Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL302177208M **Date Concluded:** March 24, 2024
Compliance #: HL302173684C

Name, Address, and County of Licensee Investigated:
Arbor Garden Place
535 Canyon Drive NW
Eyota, MN 55934
Olmsted County

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

Evaluator's Name: Julie Serbus, 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 implement interventions to prevent falls resulting in serious injury.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility failed to re-assess the resident and implement interventions to prevent further falls. The resident did not return to baseline after the last fall with hospitalization.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member. The investigation included review of facility progress notes, incident reports, service plan, assessments, and hospital records. During an onsite visit, the investigator made observations of staff interactions with residents.

The resident resided in an assisted living facility. The resident's diagnoses included dementia, history of falls, and chronic low back pain. The resident's master care plan included stand by assistance with showers, medication administration, meal reminders, and safety checks twice a day.

The resident's admission assessment indicated the resident had a history of falls recently prior to admission and was at risk for falls. The same assessment indicated the resident required assistance in removing clutter in her apartment due to fall risk, had decreased strength and endurance, and impaired decision-making. The resident used a walker for ambulation.

The medical record indicated the resident fell four times within a three-week period.

The first fall occurred approximately two weeks after admission and required evaluation at the emergency department. The incident report indicated the fall was unwitnessed but occurred at the elevator and the resident had been walking. The same document indicated there was suspected head trauma and the resident transferred to the emergency department.

A review of the medical record identified the facility made no changes to the resident's care plan nor focused falls assessment after this fall.

Approximately two weeks later the resident fell three more times within a three day time-period. The second fall required evaluation at the emergency department related to hip and rib pain. The third fall occurred a day later resident when the resident was found on the floor in her apartment. The fourth and final fall happened yet another day later and resulted in the resident admitting to the hospital where she was diagnosed with a hip fracture and multiple fractured ribs. The resident did not return to the facility.

A review of the electronic medical record indicated unlicensed caregivers completed the falls in the medical record, however the time stamp for the follow-up by the facility for each of these three falls did not occur until more than two weeks after the resident had discharged from the facility.

During an interview, an unlicensed caregiver stated resident required meal reminders and at times escort to meals. The unlicensed caregiver stated resident cares and interventions are located on the care plan and staff use the care plan to determine resident cares and vulnerabilities.

During an interview, a manager stated the facility did not complete the required assessments at resident admission or after falls. The manager stated updates or changes were not made to the plan of care after each fall to prevent a future fall.

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
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The administration and licensed staff member are no longer employed by the facility.

Action taken by the Minnesota Department of Health:
No further action taken at this time.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30217	A. BUILDING: _____ B. WING _____	C 03/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR GARDEN PLACE	535 CANYON DRIVE NW EYOTA, MN 55934

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** HOME CARE PROVIDER/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: #HL302173684C/#HL302177208M #HL302176688C On March 4, 2024, through March 5, 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 37 residents receiving services under the provider's Assisted Living with Dementia Care license. For #HL302176688C there were no correction orders issued. The following correction orders are issued for #HL302173684C/#HL302177208M, tag identification 1610, 1620, 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.	
01610 SS=D	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring	01610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30217	A. BUILDING: _____ B. WING _____	C 03/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR GARDEN PLACE	535 CANYON DRIVE NW EYOTA, MN 55934

(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
01610	Continued From page 1 (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on document review and interview, the licensee failed to ensure a registered nurse (RN) conducted a pre-admission assessment prior to the resident move-in-date for one of one residents (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a residents 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: Review of R1's medical record on March 4, 2024,	01610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30217	A. BUILDING: _____ B. WING _____	C 03/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR GARDEN PLACE	535 CANYON DRIVE NW EYOTA, MN 55934

(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
01610	Continued From page 2 at 3:15 p.m., indicated R1's diagnoses included dementia, history of falls, and chronic low back pain. The facility's medical record lacked evidence of the following: - pre-admission assessment prior to admission. - 14-day assessment - Focused Falls Assessments and Screening after falls - care plan updates after initial move in date. During an interview on March 5, 2024, at 10:00 a.m., ADM/RN-B confirmed the licensee did not complete nursing assessments within the timeframe required. The licensee 6.01 Assessments, Reviews & Monitoring policy, dated August 1, 2022, indicated resident reassessment and monitoring must be conducted no more than 14 calendar days of services initiated and ongoing based on changes in needs and cannot exceed 90 calendar days from the last date of assessments. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30217	A. BUILDING: _____ B. WING _____	C 03/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR GARDEN PLACE	535 CANYON DRIVE NW EYOTA, MN 55934

(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
01620	Continued From page 3 services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to complete the required 14-day assessment and ongoing focused falls assessments and screenings for one of one 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's start of care date for services was May 28, 2023. R1's diagnoses included dementia, chronic back pain, and history of falls.	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30217	A. BUILDING: _____ B. WING _____	C 03/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR GARDEN PLACE	535 CANYON DRIVE NW EYOTA, MN 55934

(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
01620	Continued From page 4 Review of R1's initial assessment dated May 12, 2023, indicated R1 had fallen in the previous three months prior to admission, ambulated with a walker, and needed assistance to reduce falls by removing clutter in the resident's apartment. Review of R1's incident reports dated June 12, 2023, June 29, 2023, June 30, 2023, and July 1, 2023 indicated these incident reports were not reviewed by a licensed nurse until July 19, 2023, which was after R1 was discharged from the facility. During an interview on March 1, 2024, at 8:30 a.m., family member (FM)-A stated first reported fall to family was June 12, 2023. R1 was evaluated at the emergency department (ED). FM-A stated on June 29, 2023, the facility found R1 on the floor in her apartment. Again, R1 taken to the ED for evaluation. R1 was given an order for as needed (PRN) tramadol. The first dose of tramadol was administered in the ED and because the pharmacy was closed the ED provided enough medication for a 24-hour period until the medication could be filled by the pharmacy. FM-A stated at the time of R1's return to the facility a signed order was given to the facility along with the tramadol medication provided by the ED. FM-A stated a day later R1 was found on the floor in her apartment and was in pain. FM-A asked the facility to administer the PRN pain medication the provider had ordered the previous night with the facility stating they did not have an order from the tramadol. FM-A stated then on July 1, 2023, resident fell again and was in severe pain. R1 was transferred to the ED and diagnosed with a fractured hip and several fractured ribs. In additional to all the falls, FM-A stated nursing only completed a move in	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30217	A. BUILDING: _____ B. WING _____	C 03/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR GARDEN PLACE	535 CANYON DRIVE NW EYOTA, MN 55934

(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
01620	Continued From page 5 assessment and no further assessments. During an interview on March 4, 2024, at 1:35 p.m., licensed practical nurse (LPN)-E stated fall investigations are completed by the registered nurse (RN) in conjunction with the director. LPN-E stated unlicensed personnel (ULP), if trained, complete the incident report in RTasks. The incident report is then pushed forward to nursing. During an interview on March 5, 2023, at 8:55 a.m., unlicensed personnel (ULP)-C stated R1 required meal reminders and at times escort to meals. ULP-C stated resident cares and interventions are located on the care plan located on RTasks. The care plan is what staff used to guide resident cares and vulnerabilities. ULP-C stated the first fall occurred in the elevator. The fall was unwitnessed, and the resident reported hitting her head. The resident was transferred to the ED for evaluation. During an interview on March 5, 2024, at 9:20 a.m., ULP-D stated on July 1, 2023, she found R1 on the floor in her apartment and R1 stated she was in a lot of pain. ULP-D stated emergency response was called and R1 transferred to the ED for a fractured hip and fractured ribs. During an interview on March 5, 2024, at 10:00 a.m., administration/registered nurse (ADM/RN)-B stated a pre-admission assessment was not completed prior to accepting the resident. ADM/RN-B stated on May 12, 2023, the pre-admission assessment and move in assessment were both completed. ADM/RN-B stated no further assessments were completed after initial admission assessment. ADM/RN-B stated no new interventions were added to the	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30217	A. BUILDING: _____ B. WING _____	C 03/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR GARDEN PLACE	535 CANYON DRIVE NW EYOTA, MN 55934

(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
01620	Continued From page 6 care plan and no updated assessments completed for any of the four falls. The licensee 6.33 Fall Prevention and Reduction Program policy, dated August 1, 2021, indicated if the registered nurse (RN) identifies any concerns that the resident may be at risk of falls, the RN will complete a focused falls assessment and screening and will identify needed interventions. The licensee 6.01 Assessments, Reviews & Monitoring policy, dated August 1, 2022, indicated resident reassessment and monitoring must be conducted no more than 14 calendar days of services initiated and ongoing based on changes in needs and cannot exceed 90 calendar days from the last date of assessments. TIME PERIOD TO CORRECT: Twenty-One (21) days	01620		
02310 SS=G	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 standards. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide cares based on an up-to-date care plan based on accepted health care standards when R1 fell multiple times but the facility did not assess nor update R1's care plan.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30217	A. BUILDING: _____ B. WING _____	C 03/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR GARDEN PLACE	535 CANYON DRIVE NW EYOTA, MN 55934

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 7 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: 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. R1's start of care date for services was May 28, 2023. R1's diagnoses included dementia, chronic back pain, and history of falls. Review of R1's initial assessment dated May 12, 2023, indicated R1 had fallen in the previous three months prior to admission, ambulated with a walker, and needed assistance to reduce falls by removing clutter in the resident's apartment. Review of R1's incident reports dated June 12, 2023, June 29, 2023, June 30, 2023, and July 1, 2023 indicated these incident reports were not reviewed by a licensed nurse until July 19, 2023, which was after R1 was discharged from the facility. R1' progress notes dated July 1, 2023, indicated R1 was found on the floor in her complaining of leg pain wiht outward rotation. Later the same	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30217	A. BUILDING: _____ B. WING _____	C 03/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR GARDEN PLACE	535 CANYON DRIVE NW EYOTA, MN 55934

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 8 day, R1's progress notes indicated she admitted to the hospital with multiple rib fractures and a left hip fracture. During an interview on March 1, 2024, at 8:30 a.m., family member (FM)-A stated first reported fall to family was June 12, 2023. R1 was evaluated at the emergency department (ED). FM-A stated on June 29, 2023, the facility found R1 on the floor in her apartment. Again, R1 taken to the ED for evaluation. R1 was given an order for as needed (PRN) tramadol. The first dose of tramadol was administered in the ED and because the pharmacy was closed the ED provided enough medication for a 24-hour period until the medication could be filled by the pharmacy. FM-A stated at the time of R1's return to the facility a signed order was given to the facility along with the tramadol medication provided by the ED. FM-A stated a day later R1 was found on the floor in her apartment and was in pain. FM-A asked the facility to administer the PRN pain medication the provider had ordered the previous night with the facility stating they did not have an order from the tramadol. FM-A stated then on July 1, 2023, resident fell again and was in severe pain. R1 was transferred to the ED and diagnosed with a fractured hip and several fractured ribs. In additional to all the falls, FM-A stated nursing only completed a move in assessment and no further assessments. During an interview on March 4, 2024, at 1:35 p.m., licensed practical nurse (LPN)-E stated fall investigations are completed by the registered nurse (RN) in conjunction with the director. LPN-E stated unlicensed personnel (ULP), if trained, complete the incident report in RTasks. The incident report is then pushed forward to nursing.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30217	A. BUILDING: _____ B. WING _____	C 03/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR GARDEN PLACE	535 CANYON DRIVE NW EYOTA, MN 55934

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 9 During an interview on March 5, 2023, at 8:55 a.m., unlicensed personnel (ULP)-C stated R1 required meal reminders and at times escort to meals. ULP-C stated resident cares and interventions are located on the care plan located on RTasks. The care plan is what staff used to guide resident cares and vulnerabilities. ULP-C stated the first fall occurred in the elevator. The fall was unwitnessed, and the resident reported hitting her head. The resident was transferred to the ED for evaluation. During an interview on March 5, 2024, at 9:20 a.m., ULP-D stated on July 1, 2023, she found R1 on the floor in her apartment and R1 stated she was in a lot of pain. ULP-D stated emergency response was called and R1 transferred to the ED for a fractured hip and fractured ribs. During an interview on March 5, 2024, at 10:00 a.m., administration/registered nurse (ADM/RN)-B stated a pre-admission assessment was not completed prior to accepting the resident. ADM/RN-B stated on May 12, 2023, the pre-admission assessment and move in assessment were both completed. ADM/RN-B stated no further assessments were completed after initial admission assessment. ADM/RN-B stated no new interventions were added to the care plan and no updated assessments completed for any of the four falls. The licensee 6.33 Fall Prevention and Reduction Program policy, dated August 1, 2021, indicated if the registered nurse (RN) identifies any concerns that the resident may be at risk of falls, the RN will complete a focused falls assessment and screening and will identify needed interventions.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30217	A. BUILDING: _____ B. WING _____	C 03/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR GARDEN PLACE	535 CANYON DRIVE NW EYOTA, MN 55934

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 10 The licensee 6.01 Assessments, Reviews & Monitoring policy, dated August 1, 2022, indicated resident reassessment and monitoring must be conducted no more than 14 calendar days of services initiated and ongoing based on changes in needs and cannot exceed 90 calendar days from the last date of assessments. TIME PERIOD TO CORRECT: Seven (7) days	02310		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment. 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 required for tag 2360.	