

STATE LICENSING COMPLIANCE REPORT

Report #: HL27529034C

Date Concluded: November 20, 2020

Name, Address, and County of Facility

Investigated:

Lino Lakes Assisted Living LLC
725 Town Center Parkway
Lino Lakes, MN 55014
Anoka County

Facility Type: Home Care Provider

Investigator's Name:

Paul Spencer, RN
Special Investigator

The Minnesota Department of Health conducted a complaint investigation to determine compliance with state laws and rules governing the provision of care under Minnesota Statutes, Chapter 144 and 144A. The purpose of this complaint investigation was to review if facility policies and practices comply with applicable laws and rules. No maltreatment under Minnesota Statutes, Chapter 626 was alleged.

To view a copy of the correction orders, if any, please visit:

<https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html>, or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached state form.

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER LINO LAKES ASSISTED LIVING LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 725 TOWN CENTER PARKWAY LINO LAKES, MN 55014
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0 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>HOME CARE PROVIDER LICENSING CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144A.43 to 144A.482, the Minnesota Department of Health issued a correction order(s) pursuant to a survey.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p>On October 8, 2020, the Minnesota Department of Health initiated an investigation of complaint #HL27529032M/#HL27529033C and #HL27529034C. At the time of the survey, there were #101 clients receiving services under the comprehensive license.</p> <p>The following immediate correction order is issued for #HL27529032M/#HL27529033C, tag identification 265.</p> <p>The following correction orders is issued for #H27529034C, tag identification 380.</p>	0 000	<p>Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance 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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144A.474 SUBDIVISION 11 (b)(1)(2)</p>	
0 265 SS=I	<p>144A.44, Subd. 1(a)(2) Up-To-Date Plan/Accepted Standards Practice</p> <p>Subdivision 1. Statement of rights. (a) A client who</p>	0 265		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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0 265	<p>Continued From page 1</p> <p>receives home care services in the community or in an assisted living facility licensed under chapter 144G has these rights: (2) receive care and services according to a suitable and up-to-date plan, and subject to accepted health care, medical or nursing standards and person-centered care, to take an active part in developing, modifying, and evaluating the plan and services;</p> <p>This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to implement fall interventions after falls for 20 of 28 clients (C2, C4, C7, C9, C11, C12, C13, C14, C15, C16, C17, C18, C19, C20, C21, C22, C23, C24, C25, C26) reviewed.</p> <p>This practice resulted in a level three violation (a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at 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 clients).</p> <p>The findings include:</p> <p>The American Journal of Nursing article titled "When a Fall Occurs" dated November 2007, volume 107, number 11, indicated fall analysis should be completed to identify to the underlying causes and risk factors of the fall. Immediate follow up will help identify and enable staff to initiate preventative measures.</p>	0 265		

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0 265	<p>Continued From page 2</p> <p>Client #2 C2's medical record was reviewed. C2's diagnoses included Parkinson's disease. C2's service plan dated October 29, 2019, included assistance with medication administration, dressing, grooming, toileting, transfers, wheelchair mobility, repositioning, bathing, escorts to and from meals, and safety checks every two hours.</p> <p>C2's incident reports were reviewed. C2's incident report dated July 31, 2020, at 10:50 a.m., indicated C2 was found on the floor in his room. The same document included a section titled "Prevention of Future Incidents" which indicated "none". Interventions to prevent future incidents indicated "none".</p> <p>C2's progress notes did not include documentation of C2's fall on July 31, 2020, or fall interventions.</p> <p>C2's incident report dated August 28, 2020, at 5:00 p.m., indicated C2 was found on the floor in his room. C2 had a right hand abrasion and bruise on his right shoulder. The section "Prevention of Future Incidents" indicated "none".</p> <p>C2's progress notes did not include fall interventions for the fall occurring on August 28, 2020.</p> <p>C2's incident report dated September 28, 2020, at 7:45 p.m., indicated C2 was found on the floor in his room. The same document indicated C2 had redness on the back of his head and complained of hip pain. The section titled "Prevention of Future Incidents" indicated "none".</p> <p>C2's progress notes dated September 28, 2020,</p>	0 265		

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0 265	<p>Continued From page 3</p> <p>indicated C2 declined transfer to the emergency room. C2's progress notes indicated the licensee would continue to monitor C2, but included no interventions for fall prevention.</p> <p>C2's incident report dated September 30, 2020, at 3:20 p.m., indicated C2 was found on the floor in his room. The section titled "Prevention of Future Incidents" indicated "none".</p> <p>C2's progress notes did not include documentation of C2's fall on September 30, 2020, or fall interventions.</p> <p>Client #4 C4's medical record was reviewed. C4's diagnoses included diabetes, atrial fibrillation, and muscle weakness. C4's service plan dated January 29, 2020, included assistance with medication administration, dressing, grooming, toileting, bathing, transfers, one staff assist using a gait belt and walker for mobility, escorts to and from meals, and safety checks every two hours.</p> <p>C4's incident report was reviewed. C4's incident report dated August 18, 2020, at 9:00 a.m., indicated C4 had a witnessed fall walking from his wheelchair to recliner. The section titled "Prevention of Future Incidents" indicated "none".</p> <p>C4's progress note did not include documentation of C4's fall on August 18, 2020, or fall interventions.</p> <p>Client #7 C7's medical record was reviewed. C7's diagnoses included dementia, chronic kidney disease, and osteoarthritis. C7's service plan dated December 24, 2019, included assistance with medication administration, bathing, and</p>	0 265		

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0 265	<p>Continued From page 4</p> <p>safety checks every two hours during the overnight shift.</p> <p>C7's incident report was reviewed. C7's incident report dated September 12, 2020, at 10:45 p.m., indicated C7 was found on the floor in his room. The same document indicated C7 had a right elbow skin tear and received first aid. The section titled "Prevention of Future Incidents" indicated "none".</p> <p>C7's progress notes indicated the licensee would continue to monitor C7, but included no interventions for fall prevention.</p> <p>Client #9 C9's medical record was reviewed. C9's diagnoses included Alzheimer's disease. C9's service plan dated January 9, 2020, included assistance with medication administration, dressing and grooming on bath days, toileting, bathing, and safety checks every two hours during the overnight shift.</p> <p>C9's incident reports were reviewed. C9's incident report dated September 25, 2020, at 5:00 p.m., indicated C9 was found on the floor in his room. The section titled "Prevention of Future Incidents" was left blank.</p> <p>C9's progress notes indicated the licensee would continue to monitor C9, but included no interventions for fall prevention.</p> <p>C9's incident report dated October 1, 2020, at 8:30 a.m., indicated C9 was found on the floor in his room. The same document indicated C9 had a left elbow skin tear and received first aid. The section titled "Prevention of Future Incidents" indicated "none".</p>	0 265		

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0 265	<p>Continued From page 5</p> <p>C9's progress notes indicated the licensee would continue to monitor C9, but included no interventions for fall prevention.</p> <p>Client #11 C11's medical record was reviewed. C11's diagnoses included dementia. C11's service plan dated December 20, 2019, included assistance with medication administration, dressing, grooming, toileting, bathing, escorts to and from meals, and safety checks every two hours.</p> <p>C11's incident report was reviewed. C11's incident report dated September 25, 2020, at 6:30 a.m., indicated C11 was found on the floor in her room. The section titled "Prevention of Future Incidents" indicated "none".</p> <p>C11's progress notes did not include fall interventions for the fall occurring on September 25, 2020.</p> <p>Client #12 C12's medical record was reviewed. C12's diagnoses included diabetes and hypertension. C12's service plan dated February 17, 2020, included assistance with medication administration, toileting, bathing, reminders for dressing and grooming, and safety checks every two hours during the overnight shift.</p> <p>C12's incident reports were reviewed. C12's incident reported dated August 11, 2020, at 8:39 p.m., indicated C12 was found on the floor in his room. The section titled "Prevention of Future Incidents" indicated "none".</p> <p>C12's progress notes did not include documentation of C12's fall on August 11, 2020,</p>	0 265		

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0 265	<p>Continued From page 6 or fall interventions.</p> <p>C12's incident report dated September 5, 2020, indicated C12 was found on the floor in his room. The section titled "Prevention of Future Incidents" was left blank.</p> <p>C12's progress notes did not include fall interventions for the fall occurring on September 5, 2020.</p> <p>Client #13 C13's medical record was reviewed. C13's diagnoses included diabetes, hypertension, and muscle weakness. C13's service plan dated February 10, 2020, included assistance with medication administration, dressing, grooming, toileting, bathing, two staff assist for transfers using a transfer belt, assistance with wheelchair for mobility, and safety checks every two hours during the overnight shift.</p> <p>C13's incident reports were reviewed. C13 incident report dated August 1, 2020, at 9:00 p.m., indicated C13 was found on the floor in her room. The section titled "Prevention of Future Incidents" was left blank.</p> <p>C13's progress notes indicated the licensee would continue to monitor C13, but included no interventions for fall prevention.</p> <p>C13's incident report dated August 24, 2020, at 9:30 p.m., indicated C13 was found on the floor in her room. C13 had a head laceration and bruising. C13 transferred to the emergency room for evaluation. The section titled "Prevention of Future Incidents" included placing the client on alert.</p>	0 265		

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0 265	<p>Continued From page 7</p> <p>C13's progress note dated August 25, 2020, at 8:54 a.m., included a late entry indicated C13 returned from the hospital with four staples closing the head laceration.</p> <p>C13's indicated the licensee would continue to monitor C13, but included no interventions for fall prevention.</p> <p>Client #14 C14's medical record was reviewed. C14's diagnoses included diabetes, hypertension, and weakness. C14's service plan dated December 12, 2019, included assistance with medication administration, dressing, grooming, toileting, bathing, and safety checks every two hours.</p> <p>C14's incident report was reviewed. C14's incident report dated September 17, 2020, at 7:30 p.m., indicated C14 was found on the floor in her bathroom. The section titled "Prevention of Future Incidents" indicated "none".</p> <p>C14's progress notes did not include fall interventions for the fall occurring on September 17, 2020.</p> <p>Client #15 C15's medical record was reviewed. C15's diagnoses included diabetes and muscle weakness. C15's undated service plan included assistance with medication administration, assistance in and out of shower, and safety checks every two hours during the overnight shift.</p> <p>C15's incident report was reviewed. C15's incident report dated September 28, 2020, at 11:30 a.m., indicated C15 was found on the floor in his room. The section titled "Prevention of Future Incidents" indicated "none".</p>	0 265		

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0 265	<p>Continued From page 8</p> <p>C15's progress notes indicated the licensee would continue to monitor C15, but included no interventions for fall prevention.</p> <p>Client #16 C16's medical record was reviewed and C16 had no documented diagnoses. C16's service plan dated June 9, 2020, included assistance with medication administration, dressing, grooming, bathing, and safety checks every two hours during the overnight shift.</p> <p>C16's incident reports were reviewed. C16's incident report dated July 18, 2020, at "12:00-1:00 a.m." indicated C16 was found on the floor in his room. The same document indicated C16 had a laceration on his left arm and left hand. C16 transferred to the emergency room. The section titled "Prevention of Future Incidents" was left blank.</p> <p>C16's progress notes dated July 18, 2020 at 7:39 a.m., indicated C16 transferred to the hospital for stitches.</p> <p>C16's progress notes did not include fall interventions for the fall occurring on July 18, 2020.</p> <p>C16's incident report dated July 31, 2020, at 6:58 p.m., indicated C16 was found on the floor in his room. The section titled "Prevention of Future Incidents" indicated "none".</p> <p>C16's progress notes indicated the licensee would continue to monitor C16, but included no interventions for fall prevention.</p> <p>Client #17</p>	0 265		

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0 265	<p>Continued From page 9</p> <p>C17's medical record was reviewed. C17's diagnoses included Alzheimer's disease. C17's service plan dated October 25, 2019, included assistance with medication administration, dressing, grooming, toileting, bathing, escorts to and from meals, and safety checks every two hours.</p> <p>C17's incident reports were reviewed. C17's incident report dated August 6, 2020, at 1:15 p.m., indicated C17 was found on the floor in the activity room. The section titled "Prevention of Future Incidents" indicated "none".</p> <p>C17's progress notes did not include documentation of C17's fall on August 6, 2020, or fall interventions.</p> <p>C17's incident report dated September 7, 2020, at 5:00 p.m., indicated C17 was found on the floor in her room. The same document indicated C17 had a laceration near her elbow and received first aid. The section titled "Prevention of Future Incidents" indicated "none"</p> <p>C17's progress notes indicated the licensee would continue to monitor C17, but included no interventions for fall prevention.</p> <p>Client #18 C18's medical record was reviewed. C18's diagnoses included chronic obstructive pulmonary disease, and hypertension. C18's service plan dated December 18, 2019, included assistance with medication administration, bathing, and assistance with compression stockings, and safety checks every two hours during the overnight shift.</p> <p>C18's incident report was reviewed. C18's</p>	0 265		

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0 265	<p>Continued From page 10</p> <p>incident report dated September 27, 2020, at 7:30 p.m., indicated C18 reported she fell and hit her head. C18 was provided an ice pack. The section titled "Prevention of Future Incidents" was left blank.</p> <p>C18's progress notes indicated the licensee instructed C18 to notify staff if she has pain or symptoms, but included no interventions for fall prevention.</p> <p>Client #19 C19's medical record was reviewed. C19's diagnoses included diabetes, hypertension, osteoporosis, and long term use of anticoagulants (blood thinner). C19's service plan dated December 20, 2019, included assistance with medication administration, dressing, grooming, bathing, and safety checks every two hours during the overnight shift.</p> <p>C19's incident reports were reviewed. C19's incident report dated August 7, 2020 at 4:40 p.m., indicated C19 was found on the floor. The section titled "Prevention of Future Incidents" was left blank.</p> <p>C19's progress notes indicated the licensee would continue to monitor C19, but included no interventions for fall prevention.</p> <p>Client #20 C20's medical record was reviewed. C20's diagnoses included hypertension and anxiety. C20's service plan dated May 26, 2020, included assistance with medication administration, dressing, and grooming.</p> <p>C20's incident reports were reviewed. C20's incident report dated August 10, 2020, at 5:35</p>	0 265		

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0 265	<p>Continued From page 11</p> <p>p.m., indicated C20 was found sitting on the floor in the living room. C20 reported hitting her head on the bathroom floor. The section titled "Prevention of Future Incidents" was left blank.</p> <p>C20's progress notes did not include documentation of C20's fall on August 10, 2020, or fall interventions</p> <p>C20's incident report dated September 29, 2020, at 5:00, indicated C20 was found on the floor in her room. The section titled "Prevention of Future Incidents" was left blank.</p> <p>C20's progress notes did not include documentation of C20's fall on September 29, 2020, or fall interventions.</p> <p>Client #21 C21's medical record was reviewed. C21's diagnoses chronic obstructive pulmonary disease, chronic kidney disease, and osteoarthritis. C21's service plan dated December 30, 2019, included assistance with medication administration, dressing, bathing, escorts to and from meals and safety checks every two hours during the overnight shift.</p> <p>C21's incident report dated September 12, 2020, "around 12:15 p.m." indicated C21 was found on the floor in his bathroom. The section titled "Prevention of Future Incidents" indicated "none".</p> <p>C21's progress notes did not include documentation of C21's fall on September 12, 2020, or fall interventions.</p> <p>C21's incident report dated September 13, 2020, at 8:35, indicated C21 was found on his bathroom floor. The section titled "Prevention of Future</p>	0 265		

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NAME OF PROVIDER OR SUPPLIER LINO LAKES ASSISTED LIVING LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 725 TOWN CENTER PARKWAY LINO LAKES, MN 55014
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0 265	<p>Continued From page 12</p> <p>Incidents" was left blank.</p> <p>C21's progress notes did not include documentation of C21's fall on September 13, 2020, or fall interventions.</p> <p>C21's incident report dated September 20, 2020, at 7:30 a.m., indicated C21 was found on his bathroom floor. The section titled "Prevention of Future Incidents" indicated "none".</p> <p>C21's progress notes did not include documentation of C21's fall on September 20, 2020, or fall interventions.</p> <p>Client #22 C22's medical record was reviewed. C22's diagnoses included dementia, macular degeneration, and history of falls. C22's service plan dated June 30, 2020, included assistance with medication administration, dressing, grooming, toileting, bathing, transfers, escorts to and from meals, and safety checks every two hours during the overnight shift.</p> <p>C22's incident reports were reviewed. C22's incident report dated July 21, 2020, at 1:15 p.m., indicated C22 had a witnessed fall off the dining room chair. The section titled "Prevention of Future Incidents" indicated "none".</p> <p>C22's progress notes did not include documentation of C22's fall on July 21, 2020, or fall interventions.</p> <p>C22's incident report dated August 1, 2020, at 7:30 a.m., indicated C22 was found on the floor in her room and complained of pain. The section titled "Prevention of Future Incidents" indicated "none".</p>	0 265		

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0 265	<p>Continued From page 13</p> <p>C22's progress notes dated August 1, 2020, indicated C22 had a second fall at 12:00 p.m. C22's progress notes indicated the licensee would continue to monitor C22, but included no interventions for prevention of falls.</p> <p>C22's incident report dated September 21, 2020, at 11:00 a.m., indicated C22 was found on the floor in her room. C22 had a bruise on her right hand. The section titled "Prevention of Future Incidents" indicated "none".</p> <p>C22's progress notes indicated the licensee would continue to monitor C22, but included no interventions for prevention of falls.</p> <p>C22's incident report dated September 30, 2020, at 1:15 p.m., indicated C22 was found on the floor in her room. The section titled "Prevention of Future Incidents" indicated "none".</p> <p>C22's progress notes indicated the licensee would continue to monitor C22, but included no interventions for prevention of falls.</p> <p>Client #23 C23's medical record was reviewed. C23's diagnoses included diabetes and long term use of anticoagulants. C23's service plan dated October 1, 2020 included assistance with medication administration, dressing, grooming, toileting, bathing, and safety checks every two hours.</p> <p>C23's incident reports were reviewed. C23's incident report dated September 8, 2020, at 2:30, indicated C23 was found on the floor in his room. The section titled "Prevention of Future Incidents" was left blank.</p>	0 265		

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0 265	<p>Continued From page 14</p> <p>C23's progress notes did not include documentation of C23's fall on September 8, 2020, or fall interventions.</p> <p>C23's incident report dated October 1, 2020 at 12:35 p.m., indicated C21 was found on the floor in his room. The section titled "Prevention of Future Incidents" indicated "none".</p> <p>C23's progress notes did not include documentation of C23's fall on October 1, 2020, or fall interventions.</p> <p>Client #24 C24's medical record was reviewed. C24's diagnoses included diabetes, chronic obstructive pulmonary disease, muscle weakness, and hypertension. C24's service plan dated December 27, 2019, included assistance with medication administration, dressing, grooming, toileting, transfers, bathing, escorts to and from meals and safety checks every two hours during the overnight shift.</p> <p>C24's incident report dated September 22, 2020, at 6:45 a.m., indicated C24 had a witnessed fall in her bathroom. C24 fell and hit her head on the wheelchair. The section titled "Prevention of Future Incidents" indicated "none"</p> <p>C24's progress notes did not include documentation of C24's fall on September 22, 2020, or fall interventions.</p> <p>Client #25 C25's medical record was reviewed. C25's diagnoses included diabetes, hypertension, and atrial fibrillation. C25's service plan dated February 17, 2020, included assistance with medication administration, dressing, grooming,</p>	0 265		

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0 265	<p>Continued From page 15</p> <p>transfers, bathing, escorts to and from meals and safety checks every two hours during the overnight shift.</p> <p>C25's incident reports were reviewed. C25's incident report dated July 21, 2020, indicated C25 reported her knees gave out and was found on the floor in the hallway. The section titled "Prevention of Future Incidents" indicated the licensee instructed C25 to take it slow when walking.</p> <p>C25's progress notes did not include documentation of C25's fall on July 21, 2020, or fall interventions.</p> <p>C25's incident report dated August 7, 2020, at 2:45 a.m., indicated C25 was found on the floor in her room. The section titled "Prevention of Future Incidents" indicated "none".</p> <p>C25's progress notes did not include documentation of C25's fall on August 7, 2020, or fall interventions.</p> <p>C25's incident report dated August 17, 2020, indicated C25 reported slipping on the floor and bumping her head. C25 was found on the bathroom floor. The same document indicated C25 had a skin tear and received first aid. The section titled "Prevention of Future Incidents" indicated "none".</p> <p>C25's progress notes did not include documentation of C25's fall on August 17, 2020, or fall interventions.</p> <p>Client #26 C26's medical record was reviewed. C26's diagnoses included cerebrovascular accident</p>	0 265		

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0 265	<p>Continued From page 16</p> <p>(stroke), diabetes, and chronic obstructive pulmonary disease. C26's service plan dated October 2, 2020, included assistance with medication administration, dressing, grooming, bathing, and safety checks every two hours during the overnight shift.</p> <p>C26's incident report was reviewed. C26's incident reported dated August 15, 2020, at 6:50 p.m., indicated C26 had a witnessed fall in the parking lot. The same document indicated C26 had skin tears and received first aid. The section titled "Prevention of Future Incidents" indicated "none".</p> <p>C26's progress notes did not include documentation of C26's fall on August 15, 2020, or fall interventions.</p> <p>During an interview on October 13, 2020, at 1:23 p.m., the assistant director of nursing (ADON)-A stated there is a fall assessment in addition to the incident report. When asked where to find documentation for fall interventions, the ADON stated the interventions might be documented on the fall assessment. The ADON-A also stated anytime there is a fall the facility needs to identify interventions to prevent future falls.</p> <p>During an interview on October 13, 2020, at 2:20 p.m., the director of nursing (DON)-E stated that there is no additional fall assessment completed in addition to the incident report.</p> <p>The licensee polity titled "Falls Prevention and Reduction" dated August 29, 2014, indicated the Registered Nurse will conduct a falls assessment to evaluate potential interventions to reduce or eliminate the risks of falls and incorporate interventions into the care plan.</p>	0 265		

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0 265	Continued From page 17	0 265		
0 380 SS=D	<p>144A.441 Assisted Living Bill Of Rights Addendum</p> <p>144A.441 ASSISTED LIVING BILL OF RIGHTS ADDENDUM.</p> <p>Assisted living clients, as defined in section 144G.01, subdivision 3, shall be provided with the home care bill of rights required by section 144A.44, except that the home care bill of rights provided to these clients must include the following provision in place of the provision in section 144A.44, subdivision 1, clause (17):</p> <p>"(17) the right to reasonable, advance notice of changes in services or charges, including at least 30 days' advance notice of the termination of a service by a provider, except in cases where:</p> <p>(i) the recipient of services engages in conduct that alters the conditions of employment as specified in the employment contract between the home care provider and the individual providing home care services, or creates an abusive or unsafe work environment for the individual providing home care services;</p> <p>(ii) an emergency for the informal caregiver or a significant change in the recipient's condition has resulted in service needs that exceed the current service provider agreement and that cannot be safely met by the home care provider; or</p> <p>(iii) the provider has not received payment for services, for which at least ten days' advance</p>	0 380		

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0 380	<p>Continued From page 18</p> <p>notice of the termination of a service shall be provided."</p> <p>This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to provide at least 30 days' advance notice of the termination of services for 1 of 3 clients (C1) reviewed.</p> <p>This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety) and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).</p> <p>The finding include:</p> <p>C1's medical record indicated C1's diagnoses included anxiety and gait problems. C1's service plan dated December 9, 2019, included assist of two staff members for dressing and toileting. C1 transferred with two staff members and a total-assist lift. C1 used a wheelchair.</p> <p>C1's Assisted Living Residency Agreement dated January 13, 2016, indicated the facility might terminate services by providing 30-day notice. The same document indicated the facility would provide a written explanation if the facility terminated services with less than a 30-day notice.</p> <p>C1's 90 Day Service Plan dated September 1, 2020, indicated C1 needed assist from two staff members for turning in bed, dressing, and transfers.</p>	0 380		

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0 380	<p>Continued From page 19</p> <p>C1's Incident Report dated September 7, 2020, at 4:00 p.m., indicated C1 fell out of her wheelchair onto the floor.</p> <p>C1's progress notes included a late entry dated September 8, 2020, at 13:14 (1:14 p.m.), indicated C1 had left ankle pain and swelling after falling on September 7, 2020.</p> <p>An email dated September 8, 2020, at 3:49 p.m., from the director of nursing (DON)-E to C1's case manager (CM)-J indicated C1 would be better suited for a skilled nursing facility as C1 was not helping with transfers anymore and was an injury risk for staff. It also indicated C1 would benefit from additional cares. The email did not include mention of C1's fall from September 7, 2020.</p> <p>C1's progress notes dated September 8, 2020, at 20:17 (8:17 p.m.), indicated C1 requested hospitalization due to left ankle pain. C1 admitted to the hospital.</p> <p>C1's nursing home medical record indicated she discharged to a skilled nursing facility on September 12, 2020.</p> <p>An email dated September 16, 2020, at 10:46 a.m., from the assistant director of nursing (ADON)-A to CM-J indicated the reason C1 could not return included safety for C1 and C1's non-compliance with cares. The email indicated C1 needed more care than the licensee could provide.</p> <p>C1's progress notes included a late entry dated September 21, 2020, at 17:44 (5:44 p.m.), indicating C1 fell on September 7, 2020, causing a painful and swollen ankle. C1 was unable to</p>	0 380		

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0 380	<p>Continued From page 20</p> <p>move and required four staff member to provide her cares.</p> <p>C1's progress notes included a late entry dated September 22, 2020, at 15:17 (3:17 p.m.), indicating C1 had an ankle fracture from her fall, which required a cast.</p> <p>C1's progress notes included a late entry dated September 22, 2020, at 15:21 (3:21 p.m.), indicating the facility cannot meet C1's needs because C1 transfers with a total-assist mechanical lift, with up to four staff at a time.</p> <p>C1's progress notes included a late entry dated September 22, 2020, at 15:22 (3:22 p.m.), indicating C1 transferred to a skilled nursing facility.</p> <p>During an interview on October 8, 2020, at 3:00 p.m., the executive director (ED) stated the facility did not send a letter to C1 explaining why she did not receive a 30-day notice of termination of services.</p> <p>During an interview on October 8, 2020, at 3:50 p.m., DON-E, stated C1's assessment dated September 1, 2020, indicated C1 required assist of two staff members. DON-E stated he did not know C1 required assist of three or four staff until after C1 admitted to the hospital. DON-E stated C1 did not return to the facility because C1 required three to four staff members to provide her cares. DON-E stated the facility did not send C1 or C1's representative a letter explaining why she did not receive a 30-day notice of termination of services. When asked if C1 required three of four staff members to transfer while in the hospital, DON-E stated he did not ask that question.</p>	0 380		

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0 380	<p>Continued From page 21</p> <p>During an interview on October 13, 2020, at 1:22 p.m., ADON-A, a licensed practical nurse, stated C1 sometimes required assist of three or four staff members to dress or transfer for two months prior to hospitalization. ADON-A stated C1's 90 Day Service Plan dated September 1, 2020, was inaccurate when indicating C1 only needed two staff members to dress and transfer.</p> <p>During an interview on October 13, 2020, at 1:45 p.m., unlicensed personnel (ULP)-B stated C1 required two staff members for incontinence cares and transfers. ULP-B stated the only time C1 required more than two staff members was after her fall.</p> <p>During an interview on October 13, 2020, at 1:53 p.m., ULP-C stated C1 transferred with the total-assist lift and two staff members, not three or four.</p> <p>During an interview on October 13, 2020, at 2:25 p.m., ULP-D stated C1 transferred with the total-assist lift and two staff members, not three or four.</p> <p>During an interview on October 22, 2020, at 9:30 a.m., CM-J stated she learned the licensee would not re-admit C1 from the hospital claiming her level of care had changed and the licensee could no longer meet her needs. CM-J stated she was surprised the licensee would not readmit C1 as licensee had not stated they could not meet C1's needs.</p> <p>TIME PERIOD OF CORRECTION: Two (2) days.</p>	0 380		