TV set fell on her head because he was out of town. Upon arriving at the resident's room straight from work later that day, around 4:30 p.m., she found the resident seated on the couch, slouching over with food on her lap and scattered on the floor. She observed the resident appeared lethargic and noticed a bruise on her ear. She sought out staff members, who informed her that the resident had fallen and was put back to the room to rest because she seemed tired. Family member #2 stated she asked the facility why the resident had been left alone; she was told that the resident appeared fine. Upon returning to the room, she had difficulty rousing the resident but did transport the resident to urgent care, but the resident ended up going to the ER where she was admitted with a brain bleed and died 10 days later.

A facility-provided policy titled Falls Management indicated that if a nurse is onsite the nurse will assess the resident and determine if emergency services should be called. If a nurse is not onsite the facility will contact the on-call nurse to determine if it safe to move the resident. The same document indicated the facility would determine if emergency services should be called. The same document indicated a “team member” was to remain with the resident until emergency services arrived.

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. The resident was deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility did an assessment after the fall and notified family.

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
Blue Earth County Attorney
Mankato City Attorney
Mankato Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24718	A. BUILDING: _____ B. WING _____	C 04/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - MANKATO	100 DUBLIN ROAD MANKATO, MN 56001

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0 000	Initial Comments On April 30, 2024, the Minnesota Department of Health initiated an investigation of complaint HL247189888M/HL247188102C. The following correction orders are issued 0620, 2310, 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 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	0 620		

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0 620	Continued From page 1 (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 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.	0 620		

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0 620	Continued From page 2 (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 immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) an unwitnessed fall with injury for one of three residents (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 situation has occurred only occasionally). The findings include: R1 was admitted May 2, 2023.	0 620		

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0 620	Continued From page 3 R1's diagnoses included dementia. R1's service agreement dated May 2, 2023, indicated R1 received assistance with medication management, dressing, grooming, bathing, housekeeping and laundry. R1's progress notes dated November 3, 2023, as a late entry indicated R1 was found in another resident's room on November 2, 2023, around 4:30 p.m. R1 was lying on the floor in front of an entertainment stand with a flat screen television fell on her. When interviewed on May 6, 2024, at 6:58 a.m., registered nurse (RN)-D stated she only called to notify the family and did a fall assessment. The licensee's Vulnerable Adult Maltreatment policy indicated any staff person who witness, or suspects maltreatment of a vulnerable adult would report the incident immediately to management staff, and that person would complete an incident report. If the incident appears to be suspected abuse, neglect or financial exploitation, management staff would immediately make a report. TIME PERIOD FOR CORRECTION: Seven (7) Days.	0 620		
02310 SS=H	144G.91 Subd. 4 (a) Appropriate care and services (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	02310		

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02310	Continued From page 4 standards. This MN Requirement is not met as evidenced by: Based on the interview and record review, the licensee failed to provide appropriate services based on the resident's needs and accepted health care standards for three of three (R1, R2, and R3) resident reviewed. After discovering R1 on the floor with a television on top of her, the facility failed to update R1's medical provider nor did the facility monitor her after the fall as she had a change in her level of consciousness. The facility notified R1's family and suggested urgent care but did not call emergency services. When R1 eventually went the emergency room, it was found R1 sustained an intracranial hemorrhage, which contributed to her death. Regarding R2 and R3, the licensee failed to implement appropriate interventions while both residents fell on multiple occasions according to accepted health care standards. 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 a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: The American Journal of Nursing article titled "When a Fall Occurs" dated November 7, 2007,	02310		

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02310	Continued From page 5 volume 107, number 11, indicated fall analysis should be completed to identify the underlying causes and risk factors of the fall. Immediate follow-up will help identify and enable staff to initiate preventive measure. The same document indicated medical providers should be notified of a fall according to the facility's policy. R1 R1's diagnoses included dementia. R1's service agreement dated May 2, 2023, indicated caregivers to cue and prompt the resident four to six times in 24-hour period. It also indicated caregivers would provide toilet assistance four to seven times a day, the facility did not provide a schedule or times for these cues or toilet assistance. The service agreement indicated R1 was also at risk for falls. R1's assessment dated August 9, 2023, indicated R1 was not able to use pendant, nor did she transfer independently. The assessment also indicated R1 had history of falls and confused. R1's progress notes dated November 3, 2023, as a late entry indicated R1 was found in another resident's room on November 2, 2023, around 4:30 p.m. R1 was lying on the floor in front of an entertainment stand with a flat screen television on top of her. The same document indicated the resident had no bumps on her head but did have an injury to her left thumb and a skin tear on the back of her neck. The facility contacted the family and offered them a choice of 911 or family could take her to an urgent care. R1's fall assessment, dated November 2, 2023, indicated R1 was a wanderer and went into another resident's room. The assessment also	02310		

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02310	Continued From page 6 indicated there was no suspected impact to the head or face of the resident during the cognition test but stated in the root cause section that the television fell onto the resident. In the referral section of the form, it indicated "urgent care". A review of the resident's records did not identify documentation the facility contacted the resident's medical provider regarding the fall on the day it occurred. A further review of the records kept by the resident's medical provider did not identify documentation that the facility notified the medical provider of the resident's fall on the day it occurred. R1's hospital records dated November 3, 2023 indicated a head CT (Computer Tomography) scan revealed intracranial hemorrhage. After consultation with palliative care, R1 was transitioned to comfort care. R1's Documentation of Death indicated R1 passed away on November 12, 20203, listing the cause of death as complications from intracranial head injury resulting from a fall onto the floor and being struck by a falling television. When interviewed on May 6, 2024, at 6:58 a.m., registered nurse (RN)-D stated she worked on the day the incident happened. She said the licensed assisted living director (LALD) was rounding in the memory care unit and had found the resident on the floor in another resident's unit. The resident's family was notified. RN-D could not remember whether she notified the doctor or not. She said she called the family, and they decided to take the resident to the Emergency Room (ER). RN-D also said she did an assessment and remembered the resident had a couple of lacerations and that her vital signs were	02310		

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02310	Continued From page 7 normal. She explained that if there was an obvious wound, or the resident hit their head, was on blood thinners, had abnormal vital signs, pain, or anything not at their baseline, then they would send the resident to the ER right away. RN-D said the resident seemed fine, so she did not send her to ER and let the family decide. She confirmed that staff did not have any specific time to check on the resident unless it was specified in their care plan. When interviewed on May 2, 2024, at 12:59 p.m., family member (FM)-H stated he got a call from RN-D informing him that R1 had fallen, and a TV set had fallen on top of her. He inquired about R1's condition, to which the nurse said R1 had a cut on her fingers and complained of leg pain. When he asked if an ambulance was necessary, RN-D indicated she did not believe so but suggested taking the resident to urgent care. FM-H stated that the decision to seek medical attention was left to family members. Being out of town, he had to contact his sister to arrange for the resident's urgent care visit. When interviewed on May 1, 2024, at 1:12 p.m., family member (FM)-I stated she received a call from FM-H around 1:30 p.m. asked her to take R1 to urgent care after a TV set fell on her head. Upon arriving at R1's room straight from work later that day, around 4:30 p.m., she found R1 seated on the couch, slouching over with food on both her lap and scattered on the floor. FM-I observed R1 appeared lethargic and noticed a bruise on her ear. FM-I sought out staff members, who informed her R1 had fallen and was put back to the room to rest because she seemed tired. Questioning why R1 had been left alone, FM-I was told that R1 appeared fine. Upon returning to the room, FM-I had difficulty rousing R1. She then	02310		

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02310	Continued From page 8 transported R1 to urgent care, but from there R1 required the emergency room. R1 was admitted to the hospital with brain bled and passed away 10 days later. R2 R2's diagnoses included dementia and lived on the memory care unit. R2's service agreement dated April 30, 2024, indicated R2 required cues to stay seated in a wheelchair due to imbalance. While the cues were set up for more than 10 times in a 24-hour period the facility did not provide a schedule or times for these cues. R2's progress notes dated February 25, 2024, indicated R2 was sent to the hospital due to a fifth fall within 36 hours. The same document indicated R2 would require "1:1" supervision if R2 returned to the facility. The same document indicated the family stated they would not be providing one-on-one care. R2's progress notes dated March 4, 2024, indicated the facility went to the hospital, conducted an assessment, and accepted the resident back to the facility. R2's medical record included dated March 6, 2024, which indicated the medical provider wrote "Unable to prevent falls related to resident having a diagnosis of dementia; resident will continue to fall." The same document did not include how the medical provider made this determination. R2's progress notes dated March 20, 2024, indicated R2 had an unwitnessed fall in the dining room at 6:22 p.m.	02310		

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02310	Continued From page 9 Under Falls Management, a review R2's service plan did not identify an intervention after this fall. R2's progress notes dated April 2, 2024, indicated R2 was found lying on her back in her apartment at 5:10 p.m. Under Falls Management, a review R2's service plan did not identify an intervention after this fall. R2's progress notes dated April 4, 2024, indicated R2 had a witnessed fall in the dining room while using her wheelchair at 11:57 a.m. Under Falls Management, a review R2's service plan did not identify an intervention after this fall. R2's progress notes dated April 7, 2024, indicated R2 was found lying on her back at approximately 2:20 a.m. Under Falls Management, a review R2's service plan did not identify an intervention after this fall. R2's progress notes dated April 7, 2024, indicated R2 was found on the floor with a "positive head strike" at approximately 1:20 p.m. Under Falls Management, a review R2's service plan did not identify an intervention after this fall. R2's progress notes dated April 7, 2024, indicated at 2:20 a.m. R2 was found lying on the floor on her back, no apparent injury, unknown head strike. At 1:20 p.m. R2 was found on the floor had a positive head strike. R2 was sent to the hospital and went back to the same day with diagnosis of T11-T12 compression fracture.	02310		

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02310	Continued From page 10 R2' progress notes dated April 7, 2024, indicated R2 fell while attempting to get from her wheelchair and walk at approximately 7:00 p.m. Under Falls Management, a review R2's service plan did not identify an intervention after these falls. R2's progress notes dated April 8, 2024. indicated the facility consulted with "therapy" and determined R2 required "long term care" placement due to ongoing falls. Under Falls Management, a review R2's service plan did not identify an intervention after this fall. R2's progress notes dated April 9, 2024, indicated R2 had an unwitnessed fall in her room at approximately 12:30 a.m. R2's progress notes dated April 9, 2024, indicated R2 was found on the floor next to her bed [time unknown] later that same day. Under Falls Management, a review R2's service plan did not identify an intervention after these falls. R2's progress notes dated April 10, 2024, indicated care conference was held with R2's family to address frequent falls and therapy recommendations for "direct supervision with close proximity at all times". The same document indicated neither the family nor the facility would provide "1:1" supervision and "there will continue to be falls". The same document indicated the care plan will be increased to a "custom level". During interviews, multiple employees stated R2 fell frequently during the months of March and	02310		

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	24718	A. BUILDING: _____ B. WING _____	C 04/30/2024

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02310	Continued From page 11 April 2024 and that a care conference was held with the family with the recommendation that R2 transfer to a nursing home setting. Multiple employees stated that during the care conference a member of the management team presented a different perspective and that R2 did not need such extensive care, which conflicted with the understanding of the caregivers. Multiple employees stated the facility management decided the resident could stay at the facility with increased services. R2's progress notes dated April 11, 2024, indicated R2 had an unwitnessed fall next to her bed at 12:12 a.m., 2:13 a.m. and 4:58 a.m. during the night shift. Under Falls Management, a review R2's service plan did not identify an intervention after this fall. R2's progress notes dated April 12, 2024, indicated R2 had an unwitnessed fall with a "head strike" at 7:11 p.m. Under Falls Management, a review R2's service plan did not identify an intervention after this fall. R2's progress notes dated April 14, 2024, indicated R2 had a witnessed fall in her room at approximately 7:11 a.m. Under Falls Management, a review R2's service plan did not identify an intervention after this fall. R2's progress notes dated April 14, 2024, indicated R2 was found on the floor in her bathroom at 7:04 p.m. R2's progress notes dated April 14, 2024, indicated R2 was found on the floor in her room at 10:54 p.m. on April 14, 2024. Under Falls Management, a review R2's service	02310		

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02310	Continued From page 12 plan did not identify an intervention after these falls. R2's progress notes dated April 20, 2024, indicated a fellow resident reported to a caregiver that R2 had fallen in the dining room at 11:34 a.m. Under Falls Management, a review R2's service plan did not identify an intervention after this fall. R2's progress notes dated April 23, 2024, indicated R2 was found sitting on the floor, leaning against her bed 12:50 a.m. Under Falls Management, a review R2's service plan did not identify an intervention after this fall. The investigation included a request via email on June 4, 2024 for Incident Reports regarding falls from March through April 2024 for R2 however the facility replied to it did not have any for R2. During an interview on May 1, 2024 at 2:01 p.m. employee (EMP)-C stated the facility only had two staff members for the entire building during the overnight shift covering more than 120 residents and that no one was stationed in the memory care unit. When interviewed on April 30, 2024, at 12:36 p.m., care manager (CM)-E stated there were only two staff working in the entire building, one medication passer and one care giver. When interviewed on May 3, 2024, at 11:49 a.m., family member (FM)-B stated the staff kept R2 out in the common area all the time and just left her sitting there without anything to do. Despite that, R2 still experienced over 20 falls, mostly unwitnessed in the last two months. FM-B said	02310		

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02310	Continued From page 13 the facility suggested family member to sit with R2 all day to prevent R2 from falling because they were short staff. Additionally, FM-B said that the facility would put R2 to bed at 6 p.m. each evening and only checked on her 2-3 times throughout the night. FM-B also said the facility's claim that they could not prevent the resident from falling, yet they were raising their prices. FM-B stated that as a result of these falls R2 fractured her T11 and T12. She also said there were only two staffs working at night and it was very hard to find help. R3 R3's diagnoses included dementia. R3's service agreement dated March 26, 2024, indicated caregivers to cue and prompt R3 four to six times in 24 hours period. It also indicated caregivers would provide toilet assistance one to three times a day, the facility did not provide a schedule or times for the toilet assistance. The service agreement indicated R1 was also at risk for falls. R3's assessment dated March 26, 2024, indicated R3 was alert and resided in memory care unit. The assessment also indicated she had a history of falls. R3's progress notes dated March 8, 2024, indicated R3 had an unwitnessed fall. 911 was called and R3 was sent to the hospital. R3 had confirmed hip fracture and primary care provider was notified by fax. The hip fracture was deemed non-operative. R3's progress notes dated March 11, 2024, indicated R3 returned from the hospital and moved to the memory care unit at 12:49 p.m. R3	02310		

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02310	Continued From page 14 also had an unwitnessed fall on the same day at 8:39 p.m. R3's progress notes dated March 18, 2024 indicated late entry for March 17, 2024 at 8:34 p.m. R3 was found on the floor. Under Falls Management, a review R3's service plan did not identify an intervention after this fall. R3's progress notes dated March 21, 2024 indicated there was a note in the 24 hour shift log R3 called 911 herself and was transported to the ER. The same document indicated R3 sustained a left hip fracture and R3's family stated R3 would have the surgery done. R3's progress notes dated March 26, 2024 indicated R3 returned to the facility and needed two persons assist with an EZ stand. R3's progress notes dated March 28, 2024 indicated R3 was found sitting on the floor in her living room with her back against her couch by the caregiver. Under Falls Management, a review R3's service plan did not identify an intervention after this fall. R3's progress notes dated April 13, 2024 indicated R3 was found on the floor by the door in her room. R3 had a cut to her left middle finger and pulled out her catheter. The same documents indicated R3 was transported to the hospital. R3's progress notes dated April 15, 2024 indicated R3 had a laceration and fracture of her left middle finger as well as a left femur fracture and had been admitted to the hospital.	02310		

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02310	Continued From page 15 Under Falls Management, a review R3's service plan did not identify an intervention after this fall. The investigation included a request via email on June 4, 2024 for Incident Reports regarding falls from March through April 2024 for R3 however the facility replied to it did not have any for R3. When interviewed on May 23, 2024, at 10:39 a.m., registered nurse (RN)-C stated R3 was moved to memory care after the fall. The staff members tried to keep R3 in the common area as long as she tolerated it to keep an eye on her. She also said the staff did not document how often they checked on the residents although she claimed they did do it. When interviewed on May 6, 2024, at 6:58 a.m., RN-D stated R3 had a couple more falls and re-fractured her hip in the memory care unit. She said the family was pretty upset because the call light took so long to answer, and they ended up having to come and help her. She said the facility had one medication passer and one caregiver at night. She said R3 started using a standing (EZ) lift when she moved to memory care, and the staff tried to keep her out in a day room and offered activities to keep her busy. At shift change, she said the staff members were supposed to verbalize about the last check, but there was never any specific check scheduled or documented. When interviewed on April 30, 2024, at 5:00 p.m., family member (FM)-F stated R3 was living on the assisted living side and had a couple of falls. R3 broke her hip, had surgery, and returned to the memory care side. R3 was placed in memory care unit and within one or two days she fell	02310		

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02310	Continued From page 16 again. The family had installed a ring camera, so they knew whether staff came to help R3 or not. FM-F stated R3 was yelling, and the family ended up driving to the facility to help R3 to the bathroom. Within 24 hours, R3 was sitting on the edge of the bed and scooting on the floor for two hours at 3:00 a.m., and no one had come to help her. R3 ended up ripping her catheter out. The family talked to the director, and their only response was that they were short-staffed. When interviewed on April 30, 2024, at 12:53 p.m., family member (FM)-G stated the camera they installed showed that at night, R3 would yell for help, and no one came to assist her. There was a button to push, but R3 had dementia and did not know how to use it. R3 fell, broke her finger, and pulled out her catheter. FM-G stated that at night, the facility did not have enough staff to check on people, and R3 often fell either at night or early in the morning. FM-G stated the facility did not check on R3 at night as often as the facility said it would. The facility told her that they were short-staffed. A facility-provided policy titled Falls Management dated May 22, 2023, indicated that if a nurse is onsite the nurse will assess the resident and determine if emergency services should be called. If a nurse is not onsite the facility will contact the on-call nurse to determine if it safe to move the resident. The same document indicated the facility would determine and determine if emergency services should be called. The policy also indicated the facility that if the resident was on hospice, then the facility would call hospice or, if the resident were not receiving hospice, 911. The same document indicated a "team member" was to remain with the resident until hospice or emergency services arrived. The same	02310		

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02310	Continued From page 17 document indicated the facility would complete a Fall Evaluation after a fall, which included evaluating potential interventions to reduce the risk for falls. The same document indicated the facility would document interventions to reduce the risk of falls in the resident's service plan and communicate these interventions to team members providing the services to the resident. TIME PERIOD FOR CORRECTION: 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: 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.	