Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL315579706M
Compliance #: HL315577609C

Date Concluded: February 26, 2024

Name, Address, and County of Licensee Investigated:
Farmstead Care of Moorhead
3200 28th Street South
Moorhead, MN 56560
Clay 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 implement interventions after the resident had a series of falls. The resident sustained a fall which resulted in a brain bleed requiring hospitalization in the intensive care unit.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to assess the resident's risk for falls and implement individualized interventions to prevent falls or reduce the risk of serious injury after falling. The resident had approximately 14 falls in the month prior to the fall that resulted in a brain bleed requiring hospitalization in the intensive care unit. Emergency room physicians considered the possibility that the resident had been assaulted or abused at the facility since the injuries from the fall were so significant and the bruises observed were in various stages of healing.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement, emergency medical services staff, hospice staff, the primary care provider, and the resident's neurologist. The investigation included review of facility records, the resident's medical record, hospital records, and the ambulance report. At the time of the onsite visit, the investigator observed care and services in the facility and the resident's room where she fell.

The resident resided in an assisted living facility. The resident's diagnoses included Huntington's disease (a condition that leads to progressive degeneration of nerve cells in the brain that affects movement, cognitive functions, and emotion) and anxiety. The resident's service plan included assistance with toileting, showering, meal set up, dressing, and medication administration. In addition, the resident's service plan included safety checks six times per day to ensure she was safe in her room or the facility. The resident's assessment indicated the resident had three or more falls in the past three months and balance problems while standing or walking, decreased muscular coordination/jerking movements, and required the use of assistive devices like a walker or wheelchair. The assessment lacked an individualized assessment of the resident's current health status or individualized needs and lacked interventions specific to the resident.

The resident's progress notes indicated the resident sustained approximately 14 falls in the month leading up to her hospitalization. The facility reviewed the falls periodically at fall meetings but failed to identify interventions or assess risks related to the resident not wanting to accept additional services or participate in physical therapy. The resident was noted to be impulsive with transfers and did not remember to call for transfer assistance; however, no interventions were in place related to that risk.

Approximately two weeks prior to the resident's hospitalization, the resident requested to start using her wheelchair for locomotion, as she was frequently falling while trying to walk with a walker. A facility nurse discouraged the resident from using her wheelchair, and documented the resident "should continue to be using their walker to keep their independence they have…" The nurse told the resident that she and the resident's provider would let her know when it was time for her to start using the wheelchair. Progress notes indicated the resident had various bruising and skin tears, in various stages of healing, throughout her body due to her numerous falls.

The resident's record contained an incident report, which indicated the resident complained of feeling dizzy in the hours leading up to the fall. The resident tripped while walking in her room and hit a table before landing on the floor. The resident was unable to use her call pendant and yelled out for help. Facility staff responded and called the on-call nurse, who directed staff to call 911.

Ambulance records indicated that when emergency medical crews arrived, staff didn't know what happened. The resident was found on her bed "covered in blood and bleeding heavily

from the head. When EMS approaches the room there is blood all over the floor, walls, bed, pillows, and the patient is completely saturated in blood from head to toe." The resident reported that she "fell five or six times and had been calling for help, but nobody had heard her calls."

Hospital records indicated the resident's injuries were so traumatic and significant, with many bruises in various stages of healing, that doctors considered the possibility that the resident had been abused or assaulted at the facility. The resident reported falling six times that day, and doctors were able to rule out assault or abuse. The resident was diagnosed with two subdural hematomas (bleeding in the brain) and contusions to the scalp and eyelid. The resident was admitted to the intensive care unit and spent 13 days in the hospital. Photographs taken of the resident when she arrived at the emergency room showed the resident's face covered in dried blood, along with multiple bruises on her legs and arms.

During an interview, the clinical nurse supervisor (CNS) stated she worked remotely and did not work in the facility. The CNS confirmed she reviewed assessments completed by RNs in the facility and was on-call for emergencies and questions. The CNS stated she was aware the resident had a history of falls but was not sure what specific interventions were identified for the resident.

During an interview, a facility nurse confirmed the assessment form lacked individualized interventions but stated interventions would be identified within the progress notes. The facility nurse stated the electronic medical record used by the facility did not populate assessment forms and was not user friendly for nursing documentation.

During an interview, another facility nurse stated that the resident fell quite frequently due to her diagnosis of Huntington's disease. The nurse stated they tried to implement new interventions after each fall, but the resident refused to add additional services and stopped working with physical therapy. The nurse did not know why interventions beyond that were not considered. The nurse stated she completed assessments on the resident but relied on the assessment form provided by the facility and completed assessments as directed.

A different facility nurse stated the resident was very anxious, and many of her falls were not witnessed. The nurse indicated the resident wouldn't push her call button but instead, walked out to the nurse's station to tell someone that she fell. The facility nurse stated that the resident struggled with remembering things and was impulsive so "we would tell her if you're feeling weak, push your call light and we can help you, but that's not something she would utilize." The facility nurse stated she was not sure if the RN assessed that risk factor on the resident's assessments. The facility nurse stated she noticed the resident fell more after she received PRN (as needed) doses of clonazepam (an antianxiety medication). The nurse stated whenever staff wanted to give a PRN dose, she asked them to try non-pharmacological interventions first to decrease the resident's risk for falls. The facility nurse stated she was not

sure if the RN identified or assessed the risk certain medications presented that increased the risk for falls.

During an interview, the licensed assisted living director (LALD) stated that the day the resident fell and was hospitalized, she hit her head on a table in her room. The LALD was not sure why the resident's assessments failed to identify the resident's risk for falls or why specific interventions were not in place.

During an interview, the resident's neurologist stated that she had not seen the resident in over a year, as the resident had stopped coming to the clinic. The neurologist stated when the resident was last in the clinic, it was noted her chorea, (rapid, jerky, involuntary body movements) was mild to moderate, and given the progressive nature of Huntington's disease, it would be expected to have worsened over the last year. The neurologist stated that if they had been informed of the resident's multiple falls while trying to walk with a walker, "we would have said you need to live from a wheelchair-based setting. That guidance [to continue using a walker] should be coming from a medical doctor or advanced practice provider, not a nurse." The neurologist stated that while it would be true for a person with normal aging to be encouraged to walk to maintain strength, Huntington's is a neurodegenerative disorder, so the same approach should not be used for this resident. The neurologist stated she reviewed photos in the resident's chart after her fall and did not feel the injuries were only from that fall, and it "looked like she had been in an accident on the interstate; those were injuries in various stages of healing."

During an interview, the resident's primary care provider indicated staff did not contact her about the resident's use of a walker or wheelchair but would have told them to allow the resident to use the wheelchair. The primary care provider was not notified of the resident's fall and hospitalization and only found out after the resident was not at the facility during her regularly scheduled rounds.

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

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

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

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

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

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Clay County Attorney
Moorhead City Attorney
Moorhead Police Department
Minnesota Board of Executives for Long Term Services
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31557	A. BUILDING: _____ B. WING _____	C 02/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FARMSTEAD CARE OF MOORHEAD LP	3200 28TH STREET SOUTH MOORHEAD, MN 56560

(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: #HL315579706M/#HL315577609C On January 25, 2024, through Febrary 2, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were 100 residents, 61 receiving services under the provider's Assisted Living with Dementia Care license. The following immediate correction order is issued. Correction orders with a period to correct that are not immediate may be issued at a later date during the investigation. The following immediate correction order is issued for #HL315579706M/#HL315577609C, tag identification 2310. On February 1, 2024, the immediacy of correction order 2310, was removed, however non-compliance remains at a scope and level of	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 License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	

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0 000	Continued From page 1 F. On January 25, 2024, through Febrary 2, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were 100 residents, 61 receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued that were not issued at the time of immediate correction orders. The following correction orders are issued for #HL315579706M/#HL315577609C, tag identification 0130, 0250, 0495, 0620, 1620, 1650, 1700, 1710, 2320, 2360 and 2400.	0 000		
0 130 SS=C	144G.12, Subd. 1 Application for Licensure Each application for an assisted living facility license, including provisional and renewal applications, must include information sufficient to show that the applicant meets the requirements of licensure, including: (1) the business name and legal entity name of the licensee, and the street address and mailing address of the facility; (2) the names, e-mail addresses, telephone numbers, and mailing addresses of all owners, controlling individuals, managerial officials, and the assisted living director; (3) the name and e-mail address of the managing agent and manager, if applicable; (4) the licensed resident capacity and the license category; (5) the license fee in the amount specified in section 144.122; (6) documentation of compliance with the	0 130		

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0 130	Continued From page 2 background study requirements in section 144G.13 for the owner, controlling individuals, and managerial officials. Each application for a new license must include documentation for the applicant and for each individual with five percent or more direct or indirect ownership in the applicant; (7) evidence of workers' compensation coverage as required by sections 176.181 and 176.182; (8) documentation that the facility has liability coverage; (9) a copy of the executed lease agreement between the landlord and the licensee, if applicable; (10) a copy of the management agreement, if applicable; (11) a copy of the operations transfer agreement or similar agreement, if applicable; (12) an organizational chart that identifies all organizations and individuals with an ownership interest in the licensee of five percent or greater and that specifies their relationship with the licensee and with each other; (13) whether the applicant, owner, controlling individual, managerial official, or assisted living director of the facility has ever been convicted of: (i) a crime or found civilly liable for a federal or state felony level offense that was detrimental to the best interests of the facility and its resident within the last ten years preceding submission of the license application. Offenses include: felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions; financial crimes such as extortion, embezzlement, income tax evasion, insurance fraud, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions; any felonies	0 130		

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0 130	Continued From page 3 involving malpractice that resulted in a conviction of criminal neglect or misconduct; and any felonies that would result in a mandatory exclusion under section 1128(a) of the Social Security Act; (ii) any misdemeanor conviction, under federal or state law, related to: the delivery of an item or service under Medicaid or a state health care program, or the abuse or neglect of a patient in connection with the delivery of a health care item or service; (iii) any misdemeanor conviction, under federal or state law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service; (iv) any felony or misdemeanor conviction, under federal or state law, relating to the interference with or obstruction of any investigation into any criminal offense described in Code of Federal Regulations, title 42, section 1001.101 or 1001.201; (v) any felony or misdemeanor conviction, under federal or state law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance; (vi) any felony or gross misdemeanor that relates to the operation of a nursing home or assisted living facility or directly affects resident safety or care during that period; (vii) any revocation or suspension of a license to provide health care by any state licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a state licensing authority; (viii) any revocation or suspension of accreditation; or (ix) any suspension or exclusion from participation in, or any sanction imposed by, a	0 130		

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0 130	Continued From page 4 federal or state health care program, or any debarment from participation in any federal executive branch procurement or nonprocurement program; (14) whether, in the preceding three years, the applicant or any owner, controlling individual, managerial official, or assisted living director of the facility has a record of defaulting in the payment of money collected for others, including the discharge of debts through bankruptcy proceedings; (15) the signature of the owner of the licensee, or an authorized agent of the licensee; (16) identification of all states where the applicant or individual having a five percent or more ownership, currently or previously has been licensed as an owner or operator of a long-term care, community-based, or health care facility or agency where its license or federal certification has been denied, suspended, restricted, conditioned, refused, not renewed, or revoked under a private or state-controlled receivership, or where these same actions are pending under the laws of any state or federal authority; (17) statistical information required by the commissioner; and (18) any other information required by the commissioner. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to hold an assisted living with dementia care license for their current capacity of residents. The assisted living with dementia care license effective September 1, 2023, indicated a capacity of 93 residents, however 100 residents resided at the facility. This practice resulted in a level one violation (a	0 130		

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0 130	Continued From page 5 violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 1, 2024, at 12:30 p.m., licensed practical nurse (LPN)-A provided a current resident roster which indicated 100 total residents. LPN-A stated around 30 were not on any nursing services. LPN-A confirmed the licensee had more residents than what they were licensed for. The licensee's resident roster indicated 39 residents were not receiving any nursing services but resided within one of the two licensed buildings. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 130		
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in	0 250		

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0 250	Continued From page 6 this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency	0 250		

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0 250	Continued From page 7 level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to demonstrate they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. 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 is 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 January 25, 2024, at 9:10 a.m., licensed practical nurse (LPN)-A confirmed the the licensee's employees in charge of the facility were familiar with the assisted living regulations. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read	0 250		

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0 250	Continued From page 8 and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in	0 250		

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0 250	Continued From page 9 some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons, all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and	0 250		

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	31557	A. BUILDING: _____ B. WING _____	C 02/02/2024

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0 250	Continued From page 10 Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page five was electronically signed by owner (O)-J on May 24, 2023. The licensee had an assisted living license issued on September 1, 2023, with an expiration date of August 31, 2024. The licensee failed to ensure the following policies and procedures were developed and/or implemented: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; As a result of this survey, the following orders were issued 0130, 0495, 0620, 1620, 1650, 2800, 1710, 2310, 2320, 2360, and 2400, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		

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0 495	Continued From page 11	0 495		
0 495 SS=F	144G.41 Subd. 1 (14) Minimum Requirements (14) provide staff access to an on-call registered nurse 24 hours per day, seven days per week This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide staff access to an on-call registered nurse (RN) 24 hours per day, seven days per week. This had the potential to affect all residents receiving assisted living services. 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 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's January 2024 nurse on call schedule indicated a licensed practical nurse (LPN) was the nurse on call for 22 of 31 days. The calendar included a phone number for the "24/7 on call RN [clinical nurse supervisor (CNS)-E]" The licensee's December 2023 nurse on call schedule indicated a LPN was the nurse on call for 26 of 31 days. The calendar included a phone number for the "24/7 on call RN [CNS-E]" The licensee's November 2023 nurse on call schedule indicated a LPN was the nurse on call	0 495		

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0 495	Continued From page 12 for 23 of 30 days. The calendar included a phone number for the "24/7 on call RN [CNS-E]" On January 25, 2024, at 1:10 p.m., clinical nurse supervisor (CNS)-E stated she worked remotely and did not work in the facility. CNS-E confirmed she would oversee the assessments completed by RNs in the facility and was the person staff would call for emergencies and questions but she did not get many calls. CNS-E stated she had another full time job and lived in a city approximately 90 minutes from the facility. On January 25, 2024, at 2:45 p.m., licensed assisted living director (LALD)-C confirmed the CNS for the facility was CNS-E and that she was the RN on call for staff to contact with questions. On January 26, 2024, at 10:05 a.m., licensed practical nurse (LPN)-F stated she was the on call nurse frequently and would be expected to triage and handle all nursing related issues. LPN-F stated if they had questions on anything they were told to contact the Director of Resident Care, LPN-A. LPN-F stated it would then be LPN-A's responsibility to let the RN know if something had happened. LPN-F stated they would provide decision making and guidance to unlicensed personnel who called regarding resident care issues. LPN-F stated she was never told to call CNS-E if she had any questions but they were told there was always a RN on call. LPN-F stated CNS-E did not work in the facility and she had never met her or spoken to her. On January 26, 2024, at 12:35 p.m., LPN-I stated she was the on call nurse frequently and would be expected to triage and handle all nursing related issues and notify families and providers if needed. LPN-I stated she was told there was	0 495		

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0 495	Continued From page 13 always a RN on call but "I was never told to call [CNS-E]. There was always a RN on call written down though. They put it on a sheet of paper so if state walked in they'd see it but I never talked to her [CNS-E] ever." LPN-I stated she had never met CNS-E and if they had things that needed to be escalated or they had questions on, they were to call the Director of Resident Care, LPN-A. On January 30, 2024, at 1:05 p.m., licensed assisted living director (LALD)-C stated the LPNs on call would triage the call and contact the RN if needed. LALD-C stated she didn't think CNS-E got a lot of calls. On January 30, 2024, at 1:25 p.m., RN-D stated when she's on call she will get calls frequently. RN-D stated the LPNs would address any calls if it was within their scope of practice [under the Nurse Practice Act], but if it a serious fall or other issue, they would call and ask the RN. RN-D stated she did not have any documentation to show when the LPN had contacted the RN for a nursing related issue. The licensee's On-Call Nurse Policy dated November 2, 2021, indicated the on- call nurse will use their nursing judgement skills to determine if a resident will need immediate intervention by the information the staff reports to the nurse on-call. The LPN must update the RN on all calls regarding residents. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 495		

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0 620	Continued From page 14	0 620		
0 620 SS=D	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of 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 15 (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 immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment for one of one residents (R1) reviewed for maltreatment. 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).	0 620		

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0 620	Continued From page 16 The findings include: The licensee failed to immediately report suspected neglect after the resident was hospitalized for 13 days due to a fall. The resident was diagnosed with a brain bleed. R1 fell multiple times leading up to the fall that resulted in a hospitalization. The registered nurse failed to implement interventions to prevent additional falls or reduce the risk of significant injury from falling or assess the resident's risk for falling based on the resident's diagnosis and history of not complying with fall prevention measures. In addition, the licensee failed to complete an internal investigation into the circumstances leading up to the fall with major injury. R1's diagnoses included Huntington's disease (a condition that leads to progressive degeneration of nerve cells in the brain that affects movement, cognitive functions, and emotion) and anxiety. On January 25, 2024, at 9:05 a.m., licensed practical nurse (LPN)-A was asked if the facility had considered filing a MAARC report. LPN-A replied, "I don't understand, in what regard? On ourselves? No, I don't think that situation would warrant neglect. I don't know why it would." LPN-A stated the resident had Huntington's disease and "she falls a lot. She fell a lot at home, she falls here..." LPN-A added, "We didn't even have time to report it [to MAARC], why would we report it if we sent her in right when she fell." LPN-A stated they felt since the hospital had filed a MAARC report, they were not required to submit one as well. On January 25, 2024, at 11:45 a.m., registered nurse (RN)-D stated she was not certain if a MAARC report had been filed.	0 620		

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0 620	Continued From page 17 On January 25, 2023, at 1:10 p.m., clinical nurse supervisor (CNS)-E stated the facility had not considered doing a MAARC report because "when I was informed, I was told the staff were doing what they were supposed to be doing and she does fall often obviously with her diagnosis and stuff but I didn't think that it needed to be reported as a neglect thing." The licensee's Reporting Maltreatment of Vulnerable Adult Policy, dated August 1, 2021, indicated "Farmstead Living as adopted MN Statute 626.557 of Reporting of Maltreatment of Vulnerable Adult procedures." The policy indicated all employees were mandated reporters. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
01620 SS=G	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 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	01620		

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01620	Continued From page 18 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 observation, interview, and record review, the licensee failed to ensure the RN assessed one of one resident (R1) who utilized a fall alarm and a diagnosis of anxiety and documented behaviors. In addition, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment using the uniform assessment tool for one of one residents reviewed (R2) 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: BEHAVIOR ASSESSMENT The RN failed to assess the resident's history of behvaiors and anxiety and failed to implement specific, person-centered interventions related to	01620		

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01620	Continued From page 19 managing the resident's behaviors and anxiety. As a result the resident experienced increased anxiety. R1's diagnoses included Huntington's disease (a condition that leads to progressive degeneration of nerve cells in the brain that affects movement, cognitive functions, and emotion) and anxiety. R1's service plan dated April 29, 2022, indicated the resident received assistance with bathing and medication administration. R1's care plan, last updated November 2, 2023, included assistance with toileting, showering, meal set up, dressing, and medication administration. In addition, the resident had safety checks six times per day to ensure she was safe in her room or the facility. R1's most recent assessment was generic and lacked person-centered interventions specific to the resident. The assessment contained "yes" and "no" boxes for the RN to check and lacked any individualized assessment of the resident's current health status or individualized needs. R1's readmission assessment dated December 8, 2023, but not signed off by the RN until December 31, 2023, failed to assess the resident's ongoing behaviors and anxiety. The assessment contained a section for "emotional status" and noted the resident was not disoriented, lethargic, agitated, forgetful or had hallucinations. The resident was noted to be depressed and take several medications for depression. R1's most recent individual abuse prevention plan (IAPP) dated December 8, 2023, indicated the resident did not have any mental or emotional	01620		

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01620	Continued From page 20 conditions that would affect judgment. R1's progress notes contained the following entries: -October 7, 2023, the resident requested to see a nurse. A facility nurse visited with the resident who was "crying and stated "I hate my life, I can't do this anymore." Resident then complained of pain to right shoulder. Bruising in healing stage of yellow present. ROM WNL [range of motion within normal limits] Tylenol given for pain. Will continue to monitor. R1's record lacked evidence the facility took action on the resident's comment or notified her primary care provider. -November 1, 2023, the resident was noted to have behaviors including episodes of crying outbursts during lunch and throughout activities. "Staff tried to redirect patient and then resident would continue to cry again. Staff tried to comfort resident again and said if they needed to take a breather in the room and resident said she was ready for the activity. Throughout the activity resident would interrupt while staff called bingo about things they need or stuff not related to the activity. Caregiver was updated on situation and will continue to monitor." -November 4, 2023, the resident was noted to have behaviors when she came to the nurses station and asked staff to help her find her glasses. When the staff and resident got to her room, the resident pointed to the glasses and said "there and could you give it to me." -November 6, 2023, the resident was noted to have behvaiors after giving conflicting stories on a fall and why her shirt was wet. The facility nurse "asked resident if they fell and stressed the	01620		

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01620	Continued From page 21 importance of being honest of falls. Resident started to stumble over their words and then asked if they could get help using the bathroom and quit talking about falls. The resident was also noted to have had behaviors related to her mother saying she couldn't use her wheelchair. Later that same day, the resident was noted to be using her call light "almost every 15 minutes on this shift for toileting assistance, wheeled her wheelchair wherever she wants to go, pick up her remote control was on the floor in front of her. Resident also cried and very emotional during lunch time at the dining table..." -November 12, 2023, the resident "has had an extremely emotional day. Activities staff sat with her for a while and comforted her..." -November 16, 2023, it was noted "resident has been emotional all day and during all activities today. Resident has been going to activities and having emotional breakouts. When going back to room, resident has door open and having emotional outbursts in room when other residents are present at activities. Staff has been trying to comfort the resident, with redirection not being successful. This occurance has happened multiple times during activities and before activities today..." -November 18, 2023, the residet was noted to have "increased anxiety today due to a family member's declining health." The resident was given PRN (as needed) clonazepam. -November 22, 2023, the resident was noted to have behaviors when she complained of shortness of breath. The resident's oxgen was documented to be 92% and temperature was 99 degrees Farenheight. "Resident very restless all	01620		

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01620	Continued From page 22 day. Been buzzing [using call light] and requested to make the bed, changed her outfit, filled her water bottle, checking her vitals three times and putting her socks on. Resident refused her supper and stayed in room. Will pass on." -November 23, 2023, the resident was noted to have behaviors when she was "buzzing [using her call light] for this entire shift. Resident can't make her mind if she's going out with family, been changing her outfit four times. Husband came and decided to let resident stayed in her room. Resident also trow up while husband was with her. PM meds was given as per husband requested. Resident is now in her room resting, will pass on. (sic)" -December 10, 2023, the on call nurse was called multiple times about the resident throughout the overnight, evening, and morning. The resident was looking for her call light and couldn't find it, but it was located around her neck. Hospice advised using as needed clonazepam and morphine throughout the night for pain control and anxiety. The resident removed her fall alarm multiple times, telling staff she felt "like a dog tied down." The resident "continued to page repetatively right after staff would leave the room. The "resident has had impaired short term memory and has been repetitevely asking the same questions, repeat cares, or looking for call light when it's on her person. Staff and oncoming nurse updated." -December 15, 2023, the resident was noted to be confused this morning, keeps buzzing [using call light] to let staff know she does not feel well which she knows we are aware of. Resident states she wants to lay down and rest, but a few times this morning she had buzzed saying she	01620		

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	31557	A. BUILDING: _____ B. WING _____	C 02/02/2024

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01620	Continued From page 23 wanted to get up and that she didn't really feel sick at all, until sitting her up and then she stated she does not feel well and has kept repeatedly asking the same questions, along with making it aware she is sick every time I enter her room. Resident wanted staff to contact husband to make him aware that she is not feeling well, which husband already knows..." Later that evening, a facility nurse documented the resident continued to have "frequent paging and increase anxiety/restlessness." Staff administered PRN clonazepam. -December 16, 2023, the resident was noted to be "very anxious this morning, can't make up her mind. Whenever she buzzed, she held her pendant non stop until writer came. When writer came to her room, resident asked to do multiple things and then change her mind. PRN clonazepam was given." -December 20, 2023, the registered nurse entered a progress note titled "assessment." The note included an assessment of the resident's emotional status which read "resident is orient to person, place and time. Resident has high anxiety and depression and takes Lithium 300 mg daily, citalopram 40 mg daily, mirtazapine 45 mg daily, olanzapine 10 mg, and clonazapine 0.5 mg TID [three times per day] and PRN. Resident's depression has gotten worse as their disease has progressed and resident has had to depend more on others to do things for them..." The RN failed to identify or implement interventions related to the resident's increasing anxiety and depression. -December 25, 2023, the resident had a behavior when she "paged and this writer [RN-D]went to go ask resident what they could help them with. Resident replied, "I can't sleep. I want morphine."	01620		

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01620	Continued From page 24 Writer then replied "morphine is not given for sleep." Resident then replied "Then give me a clonazepam." Writer again told resident "that medication is also not given to help you sleep." Resident then said "Well then I have anxiety, and I can have a clonazepam for my anxiety." Writer informed resident "since you first asked for morphine, then clonazepam to help you sleep, I want you to try some alternative things to try alleviate your anxiety before I give you medication for your anxiety." Writer did deep breathinge exercises with resident, gave resident a massage, and turned off resident's Christmas lights in their room. Writer informed resident that they would be back after finishing passing medications to other residents to check on resident and to keep working on their deep breathing. Resident agreed." Upon returning a few hours later, the resident was resting peacefully and sleeping. Despite being aware of interventions that worked to relieve the resident's anxiety, the RN failed to add these interventions to the resident's assessment. -January 21, 2024, the resident appeared to "be anxious today. Resident has received all scheduled anxiety medication and it has been somewhat effective. [R1] repeatedly calls for staff to come into her room to assist her. She pushes her pendant multiple times until staff is present. Calls typically consist of her needing to use the bathroom, needing something to drink, to pick up something she has dropped on the floor, putting her heating pad on her, asking for medication...will continue to monitor." -January 22, 2024, the resident was "anxious this shift. Buzzed for almost every 15 minutes for toilet, PRN meds, water, picking up remote control, blanket. Resident can't figure it out at	01620		

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01620	Continued From page 25 once of what she needs. Even writer went to this resident room, resident was struggled to think of what she needs. Will pass it on (sic)." Despite ongoing documentation of the resident's behavior and anxiety, the RN failed to assess the behaviors and anxiety and failed to implement specific interventions related to either. On January 30, 2024, at 1:30 p.m., registered nurse (RN)-D stated "I don't believe we have anything in place." when asked about what specific interventions had been developed to manage the resident's anxiety or behaviors. On January 30, 2024, at 2:00 p.m. unlicensed personnel (ULP)-J was asked about specific interventions used to help R1 reduce her anxiety or manage her behaviors. ULP-J stated they had PRN (as needed) medications for anxiety they could give but didn't know of any other interventions being used. ASSESSMENT OF ALARMS On January 30, 2024, at 2:00 p.m. unlicensed personnel (ULP)-J confirmed the resident would sometimes unclip her fall alarm and was not compliant with wearing it. On January 30, 2024, at 2:10 p.m., ULP-J was observed unclippling the resident's fall alarm to transfer her to a wheelchair. The fall alarm was clipped on the back of the resident's shirt when she was brought back to the sofa after using the bathroom. R1's most recent assessment dated December 8, 2023, but not signed off by the registered nurse until December 31, 2023, indicated the resident	01620		

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01620	Continued From page 26 was a fall risk and had "bed/chair alarm" R1's progress notes included the following: -December 9, 2023, a licensed practical nurse (LPN) implemented a bed and chair alarm and every two hour safety checks, along with leaving the door open to reduce the risk for falls. -December 10, 2023, LPN-F documented that she "received multiple calls about resident throughout the evening/overnight/am...received a call at 12:30 a.m. that resident had a fall looking for their call light and did hit their head...writer was notified by staff that resident has continued to remove fall alarm stating they "feel like a dog tied down" with it on..." The progress notes indicated the RN was not notified of the call to the LPN until Monday, December 11, 2023. The RN failed to assess the resident's complaints regarding the fall alarms, concerns related to the resident's compliance with wearing the alarm, and failed to assess if the alarm remained an appropriate intervention. The resident had two documented falls after the implementation of the fall alarm. The fall documentation did not address whether or not the alarm was being used appropriately when the resident fell. On January 30, 2024, at 1:35 p.m., registered nurse (RN)-D stated she felt the alarm was an appropriate intervention but the resident would unclip it at times. RN-D stated she was not aware of the comment the resident made about "feeling like a dog tied down" and had not noticed it in the progress notes prior to the investigator pointing it out. RN-D stated the comment was concerning. On January 30, 2023, at 1:45 p.m. LPN-B stated	01620		

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01620	Continued From page 27 she was not previously aware of the resident's comment about the fall alarm making her feel like a dog tied down and agreed the comment was concerning and warranted follow up. LPN-B stated she thought the resident was pretty compliant with wearing the alarm. LICENSED PRACTICAL NURSES COMPLETING ASSESSMENTS R2's record lacked a signed service plan. R2's care plan indicated the resident received assistance with showering, nail care, safety checks, ambulation, and INR checks. R2's progress notes indicated facility nursing staff were managing the resident's coumadin and other medications, as well as providing wound care services. R2's most recent assessment dated November 15, 2023, was signed by LPN-B and co signed by CNS-E. On January 25, 2024, at 1:10 p.m., CNS-E stated she worked remotely and did not work in the facility. CNS-E confirmed she would oversee the assessments completed by nurses in the facility and was the person staff would call for emergencies and questions. CNS-E confirmed she would sign off on the assessments done by LPNs and did not assess the residents herself to verify accuracy. On January 30, 2024, at 1:05 p.m., LALD-C stated facility staff would bring the original assessments to CNS-E's house approximately 90 minutes away and the CNS would review the assessments and sign off on them and the assessments would be brought back to the facility. LALD-C stated facility LPNs completed	01620		

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01620	Continued From page 28 some assessments and was not sure how the RN verified accuracy without actually assessing the resident herself. On January 30, 2024, at 1:35 p.m., LPN-B confirmed her job duties included completing some assessments. LPN-B stated with the 90 day assessments, "sometimes we do a zoom call with the RN, sometimes RN-D is here, we just go through all of that and discuss the resident." LPN-B stated when a LPN completed an assessment, it would be on a paper form and "I'm the one that either brings them to her or she meets me somewhere in town here or she was here last week, she signs and reviews everything that needs to be reviewed and I bring the assessments back to the facility." LPN-B stated the CNS "usually doesn't come in house to do them." On January 31, 2024, at 1:00 p.m., LPN-A confirmed her job duties included completing 90 day assessments that would then be taken to the clinical nurse supervisor to be signed off on. LPN-A stated she completed "a pretty basic data collection" and used an assessment form to fill in the information. LPN-A stated she was not sure how the RN verified accuracy of the assessment of the resident's condition as the CNS did not work onsite. LPN-A stated the CNS had access to the building. The investigator asked if that meant the CNS was coming onsite to see the residents. LPN-A stated, "She has access to the building. You'll have to ask her that." The licensee's undated Monitoring of Residents and Resident Services policy indicated the RN could delegate the responsibility of monitoring the resident's services to the licensed nurse for every other month monitoring visits. Upon completion of	01620		

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01620	Continued From page 29 LPN, RN will review and assess resident for accuracy and training purposes. The licensee's Delegation of Resident Assessments policy dated July 15, 2022, indicated a RN "may delegate the initial, 14 day, 90 day, and re-admission assessments to a LPN in the building with oversight/supervision by an RN on every assessment. Oversight/supervision will include a visit to the resident post-assessment, review of the assessment, and sign off on the physical copy as well as the documentation in the resident's electronic medical record with any additional comments added as needed." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01650 SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the	01650		

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01650	Continued From page 30 facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a service plan was updated to reflect current services being provided by the licensee for one of one resident (R1). 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 diagnoses included Huntington's disease (a condition that leads to progressive degeneration of nerve cells in the brain that affects movement, cognitive functions, and emotion) and anxiety. R1's service plan dated April 29, 2022, indicated the resident received assistance with bathing and	01650		

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01650	Continued From page 31 medication administration. R1's service plan was signed by R1's power of attorney and licensed practical nurse (LPN)-A on April 29, 2022. The service plan included assistance with bowel/bladder control or incontinent products circled as yes with 11/1/23 written next to it. The service plan included assistance with activities of daily living to include dressing/undressing, grooming, oral cares, and nail care circled as yes with 12/8/23 written next to it. The service plan included other licensed nurse delegated tasks to unlicensed personnel to include transfer assistance with one staff circled as yes with 12/8/23 written next to it. The service plan lacked safety checks and lacked a signature from the resident's representative and facility staff after changes were made on November 1, 2023, and December 8, 2023. R1's care plan dated December 8, 2023, included assistance with toileting, showering, meal set up, dressing, and medication administration. In addition, the resident had safety checks six times per day to ensure she was safe in her room or the facility. R1's record contained a progress note dated December 9, 2023, regarding updates to the resident's care plan. The progress note indicated staff were providing every two hour safety checks, transfers with a physical assist of one person, assistance with transfers in wheelchair, and meal set up to include cutting up meat and pouring liquids. The RN failed to add the updated services to the resident's service plan. On January 25, 2024, at 2:10 p.m., licensed practical nurse (LPN)-A stated they had reviewed the service plan with the resident's family at their quarterly care conferences.	01650		

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01650	Continued From page 32 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01700 SS=D	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by:	01700		

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01700	Continued From page 33 Based on interview, and record review, the licensee failed to ensure a medication management assessment was completed by the registered nurse/RN to determine what medication management services would be provided and included identification and review in all required areas for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1's diagnoses included Huntington's disease (a condition that leads to progressive degeneration of nerve cells in the brain that affects movement, cognitive functions, and emotion) and anxiety. R1's service plan dated April 29, 2022, indicated the resident received assistance with bathing and medication administration. R1's Resident Individualized Medication Management Plan dated April 29, 2022, indicated the facility would provide medication administration services. R1's medication administration assessment form assessed if the resident was independent, needed reminders, or needed assistance with various categories including if the resident could state the name of medications, knew what each medication was for, takes medications at the correct time, able to administer the correct dose,	01700		

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01700	Continued From page 34 open bottles, and able to report symptoms. The assessment indicated medication administration was required for the resident. The assessment was signed by registered nurse (RN)-D on December 8, 2023, and it was noted the resident's power of attorney had verbally agreed to the assessment. The resident's most recent assessment dated December 8, 2023, but not signed off by RN-D until December 31, 2023, listed several different medications the resident was taking including Lithium (a mood stabilizer) 300 mg, citalopram (antidepressant) 40 mg, mirtazapine (antidepressant) 45 mg, olanzapine (antipsychotic to treat severe agitation) 10 mg, clonazapine (antipsychotic to treat mood disorders) 0.5 mg three times per day and as needed, Tylenol (pain reliever) 650 mg, Excedrin tension headache 500-65 mg, and morphine (opioid pain medication) 4 mg as needed. R1's record lacked evidence the RN conducted a face-to-face assessment with the resident and/or their representative to include a review of all medications the resident was known to be taking to include indications for use, side effects, contraindications, allergic or adverse reactions and interventions needed in management of medications to prevent diversion. On January 31, 2024, at the investigator attempted to obtain additional documentation related to the resident's medication management assessment as the one provided was more than a year old from licensed practical nurse (LPN)-A. LPN-A stated, "You already said you don't like our form, I don't know what you're asking for or what you're wanting."	01700		

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01700	Continued From page 35 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01710 SS=D	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management reassessment at least annually for one of one resident (R1) who received medication management services. In addition, the licensee failed to ensure the RN completed a reassessment when medication related symptoms presented, and there was a change in the resident's medications for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include:	01710		

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FARMSTEAD CARE OF MOORHEAD LP	3200 28TH STREET SOUTH MOORHEAD, MN 56560

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01710	Continued From page 36 ANNUAL REASSESSMENT R1's diagnoses included Huntington's disease (a condition that leads to progressive degeneration of nerve cells in the brain that affects movement, cognitive functions, and emotion) and anxiety. R1's service plan dated April 29, 2022, indicated the resident received assistance with bathing and medication administration. R1's Resident Individualized Medication Management Plan dated April 29, 2022, indicated the facility would provide medication administration services. R1's medication administration assessment form assessed if the resident was independent, needed reminders, or needed assistance with various categories including if the resident could state the name of medications, knew what each medication was for, takes medications at the correct time, able to administer the correct dose, open bottles, and able to report symptoms. The assessment indicated medication administration was required for the resident. The assessment was signed by registered nurse (RN)-D on December 8, 2023, and it was noted the resident's power of attorney had verbally agreed to the assessment. The resident's most recent assessment dated December 8, 2023, but not signed off by RN-D until December 31, 2023, listed several different medications the resident was taking including Lithium (a mood stabilizer) 300 mg, citalopram (antidepressant) 40 mg, mirtazapine (antidepressant) 45 mg, olanzapine (antipsychotic to treat severe agitation) 10 mg, clonazapine	01710		

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01710	Continued From page 37 (antipsychotic to treat mood disorders) 0.5 mg three times per day and as needed, Tylenol (pain reliever) 650 mg, Excedrin tension headache 500-65 mg, and morphine (opioid pain medication) 4 mg as needed. On January 31, 2024, at the investigator attempted to obtain additional documentation related to the resident's medication management assessment as the one provided was more than a year old from licensed practical nurse (LPN)-A. LPN-A stated, "You already said you don't like our form, I don't know what you're asking for or what you're wanting." REASSESSMENT FOR MEDICATION RELATED SYMPTOMS R1 had a history of falls and a history of falls with serious injury. R1 was hospitalized from November 25, 2023, through December 8, 2023, and returned to the facility on hospice. On January 26, 2024, at 10:10 a.m., LPN-F stated stated she had noticed R1 would fall more after she had received a PRN (as needed) dose of clonazepam (an antianxiety medication to treat panic disorder that can cause drowsiness or dizziness) she'd fall more so whenever staff wanted to give a PRN dose she would ask them to try nonpharmalogical interventions first so the resident wouldn't have a higher risk for falls. LPN-F stated she was not sure if the RN had identified or assessed the risk certain medications presented for increasing the risk for falls. On January 31, 2024, at 1:25 p.m., RN-D	01710		

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01710	Continued From page 38 confirmed she was not aware of this observation or the role certain medications might play in the resident's risk for falls. No further information was provided TIME PERIOD FOR CORRECTION: Seven (7) days	01710		
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 observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards, for one of one residents (R1) who utilized bed rails. 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). This resulted in an immediate correction order issued on January 25, 2024.	02310		

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02310	Continued From page 39 The findings include: On January 25, 2023, at 10:00 a.m., the investigator observed R1 had a standard bed with a consumer loop shaped metal bed rail positioned on the left upper side of the bed. The base of the bed rail was not secured to the bed frame and was secured to a wood board. The board was tucked between the bed frame and the mattress. R1 also had a hospital bed with a partial hospital bed rail on the upper left side of the bed. R1 stated she used the bed rail to assist with getting in and out of bed. R1's diagnoses included Huntington's disease (a condition that leads to progressive degeneration of nerve cells in the brain that affects movement, cognitive functions, and emotion) and anxiety. R1's service plan dated April 29, 2022, indicated the resident received assistance with bathing, incontinence products, medication administration, and activities of daily living. R1's care plan, last updated November 2, 2023, included assistance with toileting, showering, meal set up, dressing, and medication administration. In addition, the resident had safety checks six times per day to ensure she was safe in her room or the facility. The care plan lacked any indication the resident used bed rails. R1's most recent assessment was dated December 8, 2023, but not signed by the registered nurse (RN)-D until December 31, 2023, lacked a comprehensive assessment on the use of an assistive device to include actual measurements of the entrapment zones and further lacked ongoing assessment for the use of an assisted device, as required in the uniform	02310		

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02310	Continued From page 40 assessment tool. The assessment further indicated the resident was at high risk for falls as she had three or more falls in the past three months, had balance problems while standing or walking, decreased muscular coordination/jerking movements, and required the use of assistive devices like a walker or wheelchair. R1's record lacked the following: -type of consumer bed rail being used; -installation and use of the device according to manufacturer's guidelines; -evidence the licensee referred to the Consumer Product Safety Commission (CSPC) for bed rail recall information; and -on going assessment for the use of an assisted device as required in the uniform assessment tool. On January 25, 2024, at 10:40 a.m., licensed practical nurse (LPN)-A confirmed they had not completed any assessments related to the use of bed rails and did not have any measurements or any other information related to the bed rails in use. LPN-A stated the resident's husband slept in the bed with the consumer grade rail and the resident did not sleep in the bed, but the resident slept in the hospital bed with the attached bed rail. On January 25, 2024, at 11:30 a.m., licensed assisted living director (LALD)-C stated she was not aware of the regulations surrounding use of bed rails and they had not received any guidance from their provider organization or the state regarding appropriate content of assessments for bed rails. On January 25, 2024, at 11:55 a.m., registered nurse (RN)-D stated she was not aware of what	02310		

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02310	Continued From page 41 needed to be assessed or documented in regards to bed rail use and had not receive any guidance from the facility about the use of bed rails. On January 25, 2024, at 12:15 p.m., LPN-A measured both bed rails with the MDH investigator present. LPN-A confirmed the consumer grade bed rail measured as follows: 12 inches wide by 19 inches tall with a gap between the rail and the mattress of three inches. LPN-A confirmed the bed rail was not attached to the mattress and could move easily. LPN-A confirmed the hospital-style bed rail measured as follows: 32 inches long by 12 inches tall with 3 inch wide openings throughout the bed rail. There was a gap between the rail and the mattress of two inches. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQs), last updated December 26, 2023, indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail. - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail. - The resident's bed rail use/need assessment:	02310		

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02310	Continued From page 42 - Risk vs. benefits discussion (individualized to each resident's risks): - The resident's preferences: - Installation and use according to manufacturer's guidelines: - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for "consumer beds", the licensees should refer to individual manufacturer's guidelines for appropriate installation, maintenance, and use. In addition, licensees should refer to the Consumer Product Safety Commission (CSPC) for the most up-to-date information related to portable bed side rail recall information. The Assisted Living Resources & Frequently Asked Questions (FAQs), last updated December 26, 2023, current recommendations for recall include the following "The United States Consumer Product Safety Commission (CSPC) works to save lives and ensure safety by reducing the unreasonable risk of injuries and deaths associated with consumer products, such as portable bed rails. The CSPC posts information on its website related to portable bed rail recalls. Licensees should review the CSPC website regularly for updates on recalled portable bed rails. The opportune time to do this would be with the 90-day assessment due to the requirement included in the uniform assessment tool for assessing assistive devices. The licensee lacked a policy regarding the use of bed rails and/or assessment for the use of bed rails.	02310		

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02310	Continued From page 43 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) Days Immediacy is removed as confirmed on February 1, 2024, however noncompliance remains at a scope and severity of F.	02310		
02320 SS=J	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 related to falls. The licensee failed to have a fall management system that ensured staff provided the resident with supervision and implemented interventions after falls for one of one resident (R1) reviewed. R1 had a known history of falls, however, the registered nurse (RN) failed to assess the resident's risk for falls and failed to implement interventions to prevent falls or reduce the risk of serious injury from falls. The resident had at least 14 falls before a fall that resulted in a 13 day hospitalization. The resident's injuries from the fall were so significant, hospital staff had to rule	02320		

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02320	Continued From page 44 out the possibility the resident had been assaulted. This practice resulted in a level four violation (a violation that results in serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1's diagnoses included Huntington's disease (a condition that leads to progressive degeneration of nerve cells in the brain that affects movement, cognitive functions, and emotion) and anxiety. R1's service plan dated April 29, 2022, indicated the resident received assistance with bathing, incontinence products, medication administration, and activities of daily living. R1's care plan, last updated November 2, 2023, included assistance with toileting, showering, meal set up, dressing, and medication administration. In addition, the resident had safety checks six times per day to ensure she was safe in her room or the facility. R1's assessment dated October 25, 2023, indicated the resident had three or more falls in the past three months and had balance problems while standing or walking, decreased muscular coordination/jerking movements, and required the use of assistive devices like a walker or wheelchair. R1's assessment was generic and lacked person centered interventions specific to the resident. The assessment contained "yes" and "no" boxes for the RN to check and lacked	02320		

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02320	Continued From page 45 any individualized assessment of the resident's current health status or individualized needs. R1's individual abuse prevention plan (IAPP) dated May 2, 2022, lacked any assessment of the resident's risk related to falls. R1's record contained the following entries: -The licensee's internal Weekly Fall Meeting minutes indicated R1 had a fall on October 9, October 11, and October 14, 2023. Interventions included a care conference to suggest toileting assistance and "family continues to decline PT [physical therapy]". In addition, hospice assessed the resident on October 2, 2023, but she did not qualify for hospice services. Despite a reported history of the family refusing to add additional service, the RN failed to include this in any assessments or IAPP identifying the risk related to refusing additional services. -October 28, 2023, the resident had an unwitnessed fall in her bathroom. The licensee's internal Weekly Fall Meeting minutes indicated R1 had a fall on October 28, 2023. Interventions included adding dressing and grooming assistance to the resident's care plan on November 1, 2023. -November 1, 2023, the resident had an unwitnessed fall while walking to her bathroom. -November 4, 2023, the resident had an unwitnessed fall in her room when she tripped and lost her balance. The resident reported she hit her head on her living room floor. The licensee's internal Weekly Fall Meeting	02320		

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02320	Continued From page 46 minutes indicated R1 had a fall on November 4, 2023, but the RN failed to identify any new interventions. Interventions listed included "added additional services onto her care plan on 11/1/23. Family continues to decline PT services." -November 5, 2023, the resident called unlicensed personnel (ULP) to her room and told staff "I just want to show you my bruises all over my body." The resident's mother was present and told the ULP "I think it's time for her use the wheelchair if she fell a lot" (sic). -November 6, 2023, registered nurse (RN)-D documented she visited with the resident regarding the concern she should be using her wheelchair more. RN-D wrote, "Writer informed resident that at this point, resident should continue to be using their walker to keep the independence they have...writer again informed resident that they need to be using their walker at this time to keep their independence at this time and their PCP [primary care provider] and this writer will let resident know when it is time for them to start using their wheelchair continuously. Resident thanked writer and was excited to hear this..." -November 8, 2023, the resident had an unwitnessed fall when she tripped in her living room. -November 9, 2023, the resident had an unwitnessed fall when she tripped and hit her nose on the wall besides her bed. The resident had a small cut on her nose that was bleeding. -November 10, 2023, the resident had an unwitnessed fall when she tripped over her shoes.	02320		

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02320	Continued From page 47 -November 12, 2023, the resident had an unwitnessed fall and had a "scrape about the size of a pea" on her left knee. The licensee's internal Weekly Fall Meeting minutes indicated R1 had a series of falls with two on November 8, November 10, and November 12, 2023. The RN failed to identify any new interventions. Interventions listed included "continue with current care plan. Recently added dressing and grooming and toileting. Family declines PT services at this time. [R1] continues to be impulsive with unsafe transfer." Despite being aware the resident was not compliant with calling for help and was impulsive with transfers, the RN failed to include the information on any assessments or IAPP. -November 16, 2023, the resident had an unwitnessed fall after staff "heard a big bang on the wall inside her bathroom." -November 20, 2023, a ULP documented, "Resident had a fall at about 8:45 p.m. Resident pager is not working. Writer tested pager while visiting with resident to confirm. Writer searched for a spare but could not find. Resident's mom is spending the night." -November 21, 2023, a facility nurse assessed bruises to the resident's left knee, left hand, and a small red spot on the back of her head. The resident also had complaints of numbness in left fingers. -November 21, 2023, the resident had an unwitnessed fall while walking from her bed to the couch and "broke her fall mostly with her right knee and right forearm but did also bump head	02320		

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02320	Continued From page 48 on floor." Scraping to her right forearm and a small scrape to the right side of her forehead were noted. -November 23, 2023, the resident had an unwitnessed fall while trying to go to the bathroom. A skin tear to the left knee was noted. -November 25, 2023, at 2:15 p.m., the resident reported "having dizzy spells recently." The resident told staff the dizzy spells could happen any time of day and she would get dizzy and her eyesight would go black. RN-D spoke with the resident and advised staff to take a blood pressure and pulse if it was reported again. -November 25, 2023, at 4:44 p.m., RN-D documented she was called by staff after "resident had a bad fall and hit their head." The progress note indicated when staff entered the resident's room, she was laying in her bed but there was blood all over the living room, the resident, and her walls. RN-D had the staff member FaceTime her and "did a neuro assessment over the phone." The resident reported she was nauseated and was going to vomit and "kept trying to go to sleep." Emergency medical services were called. Ambulance records indicated when emergency medical crews arrived, staff didn't know what happened and they found the resident on her bed, "covered in blood and bleeding heavily from the head. When EMS approaches the room there is blood all over the floor, walls, bed, pillows, and the patient is completely saturated in blood from head to toe." The resident reported she "fell five or six times and had been calling for help but nobody had heard her calls."	02320		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02320	Continued From page 49 Hospital records indicated the resident's injuries were so traumatic and significant and the resident had many bruises in various stages of healing, doctors considered the possibility the resident had been abused or assaulted at the facility. The resident reported she had six falls that day and doctors were able to rule out an assault or abuse. The resident was diagnosed with two subdural hematomas (bleeding in the brain) and contusions to the scalp and eyelid. The resident was admitted to the intensive care unit and spent 13 days in the hospital. Photographs taken of the resident when she arrived to the emergency room showed the resident's face covered in dried blood, along with multiple bruises on her legs and arms. After the resident returned from the hospital, the RN failed to assess the resident's risk for falls, serious injury from falls, or implement any new interventions to reduce R1's risk for falling. R1's most recent individual abuse prevention plan (IAPP) dated December 8, 2023, lacked an assessment or any interventions related to the resident's ongoing falls. The IAPP indicated the resident had health-physical limitations and was at risk for "self mobility (wheelchair, cane, braces etc.) since she "uses wheelchair, walker due to high risk of falling." The plan to reduce risks was "if needed, uses device at all times. Room & common areas free of hazards." R1's most recent IAPP dated December 8, 2023, indicated the resident "was at risk for self-abusive behaviors" as the resident was "impulsive with decisions regarding transfers that are unsafe." Staff were to "redirect the resident and listen and report to the nurse." The IAPP lacked specific, person-centered interventions related to the resident's known history of being impulsive with transfers.	02320		

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02320	Continued From page 50 R1's readmission assessment was generic and lacked person-centered interventions specific to the resident. The assessment contained "yes" and "no" boxes for the RN to check and lacked any individualized assessment of the resident's current health status or individualized needs. R1's readmission assessment dated December 8, 2023, but not signed off by the RN until December 31, 2023, failed to assess the resident's ongoing risk for falls or identify any interventions to prevent falls or prevent injuries from falls. After returning to the facility, R1's progress notes indicated the resident's mother was observed transferring the resident several times and was educated by nursing staff that only staff should transfer the resident. Despite being aware of this risk, the RN failed to include the family's non compliance with transferring the resident to R1's assessment or IAPP. Progress notes indicated the resident had increasing anxiety and behaviors however the RN failed to assess the anxiety and behaviors or include it on the assessment or IAPP. R1's progress notes included the following: -December 9, 2023, a nurse implemented a bed and chair alarm and every two hour safety checks, along with leaving the door open to reduce the risk for falls. However, the RN failed to include this intervention on the resident's assessment or IAPP. Later that same day, the resident had a fall and hit her head. R1 reported ten out of ten pain. The RN failed to add new interventions and "resident reminded and encouraged to use call light and wait for staff to assist." Despite the resident continuing to be noncompliant and impulsive, the RN failed to	02320		

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02320	Continued From page 51 include this on R1's assessment or IAPP. -December 10, 2023, the resident "hit their head on the wall when transferring with writer to use the bathroom." -December 10, 2023, LPN-F documented that she "received multiple calls about resident throughout the evening/overnight/am...received a call at 12:30 a.m. that resident had a fall looking for their call light and did hit their head...writer was notified by staff that resident has continued to remove fall alarm stating they "feel like a dog tied down" with it on..." The progress notes indicated the RN was not notified of the call to the LPN until Monday, December 11, 2023. The RN failed to assess the resident's complaints regarding the fall alarms and failed to identify any new interventions related to the fall. On January 25, 2024, at 11:45 a.m., RN-D stated she was responsible for completing assessments for R1. RN-D stated she relied on the assessment form provided by the licensee and completed assessments as she was directed. RN-D stated the resident fell quite frequently due to her diagnosis of Huntington's disease and they tried to implement new interventions after each fall but the resident refused to add additional services and had stopped working with physical therapy. On January 25, 2024, at 1:10 p.m., clinical nurse supervisor (CNS)-E stated she worked remotely and did not work in the facility. CNS-E confirmed she would oversee the assessments completed by RNs in the facility and was the person staff would call for emergencies and questions. CNS-E was asked if any assessments using the uniform assessment tool were completed. CNS-E stated	02320		

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02320	Continued From page 52 she was "somewhat familiar" with the assisted living regulations but the "uniform assessment tool, there's so many. Uniform assessment tool, that term is not familiar to me." CNS-E stated she was aware R1 had a history of falls but was not sure what the specific interventions were. CNS-E stated, "Well, they [facility staff] would be checking on her I hope. I'm not there to oversee that but they should have been checking on her. It's independent living, are you talking like should she have alarms or that kind of thing? I'm not even sure." CNS-E stated she was not sure if the facility completed an internal investigation after the resident fell and required hospitalization. CNS-E stated the facility reviewed past falls but "I don't know if it was a formal investigation." On January 25, 2024, at 2:05 p.m., LPN-A stated the assessment form the licensee used was a form they developed with required categories. LPN-A confirmed the assessment form lacked individualized interventions but interventions were identified within the progress notes. LPN-A stated the electronic medical record used by the licensee didn't populate an assessment form and while "it's user friendly for staff [unlicensed personnel], it's not so much for the nursing part of it." LPN-A stated they had discussed the resident's falls during their fall meetings and they had asked family to add more services but the family initially refused. On January 25, 2024, at 2:45 p.m., licensed assisted living director (LALD)-C was asked why specific, person-centered interventions were not identified on any of the resident's assessments or IAPPs. LALD-C stated "they should be...I'm surprised, it should all be in there the system [electronic medical record] we have has been used since the day we opened, it's geared	02320		

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02320	Continued From page 53 towards assisted living...I feel like we did it, it's all been done, it's written in there, somehow, it just isn't reflected." On January 26, 2024, at 10:10 a.m., LPN-F stated R1 was very anxious and many of her falls were not witnessed as the resident wouldn't push her call button but instead walked out to the nurse's station to tell someone she fell. LPN-F stated R1 struggled with remembering things and was impulsive so "we would tell her if you're feeling weak, push your call light and we can help you but that's not something she would utilize." LPN-F stated she was not sure if the RN assessed that risk factor on the resident's assessments. LPN-F stated she had noticed the resident fell more after she receiving a PRN (as needed) dose of clonazepam (an antianxiety medication to treat panic disorder that can cause drowsiness or dizziness). LPN-F stated she noticed R1 fell more with the PRN medicine, so whenever staff wanted to give a PRN dose, she asked them to try nonpharmalogical interventions first, to decrease R1's risk for falls. LPN-F stated she was not sure if the RN had identified or assessed the risk certain medications presented for increasing the risk for falls. On January 31, 2024, at 2:40 p.m., R1's neurologist stated she had not seen the patient in over a year as R1 had stopped coming to the clinic. The neurologist stated when R1 was last in the clinic, it was noted her chorea (rapid, jerky, involuntary body movements) was mild to moderate and given the progressive nature of Huntington's disease, she expected over the last year that R1 would have worsened. The neurologist stated if they had been made aware of R1's multiple falls while trying to walk with a walker, she "would have said you need to live	02320		

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02320	Continued From page 54 from a wheelchair based setting. That guidance [to continue using a walker] should be coming from a medical doctor or advanced practice provider, not a nurse." The neurologist stated that while it would be true a person with normal aging should be encouraged to walk in order to maintain strength, Huntington's is a neurodegenerative disorder, and the same approach should not be used for R1. The neurologist reviewed photos in the resident's chart from after her fall and did not feel the injuries were only a result of that fall and it "looked like she had been in an accident on the interstate, those were injuries in various stages of healing." On February 5, 2024, at 10:35 a.m., the resident's primary care provider stated if R1 asked to not use her walker and wanted to use a wheelchair, she wouldn't have pushed using the walker. The primary care provider stated, "If they [facility staff] would have called me, I would have told them to let her use her wheelchair." The primary care provider stated she was not notified R1 fell and required hospitalization. The primary care provider stated she only found out after she came to the facility for regularly scheduled rounds and the resident was not there. The licensee's Resident Falls Policy & Procedure dated May 2, 2022, indicated after a fall, a fall incident report would be completed by the staff member who found the resident on he floor and the licensed nurse would complete a fall report and notify the primary care physician. Licensed nurses, the registered nurse, and physical therapy would meet weekly to review falls. The licensee's Monitoring of Residents and Resident Service policy dated indicated the	02320		

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02320	Continued From page 55 licensed nurse or registered nurse would identify any new vulnerabilities that the resident may have or any new risk that the resident may pose to other vulnerable adults and identify interventions to address the issues. If changes in resident need were identified during a reassessment, the nurse would update the resident's assessment and determine if changes are needed in the care plan and service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one residents reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No plan of correction is required for this tag.	
02400 SS=D	144G.91 Subd. 12 Visitors and social participation	02400		

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02400	Continued From page 56 (a) Residents have the right to meet with or receive visits at any time by the resident's family, guardian, conservator, health care agent, attorney, advocate, or religious or social work counselor, or any person of the resident's choosing. This right may be restricted in certain circumstances if necessary for the resident's health and safety and if documented in the resident's service plan. (b) Residents have the right to engage in community life and in activities of their choice. This includes the right to participate in commercial, religious, social, community, and political activities without interference and at their discretion if the activities do not infringe on the rights of other residents. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to respect the resident's right to receive visits at any time. This had the potential to affect the one resident (R1) at the facility. 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 diagnoses included Huntington's disease (a condition that leads to progressive degeneration of nerve cells in the brain that affects movement, cognitive functions, and emotion) and anxiety.	02400		

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02400	Continued From page 57 R1's service plan dated April 29, 2022, indicated the resident received assistance with bathing, incontinence products, medication administration, and activities of daily living. R1's care plan, last updated November 2, 2023, included assistance with toileting, showering, meal set up, dressing, and medication administration. In addition, the resident had safety checks six times per day to ensure she was safe in her room or the facility. R1's assessment dated October 25, 2023, lacked any documentation on visitor restrictions. R1's individual abuse prevention plan (IAPP) dated May 2, 2022, lacked any documentation on visitor restrictions. R1's assisted living contract dated May 3, 2022, included a section on overnight guests. Page 10, section 14 indicated "Provider is pleased to welcome all guests. You have the right to choose who, when, where, and how long you may have guests. We do, however, ask that your overnight guests observe a reasonable length of stay. You are responsible for the behavior of your guests and any damage they may cause to the Apartment Unit or the premises of Provider. We also reserve the right to ask guests to leave the premise for health, safety, or security reasons. Guests staying longer than three (3) days will be considered occupants of your Apartment Unit. Such guests must meet Provider's occupancy requirements, including submission of an approved occupancy application." A progress note dated December 20, 2023, at 9:28 p.m., included the following: "Resident's	02400		

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02400	Continued From page 58 mother stated that she was staying the night and that this was approved by LPN and hospice. This writer let her know that to her knowledge that we were not allowing family to stay per facility policy but this writer would double check. After contacting [LPN-A] this writer informed [mom] she was not allowed to spend the night. [R1's mom] stated "I stayed Sunday and everyone knew and was fine with it." and asked when the policy was changing to allow her to stay again, this writer said no changes were planned at this time. [R1's] mom yelled "God damn it! It's too late for me to go home now I have to get a hotel because of you!" Writer left the room as [R1's mom] was very angry with writer. Later after [R1's mom] left writer went to check on resident. Resident was upset about the situation and stated "I need my mom" and this writer explained that she was welcome to come any time during the day but at night when resident is sleeping, we need to be the ones assisting her. Resident stated she didn't want to talk about it. Will continue to monitor." On January 26, 2024, at 9:05 a.m., R1's mom stated she was not informed R1 had any visitor restrictions and was upset with staff because it was after 9:00 p.m. when they told her she couldn't stay the night after she had already been there for a few hours. R1's mom stated since the resident is on hospice, she wanted to spend more time with her and R1 had wanted her to stay as well and didn't understand why the facility changed its policy without notice. R1's mom stated she only wanted to stay one night every week or every other week. On January 30, 2024, at 1:05 p.m., licensed assisted living director (LALD)-C stated the facility had an end of life policy for when people can spend the night and that is what they followed.	02400		

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02400	Continued From page 59 LALD-C stated she would provide a copy of the facility policy. On January 30, 2024, at 1:35 p.m. registered nurse (RN)-D stated the facility had a policy on overnight visitors and didn't believe there were any restrictions. RN-D stated the overnight visit might not have been allowed due to illness in the facility and having restrictions related to that. On January 30, 2024, at 1:45 p.m., licensed practical nurse (LPN)-B stated to her knowledge, the policy for visitors was no overnight visits unless the resident is impending [nearing death]. The licensee's Visitor Policy dated August 18, 2022, indicated Farmstead Living is pleased to welcome all guests. All residents have the right to choose who, when, where, and how long you have guests. Farmstead Living does, however, ask that your overnight guests observe a reasonable length of stay. Guests staying longer than three days would be considered "additional submission of an approved occupancy application." The Minnesota Bill of Rights for Assisted Living Residents, last updated November 8, 2022, indicated residents have the right to individual autonomy, initiative, and independence in making life choices, including establishing a daily schedule and choosing with whom to interact. In addition, the resident has the right to meet with or receive visits at any time from the resident's family, guardian, conservator, health care agent, attorney, advocate, religious or social work counselor, or any person of the resident's choosing. This right may be restricted in certain circumstances if necessary for the resident's health and safety and if documented in the	02400		

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02400	Continued From page 60 resident's service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02400		