Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL326813123M
Compliance #: HL326815068C

Date Concluded: January 12, 2023

Name, Address, and County of Licensee Investigated:

River Oaks at Shady Ridge
225 Shady Ridge Rd. NW
Hutchinson, MN 55350
McLeod County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:
Jana Wegener, RN, Special Investigator

Finding: Substantiated, facility responsibility

Nature of Visit:
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 resident was neglected when facility staff failed to update and implement changes following a resident change resulting in a need for increased staff assistance. In addition, the facility failed to identify, assess, and implement interventions to ensure the resident's ability to smoke safely.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. Despite staff's knowledge of the resident's change in condition and assessed increase in need for assistance with activities of daily living (ADL)s, the facility failed to ensure the resident's service plan was updated and staff were aware of the changes in level of assistance required to care for the resident. In addition, the facility failed to assess the resident's ability to smoke independently despite knowledge of the resident's change in condition, multiple falls in the designated smoking area, and burns on the resident's body.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted the resident's family. The investigation included review of assessments, medication administration records, incident reports, smoking assessments, care plans, service checklists, progress notes, and hospice documentation. Also, the investigator observed other residents during the onsite visit.

The resident resided in an assisted living facility with diagnoses that included pelvic fracture, cardiopulmonary dysfunction with acute exacerbation, emphysema, weakness, and received hospice services for end-of-life care. The resident's admission smoking assessment indicated the resident was oriented, able to smoke independently, able to light and extinguish her own cigarette, and able to communicate and call for help independently. The resident's record indicated the resident was alert and oriented, able to walk independently, and was independent with activities of daily living (ADL)s including dressing at the time of admission.

The resident's record included documentation of an unwitnessed fall out of bed. Upon staff's assessment of the resident and the resident's complaints of pain, the resident was transferred to the emergency department. The resident sustained a pelvic fracture, was hospitalized overnight for pain control, and returned to the facility the following day.

A Change in Condition assessment was completed by facility nursing staff upon the resident's readmission to the facility. The assessment identified an increased need for assistance with cares and indicated the resident now required assistance and supervision with dressing, transfers, toileting, and incontinent cares.

A review of the resident's hospice record indicated following the fall and pelvic fracture, the resident was non-ambulatory, incontinent, required the use of a wheelchair, and assistance of one staff member for transfers. The record included a functional assessment which identified the resident now required a wheelchair for mobility, assistance with bathing, dressing, and grooming related to her physical impairments. The hospice record included documentation that this information was shared with facility staff.

The resident's care plan, service plan and service checklist were not updated to include the resident's assessed increased need for assistance with ADL's including dressing, toileting, or assistance with transfers.

Facility incident reports indicated following the resident's return to the facility, the resident sustained numerous, frequent, recurring falls with several falls in the designated smoking area. The incident reports identified contributing factors to the cause of the fall including end of life changes in cognition, delusions, forgetfulness, balance problems, confusion, impaired mobility, poor safety judgment, and hallucinations.

Despite knowledge of these incidents and the updated change in condition assessment, the resident's record was not updated to reflect the changes and continued to identify the resident as independent with ADL's and smoking.

A hospice note indicated the hospice nurse found the resident sitting in her room naked from the waist down during a routine visit. The note identified the resident was tearful, cold, and too weak to move independently. The hospice nurse assisted, provided cares and dressed the resident. The note indicated the resident was crying and stated, “nobody here will help me like you just did, I need to leave here”.

Another hospice note written five days later, indicated the hospice nurse found the resident sitting hunched over at the end of her bed, wearing the same clothing she had dressed her in during her last visit. The nurse documented the resident’s pants were visibly soiled, and when she asked the resident why she was still in the same clothes, the resident stated, "nobody helps me here". The hospice note indicated while she assisted the resident with dressing, she observed three round lesions that appeared to be cigarette burns. The nurse reported her concerns of the resident not receiving ADL assistance and the burns to the facility nurse.

Facility progress notes included the hospice nurse’s report of the resident’s clothes not being changed since her last visit. The note indicated services were updated at this time to include for staff to assist the resident with dressing.

However, the residents increased need for assistance was identified one month prior on the change of condition assessment and hospice functional assessments when the resident was re-admitted to the facility following a pelvic fracture. Although these assessments were completed, the identified changes were not implemented on the resident’s service list, care plan, and services checklist. As a result, staff were unaware of the resident’s increased need for assistance. The facility did not implement the resident’s increased need for assistance until after the hospice nurse reported concerns that assistance and supervision with ADL’s were not being provided.

A facility smoking assessment was not completed until seven days following the hospice nurses’ report of cigarette burns on the resident’s body. The updated smoking assessment indicated the resident was not safe to smoke independently and now required supervision and the use of a smoking apron.

The facility failed to timely assess the resident’s ability to safely smoke independently despite staff’s knowledge of a noted a decline in the resident’s physical and cognitive function and increased need for assistance with cares. As a result, the resident continued to smoke independently, had repeated falls in the smoking area, and sustained three cigarette burns on her body.

During investigative interviews, unlicensed staff stated after the resident’s fall with pelvic fracture, she declined quickly. They indicated the resident needed more help, had more confusion, and sustained multiple falls. Staff also recalled the resident frequently wore dirty clothes.

When interviewed, the hospice nurse stated the resident declined rapidly after her pelvic fracture. When the resident returned to the facility from the hospital, she required more assistance with ADL's including transfers, going to the bathroom, and getting dressed. The resident would frequently ask for help from hospice staff and stated, "no one at the facility would help". The hospice nurse stated the facility did not provide the assistance the resident needed, and indicated the resident was unkempt, found in soiled clothing with dried feces on her, sitting in her room naked, and despite calling for assistance, staff did not help her. The hospice nurse indicated the resident was often distressed, weepy, anxious, and crying, because facility staff did not help her. The nurse indicated she provided cares to the resident and then informed and re-educated facility staff that the resident required more help with ADL's. The facility staff responded, "if she can get up and go smoke, she can get herself dressed". The hospice nurse indicated she observed three circular scabbed areas on both knees that appeared to be cigarette burns. When she reported the burns to facility staff, they indicated they were aware of this, and informed the hospice nurse the resident frequently dropped cigarettes in her lap. The hospice nurse described that when the resident became bed bound toward the end of her life, she had flies in her room that crawled all over her body while she laid unresponsive and actively dying.

When interviewed the resident's family stated the resident declined after she broke her pelvis and required more assistance than what she received at the facility. The family member indicated the resident was not well cared for and described the resident as dirty and disheveled. The family member stated the resident did not receive assistance with ADLs, and indicated it was her understanding the facility did not provide hands-on care. The family member stated the resident's room was "disgusting" with a pile of urine-soaked items and flies all over. The family member stated the resident continued to smoke independently despite her decline, and indicated they were not aware of the resident having cigarette burns.

In conclusion, 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:
(a) 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.
(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or

maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Vulnerable Adult interviewed: No, deceased
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: N/A

Action taken by facility:
After the hospice nurse reported concerns with the resident not receiving assistance with ADL's including dressing, the facility added dressing assistance to the resident's services check list. The facility reassessed the resident's safety and ability to smoke independently a week after burns were found on the resident's body. The facility implemented staff worksheets which included fall risks, safety interventions, and resident needs for each shift.

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
Mcleod County Attorney
Hutchinson City Attorney
Hutchinson Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32681	A. BUILDING: _____ B. WING _____	C 12/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER OAKS AT SHADY RIDGE LLC	225 SHADY RIDGE ROAD NW HUTCHINSON, MN 55350

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0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING 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: HL326813123M/HL326815068C. On December 5, 2022, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 36 residents receiving services under the provider's Assisted Living license. The following correction orders are issued for HL326813123M/HL326815068C, tag identification 0730, 0800, 1620, 1640, 2310, and 2360.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 730 SS=D	144G.43 Subd. 3 Contents of resident record	0 730		

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0 730	Continued From page 1 Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and	0 730		

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0 730	Continued From page 2 any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure documentation and wound monitoring for one of one residents (R1) with cigarette burns. 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). Findings include: R1 was admitted to the facility on June 21, 2022, with diagnoses including emphysema (a disease of the lungs), cardiopulmonary dysfunction (COPD) with acute exacerbation, adult failure to thrive, weakness, and received hospice services for end-of-life care. R1's admission assessment dated June 21, 2022, indicated R1 was alert, oriented, and independent with activities of daily living (ADL)s including transfers, dressing, and toileting. On June 22, 2022, R1's admission smoking	0 730		

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0 730	Continued From page 3 assessment indicated the resident was oriented, able to light and extinguish a cigarette, able to call for help, able to move without assistance, and indicated she could smoke independently. On September 27, 2022, a hospice nurse note indicated R1 was sitting hunched over at the end of her bed wearing the same clothing the nurse had dressed R1 in five days prior. The nurse documented R1's clothing was visibly soiled, and when the nurse asked why, R1 stated "nobody helps me here". The nurse documented she assisted R1 with ADL's and observed several cuts and scrapes on both knees in various stages of healing, and three small round scabs that appeared to be cigarette burns. The note indicated injuries including burns observed on R1's body were reported to the facility registered nurse (RN). On December 5, 2022, at 11:51 a.m. during an entrance conference licensed social worker (LSW)-E indicated they were aware R1 had cigarette burns because R1 was picking at them. On December 5, 2022, at 1:00 p.m. assistant (RA)-B stated she reported seeing cigarette burns on R1's body. On December 5, 2022, at 12:33 p.m. RA-C stated R1 was burning herself when smoking, and she had reported it to the nurse. On December 22, 2022, at 3:23 p.m. hospice nurse (HN)-H stated R1 was admitted to the facility with hospice services. HN-H stated she observed multiple bruises and abrasions on both knees in various stages of healing with three circular scabs that appeared to be cigarette burns. HN-H stated she reported concerns to a	0 730		

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0 730	Continued From page 4 facility RN who indicated R1 frequently dropped cigarettes in her lap. R1's record including progress notes and incident reports was reviewed and lacked documentation of burns on R1's body. Documentation for R1's skin and wound monitoring including bruising, abrasions, contusions, and cigarette burns were requested; none were received. The facility policy and procedure titled "Initial and Ongoing Nursing Assessment - under the comprehensive license" dated July 26, 2021, indicated assessment of skin conditions, ongoing re-assessment including evaluation of the resident's treatments, and communicate any new problems or concerns to the resident's physician or health care providers. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 730		
0 800 SS=D	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by:	0 800		

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0 800	Continued From page 5 Based on interview, and record review the licensee failed to keep the physical environment in a continuous state of good repair with regard to the health, safety, comfort, and well-being for one of one resident (R1) when was repeatedly observed to be in an unkempt state in visibly soiled clothing, with piles of urine soaked clothing in her room causing a fly infestation and flies crawled on R1's body while she laid unresponsive and dying. 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). Findings include: R1 was admitted to the facility on June 21, 2022, with diagnoses including emphysema (a disease of the lungs), cardiopulmonary dysfunction with acute exacerbation, adult failure to thrive, weakness, and hospice services for end-of-life care. R1's admission Hospice Care Plan dated June 21, 2022, indicated the resident had alterations in ability to complete ADLs and required assistance with ambulation as needed, and indicated staff were to ensure the resident had good personal hygiene. On August 25, 2022, at 5:00 a.m. an incident report indicated R1 had a unwitnessed fall in her bedroom with complaints of pain, and was transferred to the emergency department (ED) by	0 800		

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0 800	Continued From page 6 ambulance. A late entry progress note for August 25, 2022, written August 27, 2022 at 1:00 p.m. indicated the ED reported the resident sustained a pelvic fracture and was admitted for pain control. R1 returned to the facility on August 26, 2022. A Change of Condition Assessment, dated August 26, 2022, indicated R1 required assistance and supervision with ADL's including toileting, incontinence care, transferring, bathing, and supervision with dressing. The assessment indicated R1 was dependant on staff for housekeeping. R1's Service Agreement dated July 28, 2022, did not include housekeeping services. The licensee failed to ensure R1's service agreement was updated following R1's pelvic fracture and change in condition assessment completed August 26, 2022. R1's Service Check Off List for August and September 2022, did not include housekeeping services. On September 14, 2022, a hospice note included an assessment of R1's status, and indicated the resident required assistance with ADL's including bathing, dressing, grooming, housekeeping, and laundry related to physical impairment. On September 27, 2022, a hospice note indicated R1 was sitting hunched over at the end of her bed wearing the same clothing the nurse had dressed R1 in five days prior. The nurse documented R1's clothing was visibly soiled, and when the nurse asked why, R1 stated "nobody helps me here".	0 800		

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0 800	Continued From page 7 The note indicated concerns were reported to the facility registered nurse (RN). On September 27, 2022, at 12:00 p.m. the staff RN documented in a progress note that a hospice nurse reported R1 had not had her clothes changed since last week. The note indicated services were added to the service check list to provide R1 assistance with dressing needs, and to empty the commode. R1's September Service Check List indicated assistance with dressing was added on September 28, 2022, to be completed twice daily. The service check list was not updated until 31 days after the resident a change in condition assessment was completed by the facility nurse following R1's return from the hospital with a pelvic fracture, which identified R1 required assistance with ADL's including transferring, toileting and incontinent care. R1's services were not updated until after a hospice nurse reported concerns that R1's ADL's were not being completed. However, R1's increased need for assistance was not included on R1's service check list, care plan, or service agreement for staff to implement. On December 22, 2022, at 3:23 p.m. hospice nurse (HN)-H stated R1 was admitted to the facility with hospice services. HN-H stated she reported concerns the resident was not receiving assistance with ADLs to a facility RN. HN-H stated what was most disturbing was when R1 was unresponsive and actively dying, she had flies crawling all over her body. On December 22, 2022, at 2:59 p.m. during an interview with R1's family member (FM)-I stated the facility did not provide hands-on care and	0 800		

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0 800	Continued From page 8 assistance with ADL's and R1 needed more assistance than the facility provided. FM-I stated R1 appeared disheveled, and her room was disgusting with piles of urine-soaked clothing that was infested with flies. On December 23, 2022, at 9:36 a.m. during an interview with a corporate RN, and director of nursing (DON)- F they stated a fly infestation would not be acceptable, however DON-F was not the DON at the time this occurred. The RN and DON-F indicated something should have been done right away, including assessment of the situation, room sweeps and ensuring that the room was clean and tidy. RN and DON-F indicated maintenance and pest control should have also been involved. The RN stated just because R1 could propel herself, did not mean she could complete her own ADL's. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
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	01620		

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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
01620	Continued From page 9 and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview, and record review the licensee failed to provide individualized reassessment and monitoring based on changes in the needs for one of one resident's (R1) when she had a change in condition following a pelvic fracture. As a result, the resident was harmed when she continued to smoke independently and sustained cigarette burns on her body. This practice resulted in a level three violation (a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings include: R1 was admitted to the facility on June 21, 2022, with diagnoses including emphysema (a disease of the lungs), cardiopulmonary dysfunction with	01620		

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	32681	A. BUILDING: _____ B. WING _____	C 12/05/2022

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01620	Continued From page 10 acute exacerbation, adult failure to thrive, weakness, and received hospice services for end-of-life care. R1's admission assessment dated June 21, 2022, indicated R1 was alert, oriented, and independent with activities of daily living (ADL)s including transfers, dressing, and toileting. On June 22, 2022, R1's admission smoking assessment indicated the resident was oriented, able to light and extinguish a cigarette, able to call for help independently, able to move without assistance, and indicated she could safely smoke independently. On July 11, 2022, at 1:48 p.m. a progress note indicated R1 had a fall on July 8, 2022, at 5:30 p.m. in the designated smoking area. On August 25, 2022, at 5:00 a.m. an incident report indicated R1 had a unwitnessed fall in her bedroom with complaints of pain, and was transferred to the emergency department (ED) by ambulance. A late entry progress note for August 25, 2022, written August 27, 2022, at 1:00 p.m. indicated the ED reported R1 sustained a pelvic fracture and was admitted for pain control. R1 returned to the facility on August 26, 2022. A Change of Condition Assessment was completed on August 26, 2022, and indicated R1 required assistive devices including a walker and wheelchair for mobility. The assessment indicated R1 required assistance and supervision with ADL's including toileting, incontinence care, transferring, bathing, and supervision with	01620		

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01620	Continued From page 11 dressing. The licensee failed to complete an assessment of the resident's ability to smoke safely and independently after she fell and sustained a pelvic fracture and a change in needs was identified on the assessment completed following her return to the facility. On September 9, 2022, at 4:05 p.m. an incident report indicated R1 had an unwitnessed fall in the hallway. R1 stated she saw something or a man running by on the floor, and she tried to climb up and around her wheelchair because she was scared. The report indicated R1 had nonsensical incoherent ramblings. The incident report indicated the resident had a history of falls and a recent fall resulting in a fractured pelvis, R1 was weak and required the use of a wheelchair at all times, had an impaired mental status, was impulsive, and had poor safety awareness. On September 11, 2022, at 9:45 p.m. an incident report indicated R1 sustained another fall in the outside designated smoking area. However, no smoking assessment was completed following the fall to determine if she was able to smoke independently or safely. On September 22, 2022, at 3:45 p.m. an incident report indicated the resident fell for the third time in the designated smoking area. The assessment indicated R1 had a change in her cognition and a decline related to end-of-life changes causing delusions and hallucinations on a daily basis. The incident report indicated R1 had weakness, impaired mental status, and impaired safety and judgment. Although the resident had three falls in the designated smoking area, and physical and cognitive changes were identified, the licensee failed to re-assess R1's ability to smoke independently or safely.	01620		

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01620	Continued From page 12 On September 23, 2022, a hospice nurse note indicated when the nurse entered R1's room she was sitting in her room naked from the waist down crying, and verbalized being cold. The note indicated R1 was too weak to move without assistance from the hospice nurse, who assisted the resident to get cleaned up and dressed. The note indicated the resident was tearful and stated, "nobody here will help me like you just did, I need to leave here". On September 27, 2022, a hospice nurse note indicated R1 was sitting hunched over at the end of her bed wearing the same clothing the nurse had dressed R1 in five days prior. The nurse documented R1's clothing was visibly soiled, and when the nurse asked why, R1 stated "nobody helps me here". The nurse documented she assisted R1 with ADL's and observed several cuts and scrapes on both knees in various stages of healing, including three small, round, scabs that appeared to be cigarette burns. The note identified the hospice nurse's concerns of R1 not receiving assistance with ADL's and injuries sustained including burns observed on R1's body and the hospice nurse reported to this to the facility registered nurse (RN). On September 27, 2022, at 12:00 p.m. the staff RN documented in a progress note that a hospice nurse reported R1 had not had her clothes changed since last week. The note indicated services were added that day to R1's service check list to provide R1 assistance with dressing needs, and to empty the commode, despite these needs being identified one month prior on the resident's assessment upon return from the hospital.	01620		

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01620	Continued From page 13 A smoking assessment dated October 3, 2022, completed seven days after the hospice nurse reported finding cigarette burns on R1's body, indicated R1 could not safely smoke independently and required staff supervision and an apron to smoke. On December 5, 2022, 11:22 a.m. during a tour, Administrator-G stated a smoking assessment should be completed on admission, quarterly, with any changes or decline, or if an injury occurred from smoking. On December 5, 2022, at 11:51 a.m. Licensed Social Worker (LSW)-E stated they were aware R1 had cigarette burns because R1 was picking at them. On December 5, 2022, at 1:00 p.m. resident assistant (RA)-B stated she reported seeing cigarette burns on R1's body, and she thought the burns occurred when R1 hunched over into her lap. On December 5, 2022, at 12:33 p.m. RA-C stated R1 was burning herself when smoking, and she had reported it to the nurse. On December 5, 2022, at 12:15 p.m. RA-D stated R1 had falls outside in the designated smoking area. On December 22, 2022, at 3:23 p.m. hospice nurse (HN)-H stated when she assisted R1 with ADL's, she observed multiple bruises and abrasions on both knees in various stages of healing with three circular scabs that appeared to be cigarette burns. HN-H stated she reported the burns to a facility RN who indicated R1 frequently dropped cigarettes in her lap.	01620		

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01620	Continued From page 14 On December 23, 2022, at 9:36 a.m. during an interview with a corporate RN, and the director of nursing (DON)- F, they confirmed a change of condition assessment should be completed after R1's return from the hospital. The assessment should have included assistance and supervision needed with ADLs after a pelvic fracture and the change in needs implemented on R1's service plan. DON-F said she would expect a smoking re-assessment to be completed to ensure the resident was safe to continue smoking independently if other changes in needs had been identified. The facility policy and procedure titled "Initial and Ongoing Nursing Assessment - under the comprehensive license" dated July 26, 2021, indicated in Section M. the assessment would include risk indicators including smoking and the resident's ability to smoke without causing burns or injury. Although the facility identified R1 had changes in cognition, mobility impairment related to the dying process causing delusions/hallucinations, and staff interviews who stated they knew R1 dropped her cigarettes and had burns on her body, the licensee failed to complete a smoking assessment until seven days after R1's cigarette burns were reported by the hospice nurse. The facility policy and procedure titled "Safe Smoking Policy - Outdoors" dated February 24, 2020, indicated a smoking assessment would be completed by an RN on admission, quarterly, and with any significant change. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01620		

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01620	Continued From page 15 days	01620		
01640 SS=G	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a service plan was revised, entered into the resident record, and implemented for one of one resident (R1) when R1 had a change in condition following a pelvic fracture. As a result, the resident sustained numerous falls, multiple abrasions, bruises, and was repeatedly observed to be in a unkempt state	01640		

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01640	Continued From page 16 in visibly soiled clothing. In addition, there were piles of urine soaked clothing in R1's room causing a fly infestation and flies crawled on R1's body while she laid unresponsive and dying. This practice resulted in a level three violation (a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings include: R1 was admitted to the facility on June 21, 2022, with diagnoses including emphysema (a disease of the lungs), cardiopulmonary dysfunction with acute exacerbation, adult failure to thrive, weakness, and received hospice services for end-of-life care. R1's admission assessment dated June 21, 2022, indicated R1 was alert, oriented, and independent with activities of daily living (ADL)s including transfers, dressing, and toileting. R1's admission Hospice Care Plan dated June 21, 2022, indicated the resident had alterations in ability to complete ADLs and required assistance with ambulation as needed, and indicated staff were to ensure the resident had good personal hygiene. On August 25, 2022, at 5:00 a.m. an incident report indicated R1 had a unwitnessed fall in her bedroom with complaints of pain, and was transferred to the emergency department (ED) by	01640		

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01640	Continued From page 17 ambulance. A late entry progress note for August 25, 2022, written August 27, 2022, at 1:00 p.m. indicated the ED reported the resident sustained a pelvic fracture and was admitted for pain control. A late entry progress note for August 26, 2022, was entered on August 27, 2022, at 4:15 p.m. that indicated R1 readmitted to the facility. A Change of Condition Assessment was completed on August 26, 2022 which indicated R1 required assistive devices including a walker and wheelchair for mobility. The assessment indicated R1 now required assistance and supervision with ADL's including toileting, incontinence care, transferring, bathing, and supervision with dressing. R1's Care Plan updated August 31, 2022, indicated staff would observe for changes in ability, strength, and endurance, but failed to indicate R1 now required assistance with activities of daily living (ADL)s including transferring, dressing, toileting or incontinence care. R1's Service Agreement dated July 28, 2022, indicated R1 required assistance with bathing, wellness checks, behavior management, and medication management and administration services. R1's Service agreement was not updated following R1's change in condition and needs identified in the August 26, 2022, assessment. R1's Service Check Off List for August 2022, failed to include R1's increased need for assistance and supervision with transfers,	01640		

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01640	Continued From page 18 toileting, incontinence care, or dressing. On August 29, 2022, at 9:01 p.m. an incident report indicated R1 had an unwitnessed fall after attempting to toilet and transfer herself back into her wheelchair. The incident report indicated R1 had limited mobility, was unable to walk following a recent fall with pelvic fracture, and required the use of a wheelchair. The incident report indicated R1 was forgetful, continued to self-transfer, and forgot to use wheelchair brakes. The incident report indicated a fall prevention plan was in place, but it did not include the use of R1's wheelchair. The incident report indicated R1 was instructed to not transfer herself, and staff were to encourage the resident to use a wheelchair at all times. On September 2, 2022, a hospice visit note indicated the resident was unable to walk, was incontinent, required a wheelchair, and assistance of one staff member to pivot transfer. The hospice visit note indicated this information was shared with the facility. On September 9, 2022, at 4:05 p.m. an incident report indicated R1 had an unwitnessed fall in the hallway. R1 said she saw something or a man running by on the floor, and she tried to climb up and around her wheelchair because she was scared. The report indicated R1 had nonsensical incoherent ramblings. The incident report indicated the resident had a history of falls and a recent fall resulting in a fractured pelvis, was weak requiring the use of a wheelchair at all times, had an impaired mental status, was impulsive, had poor safety awareness, and indicated R1 was non-compliant with the care plan. However, the care plan failed to indicate R1 was mobility impaired and required assistance	01640		

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01640	Continued From page 19 with ADL's including transfers. The incident report indicated R1 was reminded to use a call light for assistance. On September 11, 2022, at 9:45 p.m. an incident report indicated R1 had another fall in the outside designated smoking area. However, no smoking assessment was completed to assess R1's ability to smoke independently or safely. On September 14, 2022, a hospice nurse note included an assessment of R1's status, and indicated R1 required assistance with ADL's including bathing, dressing, grooming, housekeeping, and laundry related to physical impairment. On September 20, 2022, a hospice nurse note indicated collaboration and education was provided to the facility staff and reinforced R1's need for assistance of one staff with transfers related to low oxygen levels and pain from a recent pelvic fracture. On September 22, 2022, at 3:45 p.m. an incident report indicated the resident fell for the third time in the designated smoking area. The assessment indicated R1 had a change in cognition and a decline related to end-of-life changes causing delusions and hallucinations on a daily basis. The incident report indicated R1 had weakness, impaired mental status, and impaired safety and judgment. However, R1's care plan failed to indicate R1 was mobility impaired, required the use of a wheelchair, and staff assistance with ADL's, including transfers. There was no assessment completed related to R1's ability to safely smoke independently. On September 23, 2022, a hospice nurse note	01640		

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01640	Continued From page 20 indicated when the nurse entered R1's room, R1 was sitting in her room naked from the waist down crying, and verbalized being cold. The note indicated R1 was too weak to move without assistance from the hospice nurse, who assisted the resident to get cleaned up and dressed. The note indicated the resident was tearful and stated, "nobody here will help me like you just did, I need to leave here". On September 26, 2022, at 2:50 p.m. R1 had an unwitnessed fall in the common area. The report indicated interventions included keeping articles of need within easy reach, R1's bed in low position, and wellness/safety checks. R1's care plan and service agreement failed to indicate R1 was cognitively impaired, mobility impaired, required the use of a wheelchair, and staff assistance with ADL's, including transfers. On September 27, 2022, a hospice nurse note indicated R1 was sitting hunched over at the end of her bed wearing the same clothing the nurse had dressed R1 in five days prior. The nurse documented R1's clothing was visibly soiled, and when the nurse asked why, R1 stated "nobody helps me here". On September 27, 2022, at 12:00 p.m. the staff RN documented in a progress note that a hospice nurse reported R1 had not had her clothes changed since last week. The note indicated services were added R1's service check list to provide R1 assistance with dressing needs, and to empty the commode. R1's August 2022, service check list failed to include R1's need for assistance with ADL's including transferring, toileting, incontinence care, and dressing following R1's change in condition	01640		

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01640	Continued From page 21 after the pelvic fracture. R1's September Service Check List indicated assistance with dressing was added on September 28, 2022, to be completed twice daily, despite these needs being identified on the August 26, 2022, change in condition assessment completed following R1's return from the hospital. R1's service checklist was not updated until 31 days after the resident had a change in condition assessment completed following a pelvic fracture, which identified R1 required assistance with ADL's including transferring, toileting and incontinence care. R1's increased need for assistance was not included on R1's service checklist, care plan, or service agreement for staff to implement. On December 5, 2022, at 1:00 p.m. resident assistant (RA)-B stated R1 was independent on admission, then started declining and would often wear soiled clothing. On December 5, 2022, at 12:15 p.m. RA-D stated she frequently observed R1 in the same dirty clothing for days. On December 22, 2022, at 3:23 p.m. hospice nurse (HN)-H stated R1 was admitted to the facility with hospice services. HN-H stated when R1 returned from the hospital she required assistance with transfers, toileting, and was not able to walk and required a wheelchair for mobility. HN-H stated R1 reported she asked facility staff for assistance, but no one would help her. HN-H stated staff were not providing ADL assistance to R1, and R1 was frequently observed in soiled, incontinent, clothing and appeared un-cared for with dried incontinent stool	01640		

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01640	Continued From page 22 on her body. HN-H stated one day R1 was sitting in her room crying naked from the waist down. HN-H stated R1 rang for assistance from staff, but they did not responded. HN-H stated she assisted R1 to get cleaned up and dressed. Additionally, the following week, HN-H found R1 in the same clothes,visibly soiled and it appeared staff did not care for R1. HN-H stated what was most disturbing, was when R1 was unresponsive and actively dying, she had flies crawling all over her body. HN-H stated R1 was often anxious and weepy, and the lack of support provided by staff, contributed to R1's distress at the end of her life. R1 feared that no one would help her. On December 22, 2022, at 2:59 p.m. during an interview with R1's family member (FM)-I, they stated R1 had frequent and reoccurring falls, increased confusion, and physical decline after she fractured her pelvis. FM-I stated the facility did not provide hands-on care and assistance with ADL's and R1 needed more assistance than the facility was providing. FM-I stated R1 appeared disheveled, her room was disgusting, and there were piles of urine-soaked clothing on the floor that was infested with flies. On December 23, 2022, at 9:36 a.m. during an interview with a corporate RN, and director of nursing (DON)- F, they confirmed a change of condition assessment should have been completed after R1's return from the hospital. The assessment should have reflected R1's change in need for assistance and supervision with ADLs following the pelvic fracture. DON-F stated after the assessment, the changes should have been included and implemented on the resident's service plan, services check list, and care plan immediately and this should have been communicated to staff.	01640		

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	32681	A. BUILDING: _____ B. WING _____	C 12/05/2022

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01640	Continued From page 23 The facility policy and procedure titled "Initial and Ongoing Nursing Assessment - under the comprehensive license" dated July 26, 2021, indicated in Section 1. a RN would complete a comprehensive nursing assessments of the resident's physical, mental, and cognitive needs with a change in resident condition. Section 3. indicated the assessment would include activities of daily living, including toileting pattern, bowel, and bladder control, dressing, grooming, bathing, and personal hygiene, mobility, including ambulation, transfers, and assistive devices. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01640		
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 appropriate care and services according to an up-to-date service plan and accepted health care standards for one of one resident's (R1) when the R1 experienced a change in condition following a pelvic fracture. As a result, R1 sustained numerous falls, multiple abrasions, bruises, and cigarette burns on her body. R1 was repeatedly	02310		

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02310	Continued From page 24 observed to be in a unkempt state in visibly soiled clothing. In addition, R1's room had piles of urine soaked clothing causing a fly infestation, and flies crawled on R1's body while she laid unresponsive and dying. This practice resulted in a level three violation (a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings include: R1 was admitted to the facility on June 21, 2022, with diagnoses including emphysema (a disease of the lungs), cardiopulmonary dysfunction with acute exacerbation, adult failure to thrive, weakness, and received hospice services for end-of-life care. R1's admission assessment dated June 21, 2022, indicated R1 was alert, oriented, and independent with activities of daily living (ADL)s including transfers, dressing, and toileting. On June 22, 2022, R1's admission smoking assessment indicated the resident was oriented, able to light and extinguish a cigarette, able to call for help independently, able to move without assistance, and indicated she could smoke independently. R1's admission Hospice Care Plan dated June 21, 2022, indicated the resident had alterations in ability to complete ADLs, required assistance with	02310		

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02310	Continued From page 25 ambulation as needed, and indicated staff were to ensure the resident had good personal hygiene. On July 11, 2022, at 1:48 p.m. a progress note indicated R1 sustained a fall on July 8, 2022, at 5:30 p.m. in the designated smoking area. On August 25, 2022, at 5:00 a.m. a incident report indicated R1 had a unwitnessed fall in her bedroom with complaints of pain, and was transferred to the emergency department (ED) by ambulance. The incident report indicated safety checks were in place at the time of the fall, and indicated hourly checks were implemented. A late entry progress note for August 25, 2022, written August 27, 2022, at 1:00 p.m. indicated the ED reported the resident sustained a pelvic fracture and was admitted for pain control. A late entry progress note for August 26, 2022, written on August 27, 2022, at 4:15 p.m. indicated R1 was readmitted to the facility. A Change of Condition Assessment was completed on August 26, 2022, after R1's facility readmission to the facility following the pelvic fracture. The assessment indicated R1's goals were to be able to use her walker again, and identified she required assistive devices including a walker and wheelchair for mobility. The assessment indicated R1 required assistance and supervision with ADL's including toileting, incontinence care, transferring, bathing, and supervision with dressing. The licensee failed to complete an assessment of the resident's ability to smoke safely and independently after she fell and sustained a pelvic fracture and was assessed and determine she needed an increase in assistance with cares.	02310		

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02310	Continued From page 26 R1's Care Plan updated August 31, 2022, after R1 fell and sustained a pelvic fracture, identified R1 had a history of falls on admission. R1's care plan included interventions of having staff encourage R1 to be aware of surroundings, turn around slowly when using her walker, keep R1's room free of clutter, safety checks, bed in low position, and indicated staff should encourage the resident to use a wheelchair, and call light for assistance. The care plan instructed staff to observe R1 for changes in ability, strength, and endurance, but failed to include any assistance with activities of daily living (ADL)s including transferring, dressing, toileting or incontinent care. R1's Service Agreement dated July 28, 2022, indicated the resident was able to walk independently with a walker, and required assistance with bathing, wellness checks, behavior management, and medication management and administration services. The service agreement indicated the licensee failed to include housekeeping services. The licensee failed to ensure R1's service agreement was updated following R1's pelvic fracture and change in condition with assessed increase in need for assistance. R1's Service Check Off List for August 2022, included wellness safety checks, however the resident continued to have frequent reoccurring falls, indicating the safety checks were not effective to reduce R1's falls. The service check off list failed to include R1's need for assistance and supervision with transfers, toileting, incontinence care, or dressing. On August 29, 2022, at 9:01 p.m. an incident	02310		

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02310	Continued From page 27 report indicated R1 sustained an unwitnessed fall after independently toileting and transferring herself back into her wheelchair. The incident report indicated R1 had limited mobility, was unable to walk following a recent fall with pelvic fracture and required the use of a wheelchair. The incident report indicated R1 was forgetful and continued self-transfer attempts and forgot to use wheelchair brakes. The incident report indicated a fall prevention plan was in place, but it did not include the use of R1's wheelchair. The incident report indicated R1 was instructed to not transfer herself, and staff were to encourage R1 to use a wheelchair at all times. On September 2, 2022, a hospice visit note indicated R1 was unable to walk, was incontinent, required a wheelchair, and assistance of one staff member to pivot transfer. The hospice visit note indicated this information was shared with the facility. On September 9, 2022, at 4:05 p.m., an incident report indicated R1 had an unwitnessed fall in the hallway. R1 said she saw something or a man running by on the floor, and she tried to climb up and around her wheelchair because she was scared. The report indicated R1 had nonsensical incoherent ramblings. The incident report indicated R1 had a history of falls, a recent fall resulting in a fractured pelvis, was weak, and required the use of a wheelchair at all times. The report further included R1 had impaired mental status, was impulsive, had poor safety awareness, and was non-compliant with the care plan. However, the care plan failed to indicate R1 was mobility impaired and required assistance with ADL's including transfers. The incident report indicated R1 was reminded to use a call light for assistance.	02310		

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02310	Continued From page 28 On September 11, 2022, at 9:45 p.m. an incident report indicated R1 had another fall in the outside designated smoking area. However, no smoking assessment was completed after the fall to determine if she was able to smoke independently or safely, despite staff's previous assessment on August 26, 2022, of the resident's change in need for assistance with cares. On September 14, 2022, a hospice nurse note included an assessment of R1's status, and indicated the resident required assistance with ADL's including bathing, dressing, grooming, housekeeping, and laundry related to physical impairment. On September 20, 2022, a hospice nurse note indicated collaboration and education was provided to facility staff and reinforced R1's need for assistance of one staff with transfers, related to low oxygen levels and pain from a recent pelvic fracture. On September 22, 2022, at 3:45 p.m. an incident report indicated R1 fell for the third time in the designated smoking area. The assessment indicated R1 had a change in her cognition and a decline related to end-of-life changes which caused delusions and hallucinations on a daily basis. The incident report indicated R1 had weakness, impaired mental status, and impaired safety and judgment. However, R1's care plan failed to indicate R1 was mobility impaired, required the use of a wheelchair, and assistance with ADL's including transfers. Although R1 had three falls in the designated smoking area, and physical and cognitive changes were identified, the licensee failed to re-assess R1's ability to smoke independently or safely.	02310		

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02310	Continued From page 29 On September 23, 2022, a hospice nurse note indicated when the nurse entered R1's room she was sitting in her room naked from the waist down crying, and verbalized being cold. The note indicated R1 was too weak to move without assistance from the hospice nurse, who assisted R1 to get cleaned up and dressed. The note indicated R1 was tearful and stated, "nobody here will help me like you just did, I need to leave here". On September 26, 2022, at 2:50 p.m. R1 had an unwitnessed fall in the common area. The report indicated interventions of keeping articles of need within easy reach, R1's bed in the low position, and wellness/safety checks. R1's care plan and service agreement failed to indicate R1 was cognitively impaired, mobility impaired, and required the use of a wheelchair, and assistance with ADL's including transfers. On September 27, 2022, a hospice nurse note indicated R1 was sitting hunched over at the end of her bed wearing the same clothing the nurse had dressed R1 in five days prior. The nurse documented R1's clothing was visibly soiled, and when the nurse asked why, R1 stated "nobody helps me here". The nurse documented assisting R1 with ADL's and the nurse observed several cuts and scrapes on both of R1's knees in various stages of healing, and three small, round, scabs that appeared to be cigarette burns. The note included concerns of R1 not receiving assistance with ADL's and the observed injuries including burns. These concerns were reported to the facility registered nurse (RN). The note indicated the RN reported R1 had services in her care plan for assistance from one staff with dressing and stated, "this is clearly not getting done".	02310		

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02310	Continued From page 30 On September 27, 2022, at 12:00 p.m. the staff RN documented in a progress note that a hospice nurse reported R1 had not had her clothes changed since last week. The note indicated services were added on that date to the services check list to provide R1 assistance with dressing needs, and to empty the commode, despite this being determined on the August 26, 2022, assessment. R1's September Service Check List indicated assistance with dressing was added on September 28, 2022, to be completed twice daily. The service check list was not updated until 31 days after completion of R1's change in condition assessment following a pelvic fracture. This assessment identified R1 required assistance with ADL's including transferring, toileting and incontinence care. R1's services were not updated until after the hospice nurse reported concerns the ADL's were not being completed. However, R1's increased need for assistance was not included on R1's services check list, care plan, or service agreement for staff's knowledge to implement. As a result, R1 continued to have numerous recurring falls. A smoking assessment dated October 3, 2022, completed seven days after the hospice nurse reported finding cigarette burns on R1's body, indicated R1 was unsafe to smoke independently and required staff supervision and an apron to smoke. On December 5, 2022, 11:22 a.m. during a tour, Administrator-G stated a smoking assessment should be completed upon on admission, quarterly, with any changes or decline, or if an injury occurred from smoking.	02310		

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02310	Continued From page 31 On December 5, 2022, at 11:51 a.m. during an entrance conference Administrator-G, Licensed Social Worker (LSW)-E, and registered nurse director of nursing (DON)-F, they stated R1 was admitted to the facility with hospice services, and at the time of admission was independent with walking using a walker. LSW-E indicated awareness R1 had cigarette burns because R1 picked at them. LSW-E stated after the fracture, R1 would frequently spill on her clothes. Administrator-G stated after R1's fall with pelvic fracture she continued to decline and became dependent on staff. On December 5, 2022, at 1:15 p.m. when interviewed, resident assistant (RA)-A stated R1 was independent when she was admitted and needed more help sometimes. RA-A stated R1 had behaviors and confusion, but did not recall R1 burning herself. RA-A indicated R1 was unsteady and would grab her own food and coffee and spill on herself. On December 5, 2022, at 1:00 p.m. RA-B stated R1 was independent on admission, then started declining. RA-B reported seeing cigarette burns on R1's body. RA-B thought the burns occurred when R1 was hunched over into her lap. RA-B stated R1 would often wear soiled clothing. On December 5, 2022, at 12:33 p.m. RA-C stated R1 was more independent when admitted. RA-C stated R1 was burning herself when smoking, and she had reported it to the nurse. On December 5, 2022, at 12:15 p.m. RA-D said R1 fell outside in the designated smoking area, and she frequently observed R1 in the same dirty clothing for days.	02310		

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02310	Continued From page 32 On December 22, 2022, at 3:23 p.m. hospice nurse (HN)-H stated R1 was admitted to the facility with hospice services. HN-H stated R1 started having recurring falls, then fell and sustained a pelvic fracture. HN-H indicated when R1 returned from the hospital she required assist with transfers, toileting, and was not able to walk and required a wheelchair for mobility. HN-H stated R1 reported asking facility staff for assistance, but no one would help her. HN-H stated staff did not provide ADL assistance to R1, and R1 was frequently observed in soiled incontinent clothing and appeared un-cared for, with dried incontinent stool on her body. HN-H stated one day R1 was sitting in her room crying naked from the waist down. HN-H stated R1 rang for assistance from staff, but they did not respond. HN-H stated she assisted R1 to get cleaned up and dressed, and the following week, found R1 in those same clothes, visibly soiled and R1 appeared un-cared for. HN-H stated she again assisted R1 with ADL's and observed multiple bruises and abrasions on both of R1's knees in various stages of healing, with three circular scabs that appeared to be cigarette burns. HN-H stated she reported her concerns that R1 was not receiving assistance with ADLs to staff, who responded, "if R1 can get up to smoke, she can get herself dressed". HN-H reported her concerns and the injuries including burns, to a facility RN who indicated R1 frequently dropped cigarettes in her lap but refused to use a smoking apron. HN-H stated what was most disturbing was when R1 was unresponsive and actively dying, she had flies crawling all over her body. HN-H stated R1 was often anxious and weepy, and the lack of support provided by staff, contributed to R1's distress at the end of her life. R1 feared that no one would help her.	02310		

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02310	Continued From page 33 On December 22, 2022, at 2:59 p.m. during an interview with R1's family member (FM)-I, they stated R1 had frequent and recurring falls, increased confusion, and physical decline after she fractured her pelvis. FM-I stated the facility did not provide hands-on care and assistance with ADL's and R1 needed more assistance than the facility was providing. FM-I stated R1 appeared disheveled, and her room was disgusting, with piles of urine-soaked clothing that was infested with flies. On December 23, 2022, at 9:36 a.m. during an interview with a corporate RN, and director of nursing (DON)- F, they stated a change of condition assessment should be completed following a return from the hospital. R1's assessment should have included assistance and supervision needed with ADLs after the pelvic fracture. DON-F stated after the assessment, the changes should have been implemented on the resident's service plan, service check list, and care plan immediately and communicated to staff. DON-F indicated if a resident had a significant change in condition like a pelvic fracture or decline in physical and cognitive changes like hallucinations, forgetfulness and frequent falls, she expected a smoking re-assessment was completed to ensure the resident was safe to continue smoking independently. The RN indicated a fly infestation was not acceptable, and indicated something should have been done right away, including assessment of the situation, room sweeps and ensuring the room was clean and tidy. The RN indicated maintenance and pest control should have been involved. The RN further stated just because R1 could propel herself,f did not mean she could complete her own ADL's.	02310		

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02310	Continued From page 34 Documentation for R1's skin and wound monitoring including bruising, abrasions, contusions, and cigarette burns were requested, however, none were received. The facility policy and procedure titled "Initial and Ongoing Nursing Assessment - under the comprehensive license" dated July 26, 2021, indicated: Section 1. a RN would complete a comprehensive nursing assessments of the resident's physical, mental, and cognitive needs with a change in resident condition. Section 3. indicated the assessment would include activities of daily living, including toileting pattern, bowel, and bladder control, dressing, grooming, bathing, and personal hygiene, mobility, including ambulation, transfers, and assistive devices. Section M. indicated the assessment would include risk indicators including smoking and the resident's ability to smoke without causing burns or injury to the resident. Although R1 had repeated falls in the designated smoking area, and despite the facility staff identifying contributing factors for falls, including changes in cognition related to the dying process causing delusions/hallucinations, and mobility impairment with decline following a pelvic fracture, the facility failed to ensure R1's increased need for assistance with ADL's was implemented on her service agreement, care plan, and/or communicated to staff . In addition, the facility failed to complete a smoking re-assessment after identifying R1 had physical and cognitive changes following recurring falls in the designated smoking area. As a result, R1 was injured when she continued to smoke	02310		

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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
02310	Continued From page 35 independently and was burned. Despite staff interviews who stated they knew the resident dropped her cigarettes and had burns on her body, R1's facility record lacked any documentation of R1's burns. Then, licensee failed to complete a smoking assessment until seven days after R1's cigarette burns were reported by the hospice nurse. The facility policy and procedure titled "Falls Prevention and Reduction" dated November 1, 2016, for a housing with services establishment/comprehensive homecare license indicated based on the RN's initial assessment of the client and any re-assessments, if the client was at risk for falls, the RN would conduct a fall assessment, evaluate potential interventions to reduce or eliminate the risk, and educate the client. Section 2. indicated the RN would identify hazards in the client's home and make recommendations to reduce the hazards. The RN would refer the client to appropriate resources (such as Senior LinkAge Line®) for assistance in addressing environmental hazards. Section 3. indicated the RN would incorporate any interventions to prevent or reduce the risk of falls into the client's care plan and would communicate these interventions to staff providing services to the client. The facility lacked an up-to-date policy with details to include what actions the facility would take when falls occurred including; identifying and communication to staff if a resident was at a risk for falls, documenting the incident, root cause analysis, monitoring the resident, and actions taken to prevent recurring falls. A facility policy and procedure titled "Safe Smoking Policy - Outdoors" dated February 24,	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32681	A. BUILDING: _____ B. WING _____	C 12/05/2022

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02310	Continued From page 36 2020, indicated a smoking assessment would be completed by an RN on admission, quarterly, and with any significant change in condition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure one of one of one residents reviewed, (R1) was free from maltreatment. R1 was neglected. 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. No plan of correction is required for this tag.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	