Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306314662M
Compliance #: HL306316100C

Date Concluded: September 11, 2024

Name, Address, and County of Licensee Investigated:
Edgewood EGF Senior Living
608 5th Avenue NW
East Grand Forks, MN 56721
Polk County

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

Evaluator's Name: Barbara Axness, 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 staff failed to address a change in the resident's condition following a fall, resulting in a delay in care. The resident was not sent to the hospital until two days later, where he was diagnosed with a hip fracture.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The resident fell on a Friday evening. Unlicensed personnel (ULP) reported they heard a "pop" and that the resident screamed in pain and couldn't bear weight on the impacted leg. The facility registered nurse (RN) was notified, who directed staff to put the resident in bed and administer Tylenol. The resident complained of pain Friday night through Saturday and Sunday and was not able to perform activities of daily living at his normal level of function. Multiple facility staff failed to take appropriate action over the weekend, including failing to notify the RN, failing to notify the resident's provider, and failing to assess a

change in condition and the resident was diagnosed with a hip fracture that required surgical intervention.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted the resident's case worker and physician. The investigation included review of the resident records, hospital records, incident reports, personnel files, staff schedules, and related facility policies and procedures. Also, the investigator observed care, services, and medication administration in the facility.

The resident resided in an assisted living memory care unit with diagnoses of Alzheimer's disease and dementia. The resident's assessment indicated the resident could walk and transfer independently and was at risk for falls.

The resident's record indicated the resident fell on Friday evening but was not brought to the emergency room until two days later. There was no incident report or internal investigation completed related to the fall. Facility documentation indicated the resident had ongoing pain throughout the weekend and was not able to transfer or walk at his normal level of functioning and required a higher level of assistance.

Friday
The resident's record indicated the resident was given a 1 milligram (mg) dose of as-needed (PRN) Ativan (an anti-anxiety medication) at 7:22 a.m. due to being aggressive with cares. By 9:00 a.m., the resident was noted by a licensed practical nurse (LPN) to be "sleep talking at the table, unable to stay awake or ambulate." The resident required two people to transfer to a wheelchair and staff were unable to complete toileting or showering assistance "due to lack of arousability." The LPN failed to notify the RN of this change in condition. The resident was still sleepy and groggy when he was brought out for supper. The resident attempted to get up from the dining room table after supper and fell, landing on his knee and left side.

No documentation was entered in the medical record regarding the resident's change in condition or fall on Friday. A partially completed incident report was started by unlicensed personnel (ULP). The incident report was not reviewed by the RN. The report indicated the resident fell at 5:40 p.m. and was "trying to get up and lost his balance as he had been wobbly all-day. Resident had lorazepam [Ativan] earlier that morning and has been out of it since. Slept most of day, and once he woke up, he was confused and unbalanced." Several sections were left blank, including sections for if hospitalization was required and a root cause analysis of the fall. The resident's record indicated PRN Ativan was given again at 7:11 p.m. since the resident was "agitated after fall, would not let staff help him." The resident was resting by 9:15 p.m.

Saturday
The resident's record indicated a LPN gave PRN Tylenol at 11:48 a.m. that morning because the resident was "unable to extend or flex leg without crying and yelling in pain. No aggression. Assist of three for toileting." The LPN documented the Tylenol was not effective because the

resident was still yelling in pain when his knee was moved at 1:54 p.m. The LPN failed to notify the RN. The resident was given PRN Tylenol again at 4:50 p.m. by ULP since the resident was “experiencing immense pain in transfers since fall last night. Giving acetaminophen [Tylenol] in attempt to help ease that pain." The Tylenol was documented as not effective at 7:31 p.m. as the "resident still expressing pain with transfers, refusing to bear weight on leg and yelling out in pain." The ULP notified the on-call RN of the pain at 8:18 p.m. A progress note written by the on-call RN indicated staff called to report the resident was having left knee pain and the "left knee is swollen and resident unable to move left knee or bear weight. Staff reporting already given PRN Tylenol." The on-call RN advised staff to apply ice to the left knee and wait for a call back from the resident's family. Staff called the on-call nurse back at 11:03 p.m. to report "resident's daughter came to facility to assess resident's left leg. Staff reporting that resident is resting in bed and at this time resident's daughter will wait until morning to take to emergency room." The on-call nurse instructed staff to report immediately if resident's left knee condition changed and the nurse would update the family to take the resident to emergency room.

Sunday
No documentation was entered in the medical record regarding the resident’s condition.

Hospital records indicated the resident arrived in the emergency room around noon on Sunday, with "left knee pain and swelling, along with left hip pain that started after he fell on [Friday]." The resident had a fever of 100.3 degrees Fahrenheit with an elevated heart rate. The resident was diagnosed with a left displaced femoral neck fracture (a fracture of the upper hip joint) and closed left hip fracture. The resident had surgery to repair the fracture and spent 12 days in the hospital. The resident discharged to a skilled nursing facility and did not return to the assisted living.

During an interview, a ULP stated she was working when the resident fell and while she didn't see him fall, she heard him fall and immediately went to help. The ULP stated she and two other ULP tried to help him up and he was "kind of groggy, moaning a little." The ULP stated the resident was really groggy and unbalanced all day and they text the RN to let him know about the fall. The ULP wanted to get the resident back to his room so he could rest after the fall. When they stood him up, they heard a “pop”, so they set him back down and immediately called the RN. The ULP told the RN that staff when stood the resident up to transfer, they heard a pop and the resident “kind of screamed”. The ULP asked the RN what to do and the RN instructed staff to get the resident back to his room, lay him down, and give something for pain. The RN said they would be in the next morning to look at him, but the RN didn't come in the next morning. The ULP gave the resident aspirin and Ativan after the fall, but the resident was still in pain. The ULP stated they checked on the resident a few hours later and he was still in pain. The ULP told the resident they could give him Tylenol for the pain, but that was all they could do. The ULP stated they were shocked by the RN’s decision to not send the resident to the hospital and did not agree with it as the resident was in a lot of pain.

During an interview, another ULP stated she worked on Friday morning before the resident fell and noticed the resident was very groggy after he was given Ativan. The ULP stated she received report that the resident fell, and staff heard a loud crack when standing him up. The ULP thought the RN would be in the next morning (Saturday) to assess the resident. The ULP worked the day shift on Saturday and the resident was still in pain, unable to bear weight on his leg, and three people were needed for transfers. The ULP stated the LPN who worked Saturday morning was aware of the pain and would have been responsible to contact the on-call nurse if there were concerns. The ULP stated she never saw the RN come in to assess the resident. The ULP stated on Sunday morning, the resident was still in pain and staff called the resident's family to see if the resident should be sent to the hospital. The ULP stated when the ambulance came to get the resident, it took five people to transfer him. The ULP stated when she called the on-call nurse in the past she had to “call two or three times to get an answer, I've called before, and no one ever called me back."

During an interview, a ULP who worked on Saturday said she heard that the resident fell the day before. The ULP stated the resident was still in pain and had difficulty with transfers, so she gave him Tylenol. The ULP called the on-call nurse and the nurse tried to contact family to see if they would take the resident to the hospital but had difficulty reaching the resident's family. The ULP stated she was able to contact the resident's son and told him the resident was in pain and needed three people to transfer which was not normal. The resident's son asked her what they should do, and she suggested the resident get checked out at the hospital but told the resident’s family she was not a nurse and couldn’t make those decisions. The ULP stated another family member came in later that night around 9:00 p.m. when the resident was asleep and couldn’t get the resident to the ER that night.

During an interview, a ULP who observed the fall on Friday, stated the resident was very groggy most of the day. The ULP stated she heard that the resident was given two Ativan that day and he usually didn’t get Ativan so “he was kind of drugged out completely”. The ULP stated that the resident was barely able to communicate and was “out” most of the day. The ULP stated the resident lost his balance due to being so groggy from the medication and fell. The ULP stated she and two other staff had to get the resident off the floor since the resident couldn’t answer if he was in pain but as soon as they tried to move him, he screamed out in pain. The ULP stated they notified the RN that something was wrong, and that the resident was in a lot of pain. The RN told staff to try stand to him up to see if he could walk and when we did that, we heard a “crunch”, so we didn't attempt to get him up after that. The ULP stated that after the fall the resident required three staff to assist with transfers. The RN said told staff he would come in the next day to assess the resident, but the RN never came in. The ULP did not agree with the RN’s decision to put the resident in bed and give Tylenol and thought the resident should have been sent to the hospital immediately after the fall. The ULP stated that she debated calling the ambulance but knew the RN would be upset. The ULP said they knew something was wrong since the resident never screamed out in pain. The ULP called the on-call nurse again on Saturday and reported that they thought the resident should be sent to the hospital

immediately and the nurse told the ULP to call the resident's family and get them to bring him to the hospital.

During an interview, the LPN stated she administered Tylenol to the resident on Saturday morning because the resident was still in bed, was restless, complaining of pain, having difficulty with transfers, and had swelling on his knee. The LPN contacted the on-call RN and was directed to give Tylenol. The LPN stated she did not consider sending the resident to the hospital because the Tylenol helped the pain. The LPN stated she passed off in report that the resident had pain earlier that day and when she came back on Sunday, the resident was still restless, but she was informed the family would be coming in to look at him and take him to the doctor.

During an interview, the RN stated he was initially told the resident was fine after his fall, but staff called back later to say he was having knee pain. The RN stated staff did not tell him that they had heard a crack or pop sound when standing the resident up and if he would have been told something like that, he would have looked at it differently. The RN stated he did not tell staff that he would be in the next day to assess the resident but told staff to keep him posted and he could come in the next day if they needed anything. The RN stated any staff could call the ambulance and staff should feel comfortable calling the ambulance even if the nurse said no. The RN confirmed he did not investigate why the resident had the reaction he did to Ativan and if or how that may have contributed to the fall.

During an interview, the resident's primary care provider (PCP) stated he would have expected to be updated on Friday morning, when the resident was observed to be groggy after taking Ativan. The PCP stated the resident was usually awake and alert so if he was that groggy, the provider should have been called. The PCP stated if they would have been called, they would have recommended the facility administer a medication to "see if he wakes up or make sure it's not a stroke or something." The PCP stated he was not notified of the resident's fall on Friday, and only found out the resident was hospitalized while reviewing records of hospitalized residents. The PCP stated the resident should have been sent to the emergency room on Friday as a pop and screaming in pain would indicate the resident had possibly broken a hip. The PCP stated since the resident was not sent in right away and if he tried to self-transfer or do anything besides lay in bed, there was a "possibility of complications" related to the resident's hip fracture.

During an interview, the resident's family stated they visited the resident shortly before his fall on Friday and noticed he was very lethargic and groggy and was told he had gotten some medication earlier to help with agitation. The family stated the resident was not normally that "out of it" and were told additional staff were needed to help transfer him which was not normal. The family was notified of the fall but initially told there were no injuries, then were told he may have hit his knee and was having pain. A family member came see the resident around 9:00 p.m. on Saturday but the resident was sleeping and in bed and staff told them the resident's knee seemed to be hurting. Staff asked the family if they wanted the ambulance

called but the family declined because the resident was asleep and didn't think they should wake him up. Before leaving, the family told staff if the resident woke up in the middle of the night to call them, but no one ever called. When family came back on Sunday morning, the resident was asleep but when staff pressed on his leg, he woke up screaming and the family called the ambulance. The family was not informed if staff heard a pop when they got him up Friday evening and were not informed on how significant the pain was after the fall. The family stated if staff felt the resident needed to go in, they should have called the ambulance.

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, due to cognitive impairment
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
No action taken.

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

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

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

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

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

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Polk County Attorney
East Grand Forks City Attorney
East Grand Forks Police Department
Minnesota Board of Executives for Long Term Services and Supports
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30631	A. BUILDING: _____ B. WING _____	C 07/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD EAST GRAND FORKS SENIOR LIVING	608 5TH AVENUE NW EAST GRAND FORKS, MN 56721

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER 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: #HL306313341M/#HL306313451C #HL306314662M/#HL306316100C On July 15, 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. The following correction orders are issued for #HL306313341M/#HL306313451C, tag identification 0620, 2320, 2360, 2480. The following correction orders are issued for #HL306314662M/#HL306316100C, tag identification 0620, 2320, 2360, 2480.	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.	

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0 620	Continued From page 1	0 620		
0 620 SS=E	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point.	0 620		

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0 620	Continued From page 2 (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to submit a report to MAARC for one of one resident (R1) who had a delay in care after the registered nurse (RN) failed to address a change in condition. In addition, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) for one of one resident (R2) who had a delay in care after the resident fell and had significant knee pain, inability to bear weight on the affected leg, and required additional assistance with activities of daily living. The resident was sent to the emergency room two days after falling. The facility did not report the incident to MAARC until 11 days after the fall occurred and failed to initiate an internal investigation related to the allegation	0 620		

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0 620	Continued From page 3 of neglect. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a 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 licensee held a current assisted living with dementia care license. R1 R1 was hospitalized on March 3, 2024, and diagnosed with sepsis, cellulitis, a drug resistant infection, and a urinary tract infection. Clinical nurse supervisor (CNS)-A was notified of the resident's change in condition on March 2, 2024, and failed to seek immediate treatment or notify the resident's provider for the acute change in condition and failed to provide additional monitoring or supervision after he was notified of the resident's leg redness. The resident had an ongoing open area to her ankle that the facility failed to monitor, which became infected and developed into a cellulitis infection. The facility failed to investigate the delay in care and failed to submit a MAARC report related to the incident. R2 R2 fell on June 14, 2024. Unlicensed personnel (ULP) reported they heard a pop and that the resident screamed in pain and couldn't bear weight on the impacted leg. Clinical nurse supervisor (CNS)-A was notified, who directed	0 620		

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0 620	Continued From page 4 staff to put the resident in bed and give Tylenol. The resident complained of pain throughout Friday night and through Saturday and Sunday and was not able to perform activities of daily living at his normal level of function. Multiple facility staff failed to take appropriate action over the weekend, including failing to notify the RN, failing to notify the resident's provider, and failing to assess a change in condition. R2 was brought to the emergency room two days later on June 16, 2024, where he was admitted with a hip fracture. On June 24, 2024, R2's son reached out to the facility to ask questions about the circumstances surrounding the resident's fall and requested documentation related to the fall. The facility submitted a MAARC report on June 25, 2024, 11 days after the resident fell, with the allegation being a concern for self neglect. The MAARC report did not include any allegations of neglect from caregivers or facility staff. The facility failed to investigate the incident and implemented an intervention of every 30 minute safety checks to prevent future falls. The MAARC report indicated the resident's physician was updated and "family was notified appropriately..." The report indicated the "resident was doing well, waiting for rehab placement." On July 17, 2024, at 10:35 a.m., clinical nurse supervisor (CNS)-A confirmed R2's MAARC report was filed late after they realized they had to do one. CNS-A was asked if the incident was investigated and what the facility had learned from investigating the incident. CNS-A stated the facility did not do any investigation and did not know why one wasn't done but "it does sound reasonable though."	0 620		

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0 620	Continued From page 5 On July 19, 2024, at 9:15 a.m., licensed assisted living director (LALD)-B stated they filed the MAARC report for R2 "when we found out that he broke his hip, that's when we filed the MAARC report right away." LALD-B confirmed the facility did not investigate the incident and took no further action related to the incident after submitting the MAARC report. The licensee's Abuse Prevention, Intervention, Reporting, and Investigation policy dated June 2024, indicated when an incident or suspected incident occurs, the Executive Director or designee would investigate the allegation. "The individual conducting the investigation, at a minimum: a. reviews the completed resident report. b. reviews the resident's record to determine events leading up to the incident c. interviews the persons reporting the incident, d. interviews any witnesses to the incident, e. interviews the resident (if appropriate), f. contacts the resident's attending physician and provides an update, g. interviews staff members (on all shifts) who have had contact with the resident during the period of the alleged incident, h. reviews all events leading up to the alleged incident, i. maintains confidentiality and cooperates with all state agency investigation, j. updates the executive director, regional nursing director, regional vice president, and chief nursing officer with daily progress of the investigation (when the executive director is not conducting the investigation)." The Registered Nurse (or Executive Director where applicable) would provide a written report of the results of the investigation and action taken to the state licensing agency with the required time frame. No further information was provided.	0 620		

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0 620	Continued From page 6 TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
02320 SS=H	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards when a change in condition was not reported to the appropriate supervisor or healthcare professional for two of two residents (R1 and R2) reviewed. Unlicensed personnel (ULP) reported a change in condition to the registered nurse (RN) when they observed a bright red rash on the R1's leg along with a fever. The resident was not taken to the emergency room until the next morning and was hospitalized with cellulitis. ULP reported a change in condition to the RN when R2 fell and ULP heard a popping sound, followed by extreme pain and inability to bear weight on the affected leg. The resident complained of pain for almost 40 hours before he was taken to the emergency room and hospitalized with a hip fracture. In addition, the licensee failed to investigate either incident. This practice resulted in a level three violation (a	02320		

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02320	Continued From page 7 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: R1 R1's diagnoses included Alzheimer's dementia. R1's service plan dated March 10, 2023, indicated the resident received assistance with behavior monitoring, dressing, grooming, toileting, incontinence care, medication administration, and safety checks three times per day. R1's assessment indicated the resident's skin was intact. No history of skin concerns or risk factors for skin concerns were identified. The resident did not have a history of refusing cares. Service recap summaries for January, February, and March 2024, indicated R1 did not have a history of refusing cares, peri cares, or toileting. No behaviors for the resident were documented. JANUARY HOSPITALIZATION The first progress note entered in the month of January, 2024, was dated January 11, 2024, which indicated the resident's behavior documentation had been reviewed with no behaviors noted for the lookback period. Prior to the January 11th note, the next recent note was	02320		

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02320	Continued From page 8 entered on December 28, 2023. On January 12, 2024, at 7:06 p.m., RN-C documented she had "received a message at 7:05 p.m. from staff that resident had cold sweats, was shaking, and has become increasingly confused. Staff were instructed to call the POA and let her know as well as call [contracted on-call service] as they took over on-call at 7:00 p.m. Staff informed that resident had a UA today that hadn't resulted. Staff notified that POA will have to take resident to the ER if resident does not get better." A few minutes later at 7:15 p.m., RN-C added another note which read, "Staff reported that POA of resident would like writer to look at the result of the UA and see what it says. POA sent a screenshot of the labs to writer to review labs. Writer forwarded screen shot to [nurse practitioner] who instructed writer to tell POA to take resident to ER...Daughter was in agreement and came to facility to pick up her mom." R1's record lacked evidence of when the urine culture was ordered, why it was ordered, and what follow up was required. Hospital records indicated the resident admitted to the hospital on January 12, 2024, and the resident "apparently had urinalysis done this morning after developing chills, fever, diaphoresis and weakness. Urinalysis showed UTI. Later in the evening, patient symptoms worsened, therefore she was sent to the ER from her nursing home [assisted living.] Upon admission, the resident had a low grade fever and elevated heart rate. The resident was diagnosed with sepsis due to gram negative UTI. The resident was treated with IV fluids and antibiotics and discharged back to the facility two days later with new orders for antibiotics and a cream to treat a yeast infection and redness in the resident's abdominal folds.	02320		

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02320	Continued From page 9 On January 18, 2024, a progress note indicated R1's POA voiced concerns about a rash that was not being treated and RN-C noted "that area is red and inflamed from vagina to top of intergluteal cleft. Writer cleaned resident's peri area well...educated staff on applying calazine cream to entire area or asking the med passer to apply calmoseptime cream to the area..." R1's records lacked evidence staff were monitoring or documenting the status of the red areas or area impacted by the yeast infection identified by the hospital on January 14, 2024. On July 16, 2024, at 2:15 p.m. RN-C stated she was not sure when or why the urine sample was ordered or what follow up directions were given to staff while they waited for results to come back. RN-C stated she would expect to see some kind of documentation in the resident's medical record that would give context as to why they were doing a urine culture and when the sample was ordered and collected. On July 16, 2024, at 2:35 p.m., CNS-A stated he was not sure when or why the urine sample was ordered or what follow up directions were given to staff while they waited for results to come back. CNS-A stated he was not sure when the resident's symptoms began. CNS-A confirmed the resident's service plan was not updated to include treatments for a yeast infection and no documentation was initiated for tracking red areas to the resident's skin that were noted at the hospital. MARCH HOSPITALIZATION R1's progress notes indicated on March 2, 2024,	02320		

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02320	Continued From page 10 at 9:54 p.m., CNS-A received a call from staff "reporting they had noted redness to res' right leg. Forwarded picture on on call RN. Call placed to daughter to update, agreed that we would meet at the facility in the morning to discuss if she should be taken to the clinic to be evaluated." A progress note from March 3, 2024, at 8:30 a.m., indicated CNS-A "met with the resident's daughter at the facility, resident was alert and walking. Visualized redness to right leg with daughter and decided res should be evaluated at ER for possible cellulitis. Res walked to daughter's car with stand by assist and was transported per daughters vehicle." Photographs sent to the CNS on March 2, 2024, were provided to the investigator. One photograph showed the resident's right leg from the knee down. A scabbed over/partially open area was observed on the top of the resident's ankle. A bright red rash went from just above the scabbed area up to the resident's knee. The second photograph showed the resident's right leg taken from above the knee/thigh. There was a large red patch covering the resident's knee cap and extending to above the knee and around the side of the leg. The redness could be seen from the top of the knee down to the top of the scabbed over area on the ankle. Hospital records indicated the resident admitted to the hospital on March 3, 2024, at 10:36 a.m. and the resident presented "with generalized weakness as well as right leg redness. Patient resides at a memory care facility and supposedly they just noticed this yesterday evening and it has been worsening today." Fairly extensive swelling and redness were noted to the resident's right leg and she was diagnosed with cellulitis. Documentation indicated the excoriation/scabbed	02320		

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02320	Continued From page 11 area on the resident's ankle "seems to be the port of entry for the infection." Testing on the ankle grew MRSA. Lab testing indicated the resident also had a urinary tract infection with acute kidney injury. The resident was hospitalized for five days and treated with antibiotics. On July 16, 2024, at 10:30 a.m., R1's power of attorney (POA)-J stated she had raised care related concerns after the resident's January hospitalization where nurses at the hospital pointed out redness that they felt was a result of the resident not having her incontinence product changed and not having peri cares done properly. POA-J stated she met with management at the facility but she felt her concerns were minimized and tried to turn it like it wasn't their fault and "I left that meeting thinking wow, am I dumb for thinking that's a concern? I left that meeting thinking wow, I'm really stupid for even bringing this to their attention, then a month and a half later, she's in the hospital again." POA-J stated she was called the evening of March 2, 2024, and "I asked them that night if I need to take her in that night and he [CNS-A] said no, no it's not that bad, we'll check it in the morning. I'm at the mercy of them to know that because I'm not there. She was in the hospital for a week...they dress her every night, it should have been noticed and if they noticed and told anyone, no one else said anything. I left her in the hospital thinking she was going to die." On July 16, 2024, at 2:15 p.m. RN-C stated she was not aware R1 had an open area to her ankle or that it may have been when the resident's infection originated. On July 16, 2024, at 2:35 p.m., CNS-A stated the resident had a scabbed area on the top of her	02320		

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02320	Continued From page 12 foot that was "a longstanding issue. It was more like a dry callous area but there wasn't a treatment in place for it, just trying to use better fitting shoes." CNS-A stated he was notified around 9:30 p.m. on March 2, 2024, and he called the resident's daughter to see what she wanted to do and "I gave her the option, I thought she would need to be evaluated and it was likely cellulitis and she asked if we could wait and so we agreed to meet the next morning." CNS-A was asked what information was gathered when ULP called to report the redness and texted photographs of the resident's legs. CNS-A confirmed he did not direct staff to collect vitals or have the staff mark where the redness was to see if it was spreading or getting worse. CNS-A confirmed he did not direct staff to monitor overnight and call back if it spread or got worse. CNS-A was asked if the facility had done any investigation into the resident's repeated UTIs and concerns for peri cares not being completed appropriately. CNS-A stated women are more prone to getting UTIs and the resident was resistant to peri cares so she would just be more susceptible to getting UTIs so they did not investigate anything further. On July 18, 2024, at 3:05 p.m., unlicensed personnel (ULP)-D stated staff had noted edema and swelling in R1's leg a few days before she was hospitalized and they passed it on to CNS-A but she wasn't sure what happened after. ULP-D stated the resident had a scabbed over/sort of open area to the top of her right ankle that had been there for a while and she thought the nurse would monitor it with their weekly skin checks. ULP-D stated the area on the ankle developed after staff kept putting the wrong shoes on the resident and since they were too tight, it rubbed and caused that area to develop. ULP-D stated	02320		

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02320	Continued From page 13 other staff had told CNS-A about the shoes causing skin breakdown but they were never removed from the room. On July 18, 2024, at 4:40 p.m. ULP-H stated she thought R1's right leg had been "red for a week, maybe two...her legs were a little bit red like two weeks before she went in, it just looked dry at first and people were reporting to the nurse that something was off and when we report to the nurse, the nurse reports to management and they decide what they're going to do but most of the time it either doesn't get relayed to management or management doesn't do anything about it." ULP-H stated she was working with another staff member who noticed how red the leg had gotten and they were wondering why nothing was being done about it. ULP-H stated they "try to do our best if there's wound cares or anything like rashes coming we do our best to keep them clean and try but there was a very bad case where people were getting a lot of rashes under their stomachs and management knew about them but they weren't making sure they were getting better or that people were doing cares so one of the [unlicensed] staff members was taking charge to make sure PRN powders were put on and actual cares were done...we did our best for them because the management wasn't." On July 22, 2024, at 10:15 a.m., ULP-I stated she was helping R1 get ready for bed on March 2, 2024, and "I noticed her knee was super red, and it was like different spots on her leg were red. I felt them, they were super, really hot, she was sweating and she was shivering. I took her temperature and she had a fever, we were trying to cool her down with a cold rag and I remember I got ahold of [CNS-A] and asked what do you want me to do, should I send her in or what did he	02320		

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02320	Continued From page 14 want me to do and he told me just wait until the morning." ULP-I stated she texted two photographs of the resident's legs to CNS-A and, "I told him everything I was seeing on her, that she had a fever, I said she has the chills, sweating...I feel like he kinda brushed it off. I would have sent her in but I called him first because he's the manager, I didn't know what to do, I didn't know how serious it was, I didn't know it was cellulitis at the time but I would have sent her in. That's why I called him, I didn't know what to do, I said should I send her in and he said no, he'd go in and check on her the next day." ULP-I stated, "I remember thinking how has no one else noticed this, how do you not notice these red markings on someone's legs and not tell someone about it? They were really hot, I just remember thinking how long this had been here." ULP-I stated she and other staff would report concerns to CNS-A and "I just feel like from what I see, I don't think he acts on it immediately as he should. He's a RN, he's a nurse, I'd expect him to be on top of things but I feel like he just kinda waits for things to happen almost. Just stuff like that there's been multiple times I've gone to him with a concern and it's just ok thanks for letting me know and I never see him get up from his office to go see what I'm talking about." On July 23, 2024, at 12:30 p.m., R1's primary care provider (PCP)-K stated "it was surprising if she's being helped with bathing, changing clothes, that nobody had reported a change in status before it got to that point where it was so severe when she got to the hospital." PCP-K stated she was concerned the facility had delayed addressing the change in condition and had it been addressed sooner, "it could have been addressed as an outpatient and not a hospitalization. I never like to delay treatment, you	02320		

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02320	Continued From page 15 just don't know with something like that where you round the corner of having multi organ failure and death is the result, anything can happen...time is always of the essence once you've identified an infection, especially the elderly as they're at risk for infection and with other comorbidities." PCP-K stated, "You've got a population that can't advocate for themselves, and family is dependent on eyes and ears of staff and assuming, rightfully so, that their best interests are being kept on the forefront." R2 R2's diagnoses included Alzheimer's dementia with other behavioral disturbances and dementia. R2's service plan was requested but the Department of Human Services (DHS) Residential Services Plan was provided. R2's assessment dated April 9, 2024, indicated the resident could walk and transfer independently. The resident was at risk for falls. R2's medication administration record (MAR) for June 2024 included the following. R2 had an order for as needed Lorazepam 0.5 milligrams (mg) to be given every six hours as needed for agitation. That order was changed on June 6, 2024, to give 1 mg two times a day as needed for agitation. On June 14, 2024, R2 was given 1 mg at 7:22 a.m. after he was "aggressive with cares, scheduled shower day." A follow up note entered at 10:03 a.m. by LPN-G indicated the resident "fell asleep at 9:00 a.m., sleep talking at table, will open eyes when aroused but unable to stay away or ambulate. Resident assist of 2 transfer to wheelchair and assist 1 transfer to recliner to rest. Unable to complete toileting or shower due to	02320		

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02320	Continued From page 16 lack of arousability. LPN-G failed to notify the RN or provider of the resident's change in condition after taking the medication. R2 was given another dose of 1 mg Lorazepam at 7:11 p.m. for "agitated after fall, would not let staff help him." By 9:15 p.m. the resident was resting. On June 15, 2024, at 11:48 a.m., LPN-G administered as needed Tylenol because the resident was "unable to extend or flex leg without crying and yelling in pain. No aggression. Assist of three for toileting." LPN-G documented the Tylenol was not effective because the resident was still yelling in pain when his knee was moved at 1:54 p.m. LPN-G failed to notify the on-call nurse or have the resident sent to the emergency room for further evaluation. The resident was given PRN Tylenol again at 4:50 p.m. since the resident "has been experiencing immense pain in transfers since fall last night. Giving acetaminophen in attempt to help ease that pain." The Tylenol was noted to be not effective at 7:31 p.m. as the "resident still expressing pain with transfers, refusing to bear weight on leg and yelling out in pain." The staff member notified the on-call nurse of the pain at 8:18 p.m. Progress notes lacked documentation from June 14, 2024. The following progress notes were documented on June 15, 2024. At 8:18 p.m., an on-call nurse wrote that staff called to report the resident was having left knee pain and the "left knee is swollen and resident unable to move left knee or bear weight. Staff reporting already given PRN Tylenol." The on-call nurse advised staff to apply ice to the left knee and wait for a call back from the resident's family. Staff called the on-call nurse back at 11:03 p.m. to report "resident's daughter came to facility to assess resident's left leg. Staff reporting that resident is resting in bed and at this time resident's daughter will wait til	02320		

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02320	Continued From page 17 morning to take to emergency room." The on-call nurse "instructed staff to report to nurse immediately if resident's left knee condition changes and will immediately update daughter to take resident to emergency room." Progress notes lacked documentation from June 16, 2024. A progress note reviewed by CNS-A on Monday, June 17, 2024, indicated "This writer was notified via the access to care dashboard that [R2] experienced a fall on Fri, June 14, 2024, at 17:40. The resident did experience an injury. c/o knee discomfort. The resident did not experience actual or suspected head involvement...The resident is not able to stand with or without assistance..." R2's record contained a partially completed incident report for a fall on June 14, 2024. The incident report was started by an unlicensed personnel but lacked evidence the registered nurse had reviewed it. The report indicated the resident fell at 5:40 p.m. and was "trying to get up and lost his balance as he had been wobbly all day RN stated. Resident had lorazepam earlier that morning and has been out of it since. Slept most of day, and once he woke up, he was confused and unbalanced." The report further indicated the "resident went to get up and lost his balance causing him to fall over and land on his left side. Resident landed on left knee first and then rest of the left side. Resident has been unsteady all day according to the RN due to the lorazepam given this morning." The nurse notified was CNS-A. Several sections were left blank, including sections for if hospitalization was required and a root cause analysis. R2's hospital records indicated the resident arrived in the emergency room around noon on June 16, 2024, with "left knee pain and swelling,	02320		

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02320	Continued From page 18 along with left hip pain that started after he fell on 6/14/24." The resident had a fever of 100.3 degrees Fahrenheit with an elevated heart rate. The resident was diagnosed with a left displaced femoral neck fracture (a fracture of the upper hip joint) and closed left hip fracture. The resident had surgery to repair the fracture and spent 12 days in the hospital. The resident discharged to a skilled nursing facility and did not return to the assisted living. On July 17, 2024, at 10:35 a.m., CNS-A stated the resident was normally independent and the nurse should have been notified after he required more assistance with transfers and ambulation after receiving a dose of Ativan on Friday, June 14, 2024, before his fall. CNS-A stated it was his understanding when the fall happened, the resident only had some discomfort in his knee and the put him to bed because he was tired and the knee discomfort got worse on Saturday evening so the staff working called the on-call nurse service. CNS-A stated from reading the progress notes, it looked like family was notified on June 15, 2024, to see if she wanted to take the resident in to be seen and she had declined but the resident did go to the hospital on Sunday, June 16, 2024. On July 17, 2024, at 3:15 p.m., R2's son stated he was called Friday evening [June 14, 2024] and initially told everything was fine so he wasn't too concerned, "but then 24 hours later, he's in pain. My dad laid there with a broken hip for a little over 36 hours. It's complete incompetence. They didn't follow through." R2's son stated they had trusted the facility to make appropriate judgments on his dad's care and "I'm not a doctor or a nurse. I base off what they tell me is needed. Why can't they call an ambulance, why is he there, if he	02320		

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02320	Continued From page 19 needs to go to the ER, you guys are the professionals, take him there." On July 18, 2024, at 3:05 p.m., unlicensed personnel (ULP)-D stated she was working when R2 fell and while she didn't see him fall, she heard him fall and immediately went to go help him. ULP-D stated she and two other ULP tried to help him up and he was "kinda groggy, moaning a little." ULP-D stated the resident had been really groggy and unbalanced all day and they texted CNS-A to let him know about the fall. ULP-D stated they wanted to get the resident back to his room so he could rest after the fall. ULP-D stated when they stood him up "we heard a pop, so we sat him back down and after I immediately called [CNS-A] instead of texting him and told him we stood him up to transfer him and we heard a pop and he kinda screamed and I said what do you want me to do so he was like ok try get him back to his room, lay him down, give him something for pain and he said he'd be in the next morning to take a look at him. After that, I was told no, he didn't come in [the next morning]." ULP-A stated they gave R2 aspirin and Ativan after the resident fell, but the resident still had pain. ULP-D stated they checked on R2 a few hours later and he was still in pain but "I said there's nothing else we can do, we can give some Tylenol" but that was all they could do. ULP-D stated, "I did not agree with his decision [to not send the resident to the hospital] I was shocked. I've had this response from [CNS-A] before but not as severe as this was. I understand if a resident falls, we'll assess him and see how it goes but this was in like a matter of minutes from the fall when he hit the floor to when we tried to stand him up and put him in the wheelchair and that pop, it was loud, it was painful. I'm not a nurse, I'm not a professional in that kind of sense but he's in a lot	02320		

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02320	Continued From page 20 of pain, there was a pop, that would be a concern." ULP-D was asked if facility policy would allow a ULP to override the nurse if they disagreed with the decision to not send them to the hospital. ULP-D stated they would have to follow the direction of the nurse. On July 18, 2024, at 3:25 p.m., ULP-F stated she worked the morning of June 14, 2024, and noticed R2 had been very groggy throughout the day after he was given Ativan. ULP-F stated she had heard about the resident's fall during shift report and that there was a loud crack when staff were standing him up and she was under the impression CNS-A would be in the next morning, June 15, 2024, to assess the resident. ULP-F stated she worked the day shift on June 15, 2024, and the resident was still in pain and not able to bear weight on his leg and three people were needed to transfer the resident. ULP-F stated the nurse [LPN-G] doing medications that morning was aware of the pain and she would be the one to contact the on-call nurse if there were concerns. ULP-F stated she never saw CNS-A come in to assess the resident. ULP-F stated on Sunday morning, June 16, 2024, the resident continued having pain and that staff had called the resident's family to see if he should go in. ULP-F stated when the ambulance did come to get the resident, it took five people to transfer him. ULP-F stated she has had to call CNS-A as the nurse on-call in the past and "you have to call him two or three times to get an answer, I've called in the past and no one ever called me back." On July 18, 2024, at 3:40 p.m., licensed practical nurse (LPN)-G stated she was working on the morning of June 15, 2024, and knew R2 had a fall the day before. LPN-G stated the resident was	02320		

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02320	Continued From page 21 still in bed, and was restless, complaining of pain and having difficulty with transfers and had swelling on his knee so she contacted the RN on-call and was directed to give Tylenol. LPN-G stated she did not consider sending the resident to the hospital because the Tylenol helped the pain. LPN-G stated she passed off in report the resident had pain earlier and when she came back on Sunday, June 16, 2024, the resident was still pretty restless and was informed the daughter would be coming in to look at him and take him to the doctor. On July 18, 2024, at 4:10 p.m., ULP-E stated she worked on June 15, 2024, and she heard the resident fell the day before and was still having pain and difficulty transferring so she gave him Tylenol and called the on-call nurse and the nurse tried to get ahold of the family to see if they would take the resident in to be seen at the hospital but there was difficulty reaching R2's family. ULP-E stated she was able to get ahold of R2's son and she told him R2 was having pain and needed three people to transfer which was not normal for the resident and the resident's son asked her what they should do. ULP-E stated she suggested the resident get checked out but "I reiterated I'm not a nurse, I can't make those decisions." ULP-E stated R2's daughter came in later that night but it was already 9:00 p.m. and she wasn't able to get the resident to the ER that night and the resident was asleep. On July 18, 2024, at 4:40 p.m. ULP-H stated she observed R2 fall on June 14, 2024, and the resident had been very groggy most of the day. ULP-H stated she heard the resident got Ativan earlier "but someone said they gave him two that day and he usually doesn't get them so two in one day, he was kinda drugged out completely, he	02320		

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02320	Continued From page 22 was barely able to communicate, he was out most of the day and woke up right before supper...He lost his balance from being so groggy from the medication and lost his balance and fell." ULP-H stated she and two other staff had to get the resident off the floor since the resident wasn't able to answer if he was having any pain but as soon as they tried to move him, he'd scream out in pain. "We knew something was wrong...we tried to move his leg and it was just pain and we notified [CNS-A] that something was wrong and he was in a lot of pain and he said just try stand him up to see if he could walk when we did that we heard a crunch so we didn't attempt to get him up after that or walk him everything after that was a three assist we let [CNS-A] know, he said he'd come in the next morning to assess him but he never came in that whole weekend." ULP-H stated she did not agree with CNS-A's decision to put the resident in bed and give Tylenol and I thought he should have gone in immediately after the fall. I debated calling the ambulance but I knew [CNS-A] would have gotten upset but I knew he should have gone in. I knew something was wrong. [R2] doesn't ever scream out in pain or anything. I thought it was his knee since he'd fallen directly on it." ULP-H stated she called the on-call nurse again on Saturday, June 15, 2024, "to see what we should do because he needed to go in immediately and they said to call his daughter and get her to bring him in." ULP-H stated only management decides if the ambulance should be called. ULP-H stated there have been times they've called CNS-A and he'd say he'll come in but doesn't or he'll tell them to call the contracted on-call service instead and see what they have to say "but we're really relying on what he was going to say and we were hoping he'd send him in."	02320		

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02320	Continued From page 23 On July 19, 2024, at 9:15 a.m., licensed assisted living director (LALD)-B stated the only things he knew about R2's fall was from what was in the medical record and the facility had not conducted an investigation into the fall or considered the possibility of neglect. LALD-B stated as soon as they found out about the resident's broken hip, they filed a MAARC report but even after filing the report, they still did not investigate any of the events leading up to the fall or what happened after the fall and before he was sent to the hospital. LALD-B stated his role is to "serve as a support system for the nurses to see whatever they need or need done, I'm just there to support I am not a doctor or a nurse," so it would have been up to the nurses to initiate any kind of investigation. LALD-B was asked if CNS-A should have provided different guidance when unlicensed staff reported hearing a popping sound when getting R2 off the floor, followed by screaming in pain and an inability to bear weight on the impacted leg. LALD-B stated, "I mean I read the notes on it, and it may be speculative I'm not a doctor I don't know what to tell you. I know he had pain from what I understand. It's speculative because I'm 40 years old, my knee pops and cracks all the time if I'm being honest with you. My shoulders do that all the time, my knees do it...I'm not saying it's a common occurrence no but there's obviously, people have arthritis and things like that. With him having just knee pain I guess that's what I'd say about that. They did call family and ask them to take him to the hospital..." On July 22, 2024, at 9:45 a.m., R2's daughter stated she had gone to visit R2 before his fall on June 14, 2024, and noticed he was very lethargic and groggy and was told he had gotten some medication earlier to help with some agitation.	02320		

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02320	Continued From page 24 R2's daughter stated the resident was not normally that out of it and she was told additional staff were needed to help transfer him which was not normal for him. R2's daughter stated she was notified of the fall but initially told there were no injuries, then told he may have hit his knee and was having pain. R2's daughter stated she came to see the resident around 9:00 p.m. on June 15, 2024, but the resident was sleeping and in bed. R2's daughter stated facility staff had told her the resident's knee seemed to be hurting and they had asked if she wanted them to call the ambulance but she said no because the resident was asleep and she didn't think she should wake him up but she told staff if R2 did wake up in the middle of the night to call her and let her know but no one ever called. R2's daughter stated facility staff had told her she had to call the ambulance and they weren't able to call the ambulance and she asked why she had to be the one to call the ambulance and didn't get a clear answer. R2's daughter stated if staff felt the resident needed to go in, they should have called the ambulance. R2's daughter stated she came back Sunday, June 16, 2024, in the morning and R2 was still asleep and "we went to check on him and the girl kinda pressed on his leg and he woke up screaming and I said ok I'm calling the ambulance now." R2's daughter stated she was not aware staff heard a pop when they got him up Friday evening and no one had mentioned how significant the pain was after that was noted. On July 22, 2024, at 10:30 a.m., CNS-A stated he was initially told R2 was fine after his fall then staff called back to say he was having knee pain. CNS-A stated staff did not pass on that they had heard a crack or pop sound when standing the resident up and "I think if I had been told something like that, I would have looked at it	02320		

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02320	Continued From page 25 differently." CNS-A stated he did not say he would be in the next day to assess the resident and had told them instead to "keep me posted and I could come in the next day if you guys need me for anything." CNS-A stated any staff could call the ambulance and that staff would feel comfortable to call the ambulance even if the nurse had said no. CNS-A confirmed the resident's incident report was not completed since the resident did not return the the facility and there was no need to implement interventions as the resident did not come back. CNS-A confirmed he did not investigate why the resident had the reaction he did to Ativan and how that may have contributed to the fall but "at that point we didn't have any other information, he wasn't in the building...I mean I suppose we should have done some follow up on that." On July 23, 2024, at 12:15 p.m., R2's primary care provider (PCP)-L stated he would have expected to be notified on June 14, 2024, after the resident was observed to be so groggy after taking Ativan. PCP-L stated R2 was usually awake and alert so if he was that groggy, the provider should have been called and if he was called, it's likely he would have recommended the facility administer a medication to "see if he wakes up or make sure it's not a stroke or something." PCP-L stated he was not notified of R2's fall on June 14, 2024, and only found out the resident was hospitalized when he was reviewing records of hospitalized residents. PCP-L stated the resident should have been sent to the emergency room on June 14th as a pop and screaming in pain would indicate the resident had possibly broken a hip. PCP-L stated since R2 was not sent in right away and if he tried to self transfer or do anything besides lay in bed, there was a "possibility of complications" related to R2's	02320		

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02320	Continued From page 26 hip fracture. The licensee's Resident Change in Condition or Need policy dated January 2022, indicated the facility would conduct initial and ongoing resident evaluations and assessments of resident's needs as required. When changes in condition or need were identified by a Registered Nurse, the RN would initiate a change in condition assessment, manage the changes and communicate changes to staff and other health care providers as appropriate. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure two of two residents reviewed (R1, R2) were free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred for R1, and the facility and an individual were 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.	

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02360	Continued From page 27 The Minnesota Department of Health (MDH) issued a determination maltreatment occurred for R2, 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		
02480 SS=F	144G.91 Subd. 20 Grievances and inquiries Residents have the right to make and receive a timely response to a complaint or inquiry, without limitation. Residents have the right to know, and every facility must provide the name and contact information of the person representing the facility who is designated to handle and resolve complaints and inquiries. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to respond to grievances of two of two resident (R1, R2) reviewed for grievances. In addition, the licensee failed to have a process in place to respond to and resolve resident grievances. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 15, 2024, the investigator requested the	02480		

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02480	Continued From page 28 licensee's grievances for the past six months. A resident concern log was provided which listed 15 recorded concerns for six different residents. The log listed the resident's name, date, concern, action taken, and date resolved. The investigator requested additional documentation to show how concerns were resolved for R1 and R2. 23 pages of emails were provided which included various correspondence back and forth with resident representatives and county case managers. The emails failed to identify how the licensee resolved the grievances. One email sent on March 8, 2024, included questions on a possible medication error and a resident receiving medications he shouldn't be taking and also not receiving medications he should be getting. Facility documentation lacked evidence of the facility's follow up or how the issue was investigated and resolved. R1 The licensee's grievance log indicated R1 had a grievance raised on March 20, 2024, due to "billing and latest hospital stay." The resolution was "billing taken care of, set up meeting." The concern was noted to be resolved as of March 20, 2024. R1 was hospitalized on March 3, 2024, through March 8, 2024. The licensee's grievance log documentation included an email from POA-J dated March 20, 2024, to LALD-B requesting to "schedule another meeting to sit down with you and nursing staff to get some answers concerning this latest hospital stay." On July 16, 2024, at 10:30 a.m., R1's power of attorney (POA)-J stated she had raised care	02480		

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02480	Continued From page 29 related concerns about R1's care on a few occasions. POA-J stated she met with management at the facility but she felt her concerns were minimized and tried to turn it like it wasn't their fault and "I left that meeting thinking wow, am I dumb for thinking that's a concern? I left that meeting thinking wow, I'm really stupid for even bringing this to their attention, then a month and a half later, she's in the hospital again." POA-J stated she never felt like her concerns were addressed and didn't feel like the facility took her concerns seriously. POA-J stated she didn't realize her concerns were put on a grievance log and she did not recall getting any kind of formal communication to follow up on the status of her concerns and how they would be resolved. POA-J stated she wasn't aware of advocacy services like the ombudsman and the facility had never suggested involving them in her concerns. R2 The licensee's grievance log indicated R2's son raised a grievance on 7/10/24 due to a "fall and hospitalization" and the resolution was "ongoing." R2 fell on June 14, 2024, and was admitted to the hospital on June 16, 2024, with a hip fracture. The licensee's grievance log documentation included an email from RN-C dated June 25, 2024, to R2's county case manager, CNS-A, and LALD-B which read, "I am working on obtaining the paperwork that was requested. As for the video footage, our camera storage has resent since the incident. We would not be able to share the footage if we had it due to other residents also being in the frame. Once I have the paperwork together, I will send to [R2's son] and cc [county case manager], [LALD-B], and	02480		

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02480	Continued From page 30 [CNS-A], and [corporate regional nursing director.]..." The licensee's grievance log documentation included an email from RN-C dated July 10, 2024, which read "I have attached the requested paperwork to this email that you had previously requested. Please let me know if there's anything else I can help with." An email dated July 11, 2024, from R2's county case manager to facility staff read, "I received a phone call from [R2's son] and he was able to review the information and reports there is inaccurate in the incident report...Also [R2's son] is requesting the medications his father was given that specific day of the incident. Please advise and report back as soon as possible." On July 11, 2024, LALD-B replied writing, "Please let us know what you are requesting as we want to resolve this as soon as possible. Please include all on this email as we all want to make sure you're in the email. Thank you." R2's son replied on July 12, 2024, and included LALD-B, RN-C, CNS-A, and administrative employees of the corporate offices. The email read, "On June 24, 2024, I had requested the medications given to [R2] on June 13 and June 14 and a copy of an incident report related to [R2's] fall on June 14, 2024. It took you until July 10 to send the incorrect information, but now there's a sense of urgency to resolve this as soon as possible?...In regards to the fall summary, I would expect that information to also be readily available within a reasonable time frame post-incident." R2 requested an official report of R2's fall and what examinations were done after the resident fell. R2's son wrote, "[R2's] fall was described to be minor and that he was ok. The result was a broken hip and subsequent full hip replacement. Was [R2] walking on 6/15 or bedridden that day? My	02480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30631	A. BUILDING: _____ B. WING _____	C 07/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02480	Continued From page 31 assumption is that your staff performed normal cares the evening of 6/14 and 6/15 without knowing the level of pain he was experiencing..." As of July 15, 2024, the licensee had not taken any action to investigate the concerns raised by R2's son on June 24, 2024, and did not have any documentation to show what the facility had done to resolve the concerns. On July 17, 2024, at 3:15 p.m., R2's son stated he had brought concerns forward to management on multiple occasions and never felt like they were addressed or that the facility took action to figure out what happened. R2's son stated he was concerned about the circumstances around R2's June 14, 2024, fall and would have thought the facility would look into it and see if there were any issues and he felt they were just stonewalling or trying to cover things up. On July 17, 2024, at 10:35 a.m., CNS-A stated the facility would resolve grievances by talking to families and he thought all grievances had been resolved. On July 19, 2024, at 9:15 a.m., LALD-B stated the facility did not keep documentation of actions taken to investigate and resolve grievances and they would take immediate action to resolve any concerns and communicate it "mainly with a phone call to the family." The licensee's Resident Complaint/Grievance Resolution policy indicated "Edgewood Management Group (EMG) will take all necessary actions to resolve a complaint or grievance that a resident and or resident representative has reported. Communication is the key in these types of situations and needs to be implemented	02480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02480	Continued From page 32 immediately to resolve conflicts in a timely fashion." The policy listed steps that would be taken if a complaint or grievance could not be easily resolved or had not been resolved to a resident's satisfaction which included voicing concerns to Edgewood Management Group, directing concerns to the executive director or clinical services director, or the resident council. Responses to concerns would be given verbally unless requested in writing. The policy noted "Complex problems may require time to resolve and some problems may not be able to be resolved. Whatever the case, residents will be given a reasonable explanation for the action taken on their behalf." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02480		