Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL355615562M
Compliance #: HL355617784C

Date Concluded: October 17, 2024

Name, Address, and County of Licensee Investigated:
Prairie Bluffs Senior Living
10300 Hennepin Town Rd
Eden Prairie, MN 55347
Hennepin County

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

Evaluator's Name:
Jana Wegener, 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 resident was neglected when the facility failed to timely assess the resident after a change in condition/function until 2 days later when the resident was transferred to the emergency department (ED).

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility failed to timely assess the resident after staff reported an elbow injury, and left leg/hip pain with a decline in function. As a result, the resident had a delay in care when she was not transferred to the ED until 2 days later where it was identified the resident sustained an open elbow laceration with exposed bone and hip fracture requiring hospitalization and surgical repair.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member. The investigation included review of the resident record(s), resident video surveillance photos, hospital/ED records, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed resident's and staff in the facility.

The resident resided in an assisted living facility memory care unit with diagnoses including memory loss, spinal stenosis - lumbar region, and intraparenchymal hemorrhage of the brain (a type of stroke caused by bleeding within the brain tissue).

The resident's assessment indicated the resident had intermittent confusion and was orientated to herself only. The assessment indicated the resident had no reports of pain in the last 7 days, and indicated staff should notify nursing of any changes in the resident's condition.

The resident's service plan indicated the resident was independent with bed mobility including getting in/out of bed, was independent with toileting, and independent with ambulation using a 2 wheeled walker. The service plan indicated staff were to remind the resident of mealtimes but indicated the resident was independent with going to the dining room.

The resident's individual abuse prevention plan (IAPP) indicated the resident was at risk for abuse due to memory impairment and dependence on others. The IAPP indicated the resident was at a risk for falls and indicated staff should monitor for changes in the resident's ability to walk and transfer and report changes in condition to nursing promptly.

A facility incident report completed 41 days after the incident occurred indicated at 5:00 p.m. the resident had fallen and was found on the floor by 2 staff in the dining room area with an abrasion to her left elbow. The resident was assisted off the floor by the staff. The incident report indicated first aide was provided and a band aide was applied to the resident's elbow injury. The incident report indicated the resident had increased pain/swelling to her left leg over the weekend and was sent into the ED for evaluation.

A facility investigation indicated 2 staff were observed on video surveillance find the resident, assisted the resident off the floor, and brought the resident to her room to be given a shower by one of the staff. When staff undressed the resident, they found a bleeding open injury on the resident's left elbow and called triage. The investigation included interviews with staff which indicated the day after the resident fell a facility nurse checked on the resident but was "unsure if the resident's leg was broken". The investigation indicated the nurse called triage, but triage was unable to reach the resident's family. The facility investigation indicated the following day (2 days after staff reported the elbow injury and pain) ULP staff again reported the resident had left leg pain to the facility nurse. The investigation indicated another staff also reported the resident had an open elbow injury noticed while assisting to change the resident's clothing. The facility investigation indicated the facility nurse was notified who observed the resident's left

leg to be swollen and painful. A triage progress note indicated the staff again called triage and reported the resident had complaints of severe pain and it appeared the resident's left elbow was dislocated. The triage note indicated the resident was transferred to the ED by ambulance. The facility investigation identified there was a delay in evaluation and treatment for the resident's severe injury.

The resident's service delivery of care record just after the fall occurred indicated staff documented the resident had refused her shower because she was in so much pain and indicated the triage nurse was notified.

The resident's progress notes, and triage nurses call log the day of the incident indicated staff had called triage after the fall incident occurred. The triage note indicated staff called and reported the resident had generalized pain, loose stools, and was coughing. Staff were instructed to give scheduled Tylenol and ibuprofen, encourage fluids, and monitor. The triage progress notes failed to include any documentation that staff reported the resident had an elbow injury, how the injury occurred, or that the resident had refused her shower due to being in so much pain. The triage nurses note failed to indicate any direction was given to staff for the resident's pain or elbow injury.

The following day a nurse's progress note indicated Unlicensed Personnel (ULP) staff asked the facility nurse to check on the resident due to complaints of pain. The nurse documented the resident was laying on her back in bed, and when asked how she was doing, the resident pointed to her left leg and stated she was hurt. A triage phone log indicated the nurse reported the resident had pain and sensitivity in the top of her leg. The triage log indicated the resident's family member was called and a voice mail was left to determine if they wanted the resident to go to urgent care or by ambulance. The resident record lacked any documentation of actions taken by the facility after triage nursing was unable to reach the resident's family. The resident record lacked documentation triage was contacted by the nurse that day, what actions were taken for the resident, and what direction was given to staff.

The resident's hospital medical record indicated the resident presented to the ED with left hip pain on admission and an open left elbow injury after having an unwitnessed fall at the facility. The hospital admission notes indicated the resident was unable to articulate her thoughts but complained of pain in her left elbow and hip on admission. The resident assessment indicated the resident's left lower extremity was slightly shortened and rotated with tenderness to palpation over the left hip area as well as with attempted range of motion of the left hip. The resident had an open wound to the left elbow with visible joint capsule present. The left elbow was tender to palpation and the resident had restricted range of motion.

The resident's ED/hospital record included photographs of the resident's elbow injury on arrival to the ED which showed a large wound across the elbow area with a dry scabbed abrasion surrounding a laceration wound that was open into the resident's elbow joint where white exposed bone and connective tissue could be visibly seen. A radiology report indicated the

resident had a laceration into the elbow, and a mildly displaced intertrochanteric left proximal femur fracture. The hospital record indicated the resident required surgical repair of her femur fracture, and an incision/drainage, intravenous antibiotics, and daily wound care for the open left elbow wound.

When interviewed one ULP staff stated they assisted the resident off the floor after the fall occurred, called triage, and reported the resident's elbow injury. The ULP stated triage instructed her to put a bandage on the resident's elbow but that did not seem right because the injury looked severe. The ULP indicated she took a picture of the resident's wound and sent it to nursing leadership so they could follow up on the wound the next day. The staff stated the elbow was bleeding and the injury looked deep like it needed more than a bandage. The ULP stated the resident also refused her shower due to complaints of severe pain, the triage nurse was notified, and the resident was assisted to bed.

Another ULP staff stated the morning after the incident occurred the resident required extensive assistance from 2 staff to get the resident out of bed into a wheelchair, then the resident refused to eat because she was in "too much pain" and was assisted back to bed. The ULP stated the resident appeared to be in pain, with a grimaced expression of pain on her face, and repeatedly yelled, "ouch, ouch!" when she was moved/touched which was not normal for her. The ULP stated he reported the concern to the facility nurse. The ULP stated the resident needed extensive assistance with everything which was not normal.

When interviewed a facility nurse stated the morning after the incident staff reported the resident was in pain. The nurse stated when she observed the resident, she had pants on and indicated she was unable to visualize the resident's body to assess for injuries because the resident refused, but indicated when she touched the resident's left leg the resident jumped, guarded the leg, and asked to be left alone. The nurse stated she was concerned the resident had an injury, did not move the resident, and called triage. The nurse stated she checked on the resident before she left for the day and the resident appeared to be resting. The following morning the nurse stated staff again reported the resident was unable to get out of bed because she was in too much pain. The nurse stated then she observed the resident's leg which appeared visibly swollen, and the resident moaned and jumped when she touched the leg. The nurse stated she suspected something in the resident's leg was broken. The nurse stated staff also reported the resident had a wound on her elbow, and when she observed the wound, she could see a big cut with visible bone exposed and the resident was transferred to the ED. The Nurse indicated had she observed the elbow injury with exposed bone (reported to triage the previous day) she would have sent the resident to the ED sooner.

Other ULP staff interviewed stated they also had reported the resident had hip and leg pain to nursing and triage. One staff stated the resident grabbed her hip/leg and said, "please don't touch me!", "help me they are killing me!" The staff stated the resident appeared to be suffering in pain, "begged for help" and appeared to be seriously injured, but no one did anything. The staff stated she thought the resident was going to be transferred to the ED the

previous day and was shocked when the resident was still in bed suffering in pain the following day. Another ULP indicated the resident was in severe pain, unable to move, and had several changes of clothing with blood soaked through in the elbow area found in her bathroom. The ULP stated the residents elbow injury was large, very obvious, with visible bone present which would have been seen when staff changed her clothing, but no one reported the resident had an injury. The ULP stated the resident was unable to sit up or move due to severe pain, which was not normal for her, but indicated no one reported any concerns.

The resident's medication administration record (MAR) indicated the resident was prescribed scheduled ibuprofen 400 milligrams (mg) twice daily, and as needed for pain (PRN). The resident's MAR lacked any orders for Tylenol, despite triage nursing documenting verbal instruction to administer Tylenol the day of the incident. Although the resident record, interviews with staff, and facility investigation indicated the resident repeatedly reported having severe pain, no PRN ibuprofen was administered to the resident, and there was no indication any action was taken to address the resident's complaints of pain including notifying the resident's provider until 2 days later when the resident was transferred to the ED.

The resident's service delivery of care record following the incident indicated staff failed to document changes in the resident's condition, need, and assistance provided after the incident occurred including documenting the resident was in bed, unable to ambulate, transfer, toilet herself, was totally dependent on staff, and had refused to get out of bed or eat due to severe pain.

During email communication and interviews nursing leadership verified that triage nursing staff was informed of the resident's elbow injury and refusal to have a shower the night of the incident due to being in so much pain. Nursing leadership denied being sent any pictures of the resident's elbow injury the night the incident occurred. Nursing leadership indicated although triage instructed staff to put a band aide on the resident's elbow, triage failed to document the resident's elbow injury, pain, refusal of care, or what direction was given to facility staff. Nursing leadership indicated after the fall occurred staff were verbally delegated to assist the resident with all cares despite no documentation of this occurring in the resident record. Nursing leadership indicated when the resident's pain did not subside after 2 days, and after the leg/hip area began to swell the resident was sent to the ED for evaluation.

When interviewed the resident's family member indicated although she found several changes of clothing with blood saturated through in the elbow area in the resident's bathroom, she was not aware the resident had any injuries until 2 days later when the ED called her. The family stated they reviewed the resident's room camera showed the resident crying in pain while holding her arm out after the fall incident occurred 2 days prior to the resident being transferred to the ED.

A review of family provided date/time stamped pictures (about 1 hour after the fall occurred) showed the resident with staff while seated in a wheelchair wearing a night gown. The resident

appeared to have a look of distress on her face while she held her arm off the arm of the wheelchair arm rest. The resident's nightgown sleeve was pushed up and the resident appeared to have a gauze type dressing secured with paper tape on the elbow area.

The facility investigation and resident record indicated despite staff reporting the resident had severe pain, refused cares due to pain, and had an elbow injury to triage, and change in function the record lacked any documentation this occurred for staff to follow up on. As a result, the facility took no action to assess the resident's injuries, pain, or changes in function until 2 days later.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
Neglect means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: No, not interviewable.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: N/A

Action taken by facility:
Facility staff communicated the resident's elbow injury, pain, and refusal of care to triage nursing. 2 days later when the facility nurse observed the resident's elbow injury with exposed bone and left leg swelling, the resident was transferred to the ED for evaluation and treatment of her injuries. The facility provided education to staff on the facility fall protocol.

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
Hennepin County Attorney
Eden Prairie City Attorney
Eden Prairie Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35561	A. BUILDING: _____ B. WING _____	C 09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE BLUFFS SENIOR LIVING	10300 HENNEPIN TOWN ROAD EDEN PRAIRIE, MN 55347

(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: #HL355615562M/#HL355617784C On September 25, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 130 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL355615562M/#HL355617784C, tag identification 1500, 2310 and 2360.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must	01500		

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01500	Continued From page 1 complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must	01500		

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01500	Continued From page 2 include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure all employees had at least eight hours of annual training for each 12 months of employment that included required training on reporting of maltreatment of vulnerable adults, resident bill of rights, Alzheimer's dementia and related disorders, and training on the licensee policies and procedures for falls under section 626.557 for one of one employees, unlicensed personnel (ULP)-A, with employee records reviewed. This had the potential to affect all 130 residents receiving care from the licensee. 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 the potential to	01500		

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01500	Continued From page 3 affect a large portion or all of the residents). The findings include: On September 25, 2024, at 2:52 p.m. during an entrance conference email communication, unlicensed personnel ULP-A's personnel files, training, and annual training records were requested to review. ULP-A's personnel files indicated she was hired and began orientation training on June 3, 2022. On June 3, 2022, ULP-A's training record included documentation of completing maltreatment VA training, there was no documentation provided showing ULP-A had completed the training annually as required. On June 3, 2022, ULP-A's training record included documentation of completing a review of the resident's bill of rights, there was no documentation provided showing ULP-A had completed the training annually as required. A review of ULP-A's personnel file and training records failed to indicate ULP-A had any dementia Alzheimer's disease, or related disorders training upon hire or annually. The investigator requested ULP-A's training on the licensee's falls protocol and how to respond in the event of a fall, a blank falls training form was provided which included the licensee's falls protocol which included instructions to ensure the resident was safe, calling the nurse before moving the resident, obtaining vital signs, and reporting the fall to oncoming shift for ongoing observation. Documentation of ULP-A completing the falls training was again requested. Registered	01500		

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01500	Continued From page 4 Nurse Director of Nursing (RNDON)-D provided documentation of ULP-A completing a fall risk/prevention posttest. The fall risk/prevention posttest did not include any of the previously provided falls training form instructions and had no information about how to respond in if/when a fall occurred, including what actions to take, or the process/procedure for reporting a fall or completing an incident report. The investigator requested incident reports completed by ULP-A to review for competency of the licensee's policy and procedure with falls protocol. The RNDON-D provided several fall incident reports which indicated ULP-A had provided information for the incident report but had not completed any of the fall incident reports provided. As a result, the documentation provided failed to show ULP-A was competent prior to the incident, and there was no indication ULP-A had ever completed a fall incident report. On September 25, 2023, at 2:30 p.m. during entrance conference RNDON-D stated after the resident fall incident with serious injuries was not reported by ULP-A they had re-educated all staff on falls and walked them through what to do and when to call 911. The licensee provided a post incident re-education falls training following the fall incident with severe injury. The document included a handwritten date indicating the training was completed during a stand-up meeting on August 29, 2024. The documentation provided included the licensee's fall incident report form and an employee sign off sheet which was signed by 19 employees who attended the training. The licensee employee roster included 91 active/oncall employee names indicating not all	01500		

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01500	Continued From page 5 employees were re-educated on the licensee falls protocol and procedure as indicated by RNDON-D during the entrance conference. On October 2, 2024, at 10:02 a.m. ULP-A stated she had worked at the facility for over 2 years. ULP-A stated she had not received any training on dementia and did not recall any annual training on vulnerable adult/maltreatment. When asked about falls training ULP-A stated she had previous experience but had not received any training for what to do or how to respond to a resident that had fallen since she was hired by the licensee. ULP-A stated she had never seen an incident report to complete if a fall occurred. On October 3, 2024, at 2:56 p.m. ULP-F stated unlicensed staff do not report things like falls because they do not know the process. ULP-F stated dementia care training for staff was very poor and indicated staff assumed a resident who had severe pain due to serious injuries was just having behaviors. On October 8, 2024, at 4:24 p.m. during email communication when asked how the licensee ensured staff completed required training at the time of employment and annually, RNDON-D responded that staff go through orientation, skill competencies & floor training upon hire. RNDON-D provided the annual training policy below, and indicated staff utilized Educare but no Educare training records were provided for ULP-A. On October 9, 2024, at 8:47 a.m. during email communication RNDON-D and the Executive Director were informed of concerns with ULP-A having no annual training. The director responded the licensee tracked Educare monthly;	01500		

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01500	Continued From page 6 bi-monthly; and at end or year. The director indicated she reviewed compliance, and indicated when new hires started, they required all Educare to be completed to ensure requirements are met upon hire. The director indicated they assigned annual courses every other month, reminded staff, set deadlines for completion, and had staff come in to work to complete the required training if they were nearing their deadline. No annual training documentation was provided for ULP-A. A facility policy and procedure titled "Orientation and Training", dated August 1, 2021, indicated all staff would complete required training at the time of orientation. A facility policy and procedure titled " Orientation and Training - Annual Required Training", dated August 1, 2021, indicated all staff performing direct care services would complete at least 8 hours of annual training for every 12 months of employment. The policy indicated the licensee would keep a training record and track to ensure compliance with annual training requirements. The policy indicated the following training elements MUST be included every 12 months for staff who provide direct care services: 1. Training on reporting of maltreatment of vulnerable adults under section 626.557 2. Review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights 3. Review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment;	01500		

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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
01500	Continued From page 7 disinfecting environmental surfaces; and reporting communicable diseases 4. Effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders 5. Review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures 6. Principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. In addition to the topics listed above, annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: 1. An explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication 2. Health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression 3. Information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. No further information provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	01500		

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	35561	A. BUILDING: _____ B. WING _____	C 09/25/2024

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02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to provide appropriate care, services, and timely assessment after staff reported the resident had an elbow injury, and left leg/hip pain with a decline in function for one of one residents (R1). R1 was harmed when she was not transferred to the emergency department (ED) for evaluation and treatment of her injuries until 2 days later, R1 sustained an open elbow laceration with exposed bone and hip fracture requiring hospitalization and surgical repair. 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). Findings include: R1 was admitted to the licensee on August 30, 2022, with diagnoses including memory loss, spinal stenosis - lumbar region, and intraparenchymal hemorrhage of the brain (a type of stroke caused by bleeding within the brain	02310		

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02310	Continued From page 9 tissue). R1's 90 day assessment dated May 19, 2024, indicated R1 had intermittent confusion and was orientated to herself only. The assessment indicated R1 had no reports of pain in the last 7 days, and indicated staff should notify nursing of any changes in R1's condition. R1's service plan updated last on August 6, 2024, indicated R1 was independent with bed mobility including getting in/out of bed, independent with toileting, and independent with ambulation using a 2 wheeled walker. The service plan indicated staff were to remind R1 of mealtimes but indicated R1 was independent with going to the dining room. R1's individual abuse prevention plan (IAPP) indicated R1 was at risk for abuse due to memory impairment and dependence on others. The IAPP indicated R1 was at a risk for falls and indicated staff should monitor for changes in R1's ability to walk and transfer and report changes in condition to nursing promptly. On September 26, 2024, a facility incident report completed by Registered Nurse Director Of Nurses (RNDON)-D (41 days after the incident occurred) indicated on August 16, 2024, at 5:00 p.m. R1 had fallen and was found on the floor by 2 staff in the dining room area with an abrasion to her left elbow. R1 was assisted off the floor by the staff. The incident report indicated first aide was provided and a band aide was applied to R1's elbow injury. The incident report indicated R1 had increased pain/swelling to her left leg over the weekend and was sent into the ED for evaluation. An undated facility investigation indicated 2 staff	02310		

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02310	Continued From page 10 were observed on video surveillance find R1, then assisted R1 off the floor without calling triage to report the fall. R1 was then brought to her room to be given a shower by one of the staff who undressed R1 and found a bleeding open injury on R1's left elbow and called triage. The investigation included interviews with staff which indicated the day after R1 fell a facility nurse checked on R1 but was "unsure if R1's leg was broken". The investigation indicated the nurse called triage, but triage was unable to reach R1's family. The facility investigation indicated the following day (2 days after staff reported the elbow injury and pain) ULP staff again reported R1 had left leg pain to the facility nurse. The staff also reported they noticed an open elbow injury while assisting to change R1's clothing. The facility investigation indicated the facility nurse was notified who observed R1's left leg to be swollen and painful. A triage progress note indicated the facility nurse again called triage and reported R1 had complaints of severe pain and it appeared R1's left elbow was dislocated. The triage note indicated R1 was transferred to the ED by ambulance. R1's service delivery of care record on August 16, 2024, at 6:30 p.m. unlicensed personnel (ULP)-A documented R1 refused her shower because she was in so much pain and indicated the nurse was notified. On August 16, 2024, at 8:15 a.m. a triage call log indicated ULP-A called and reported R1 had generalized pain, cough and loose stools. The log indicated staff were instructed to give R1's scheduled Tylenol and Ibuprofen, encourage fluids, and monitor. R1's progress notes lacked documentation of staff calling triage at 8:15 a.m. for concerns with R1.	02310		

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02310	Continued From page 11 On August 16, 2024, at 6:18 p.m. a triage nursing progress note indicated staff called and reported R1 had generalized pain, loose stools, and was coughing. Staff were instructed to give scheduled Tylenol and ibuprofen, encourage fluids, and monitor. The triage progress note failed to include any documentation ULP-A reported R1 had an elbow injury, how the injury occurred, or that R1 had refused her shower due to being in so much pain. The triage nurses note failed to indicate any direction was given to staff for R1's pain or elbow injury. On August 17, 2024, at 1:57 p.m. Licensed Practical Nurse (LPN)-C documented in a progress note at about 1:20 p.m. staff asked for LPN-C to check on R1 due to complaints of leg and back pain. LPN-C documented upon arrival R1 was in bed laying supine, asked how she was doing and R1 replied her leg hurt, and pointed to her left leg. LPN-C documented upon examining leg pain R1 reported pain to touch and with moving the leg but had no visible bruises or discoloration. On August 17, 2024, at 2:10 p.m. the triage call log indicated LPN-C called triage and reported R1 had pain and sensitivity on the top of her leg. The log indicated family was called to determine if R1 should be sent to urgent care or by ambulance. The log indicated R1's provider was not notified. The resident record lacked any documentation of actions taken by the facility after triage nursing was unable to reach R1's family. R1's record lacked documentation triage was contacted by the nurse that day, what actions were taken for R1, and what direction was given to staff from triage.	02310		

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02310	Continued From page 12 On August 18, 2024, at 9:13 a.m. the triage call log indicated unlicensed personnel (ULP)-F called and reported R1 was in severe pain, and R1's elbow appeared to be popped out, the facility nurse LPN-C was aware. At 9:26 a.m. the call log indicated ULP-F called triage again and reported R1 had pain in her leg and stated "it felt like the bone was sticking out" of the wound on R1 elbow. The log indicated staff was instructed to call 911. On August 18, 2024, at 9:22 a.m. a triage progress note indicated they had received a call from staff who reported R1 was having severe pain and it appeared R1's elbow was dislocated, R1 was taken to the ED by ambulance. R1's outside medical hospital/ED record from August 18, 2024, indicated R1 presented to the ED with left hip pain on admission and an open left elbow injury after having an unwitnessed fall at the facility. The hospital admission notes indicated R1 was unable to articulate her thoughts but complained of pain in her left elbow and hip on admission. R1's assessment indicated R1's left lower extremity was slightly shortened and rotated with tenderness to palpation over the left hip area as well as with attempted range of motion of the left hip. R1 had an open wound to the left elbow with visible joint capsule present. The left elbow was tender to palpation and the resident had restricted range of motion. R1's ED/hospital record included photographs of the elbow injury on arrival to the ED which showed a large wound across the entire elbow area with a dry scabbed abrasion surrounding a laceration wound that was open into R1's elbow joint where white exposed bone and connective tissue of R1's elbow could be visibly seen. A radiology report indicated R1 had a laceration into the elbow, and a mildly displaced intertrochanteric left	02310		

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02310	Continued From page 13 proximal femur fracture. The hospital record indicated R1 required surgical repair of her femur fracture, and an incision/drainage, intravenous antibiotics, and daily wound care for the open left elbow wound. On October 2, at 10:02 a.m. ULP-A stated they (ULP-A and ULP-B) assisted R1 off the floor after the fall occurred, called triage, and reported R1's elbow injury, pain, and refusal to shower due to so much pain. ULP-A stated triage instructed her to put a band aide on R1's elbow but that did not seem right, the wound looked more severe. ULP-A stated triage did not ask any questions about what happened to R1, or about the wound, just said put a band aide on it. The ULP indicated she took a picture of R1's elbow wound and sent it to Registered Nurse Assistant Director of Nursing (RNADON)-N so they could follow up on the wound the next day. ULP-A stated the elbow was bleeding, looked deep like it needed more than a band aide. ULP-A stated R1 also refused her shower due to complaints of severe pain, the triage nurse was notified, and R1 was assisted to bed. On October 2, 2024, at 10:37 a.m. ULP-G stated the morning after the incident occurred R1 required extensive assistance from 2 staff to get out of bed into a wheelchair, then R1 refused to eat because she was in "too much pain" and was assisted back to bed. ULP-G stated R1 appeared very painful, with a grimaced expression of pain on her face, and repeatedly yelled, "ouch, ouch!" when she was moved/touched which was not normal for her. The ULP stated he reported the concern to Licensed Practical Nurse (LPN)-C. ULP-G stated R1 needed extensive assistance with everything which was not normal.	02310		

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02310	Continued From page 14 On October 1, 2024, at 1:11 p.m. LPN-C stated the morning after the incident staff reported R1 was in pain. The nurse stated when she observed R1, she had pants on and indicated she was unable to visualize R1's body to assess for injuries because R1 refused but indicated when she touched R1's left leg R1 jumped, guarded the leg, and asked to be left alone. The nurse stated she was concerned the resident had an injury, did not move R1, and called triage who said let's wait and see. The nurse stated she checked on R1 before she left for the day and R1 appeared to be resting. LPN-C stated the following morning staff again reported R1 was unable to get out of bed because she was in too much pain. LPN-C stated she then observed R1's leg which appeared visibly swollen, and R1 moaned and jumped when she touched R1's leg. LPN-C stated she suspected something in R1's leg was broken. LPN-C stated staff also reported R1 had a wound on her elbow, and when she observed the wound, she could see a big cut with visible bone exposed and R1 was transferred to the ED. LPN-C indicated had she observed R1's elbow injury with exposed bone (reported to triage the previous day) she would have sent R1 to the ED sooner. LPN-C indicated she did not know R1 well, and indicated if she had known R1 was usually independent and ambulatory she would have sent R1 in to the ED. LPN-C indicated R1 appeared very fragile, and was completely dependent on staff, and indicated what she observed was very different from R1's baseline. On October 3, 2024, at 2:56 p.m. ULP-F stated she reported R1 had hip and leg pain to LPN-C and triage. ULP-F stated R1 grabbed her hip/leg and said, "please don't touch me!", "help me, they are killing me!" ULP-F stated R1 was suffering in pain "begged for help" and appeared to be	02310		

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02310	Continued From page 15 seriously injured, but no one did anything. ULP-F stated after she reported R1 had severe pain to LPN-C and triage she was told R1 was going to be transferred to the ED and was shocked when R1 was still in bed suffering in pain the following day. ULP-F stated she had reported other resident wounds and had sent pictures to nursing leadership in the past and was instructed to delete them. On October 3, 2024, at 3:49 p.m. ULP-E stated R1 was in severe pain, unable to move, and she had found several changes of clothing with dried blood soaked through in the elbow area in R1's bathroom. ULP-E stated R1's elbow injury was large, very obvious, with visible bone present which would have been seen when staff changed her clothing, but no one reported R1 had an injury. ULP-E stated R1 was unable to sit up or move due to severe pain, which was not normal for her, but indicated no one reported any concerns. ULP-E stated R1 was crying in pain saying, "its broken, its broken!" and R1's leg was swollen. ULP-E stated several staff shift to shift over 2 days would have noticed R1 had a change in function/condition, severe pain, and a bleeding open elbow wound, but no one reported any concerns. R1's medication administration record (MAR) for August 2024, indicated R1 was prescribed scheduled ibuprofen 400 milligrams (mg) twice daily, and as needed for pain (PRN). R1's MAR lacked any orders for Tylenol, despite triage nursing documenting verbal instructions were given to administer Tylenol the day of the incident. Although R1's record, interviews with staff, and facility investigation indicated R1 repeatedly reported having severe pain, no PRN ibuprofen was administered to R1, and there was	02310		

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02310	Continued From page 16 no indication any action was taken to address R1's complaints of pain including notifying R1's provider prior to being transferred to the ED 2 days later. R1's service delivery of care record and progress notes following the incident indicated staff failed to document any changes in R1's condition, need, and assistance provided after the incident occurred including documenting R1 was in bed, unable to ambulate, transfer, toilet herself, was totally dependent on staff, and had refused to get out of bed or eat due to severe pain. On September 25, 2024, at 2:30 p.m. during an entrance conference RNDON-D stated ULP-A failed to report R1 had fallen to nursing triage the night the incident occurred. RNDON-D indicated she observed facility video which showed 2 staff (ULP-A and ULP-B) had found then assisted R1 off the floor without calling triage first. RNDON-D stated R1 received no PRN medication for pain, and indicated triage tried to reach out to the family on August 17, 2024, with no response. Facility video surveillance from the fall incident was requested, but not provided. RNDON-D stated there was no video evidence saved from the incident. On October 1, 2024, at 12:58 p.m. during email communication RNDON-D verified that triage nursing staff was informed of R1's elbow injury and refusal to have a shower the night of the incident due to being in so much pain. RNDON-D indicated although staff were instructed to put a band aide on R1's elbow injury, triage nursing staff did not document R1's elbow injury, pain, refusal of care, or what direction was given to staff. RNDON-D indicated after the fall occurred staff were verbally delegated to assist R1 with all	02310		

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02310	Continued From page 17 cares despite no documentation of this occurring in R1's record. RNDON-D indicated when R1's pain did not subside after 2 days, and after the leg/hip area began to swell R1 was sent to the ED for evaluation. On October 2, 2024, at 1:37 p.m. RNADON-N denied being sent any pictures of R1's elbow injury from ULP-A the night the incident occurred. When asked did anyone follow up on R1's elbow injury after it was reported to triage on August 16, 2024? RNADON-N stated she was not sure there was any note in R1's record. RNDON-N stated anytime staff called triage was required to put a progress note in the resident's record so that nursing onsite knows to follow up. RNADON-N stated staff should document and report any changes in the resident's including providing additional care service toileting using a wheelchair or increased assistance with transfers. RNADON-N indicated if staff failed to do so a change in the resident's condition may be missed. On October 1, 2024, at 11:00 a.m. R1's family member indicated although she found several changes of clothing with blood saturated through in the elbow area in R1's bathroom, she was not aware R1 had any injuries until 2 days later when the ED called her. The family stated they reviewed R1's room camera which showed R1 crying in pain while holding her arm out after the fall incident occurred 2 days prior to R1 being transferred to the ED. A review of family provided date/time stamped pictures (about 1 hour after the fall occurred) showed R1 with ULP-A while seated in a wheelchair wearing a night gown. R1 appeared to have a look of distress on her face while she held her arm off the arm of the wheelchair arm rest. R1's nightgown sleeve was	02310		

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02310	Continued From page 18 pushed up and R1 appeared to have a gauze type dressing secured with paper tape on the elbow area. The undated facility investigation and resident record indicated despite staff reporting R1 had severe pain, refused cares due to pain, and had an elbow injury to triage, and change in function the record lacked any documentation this occurred for staff to follow up on. As a result, R1 had a delay in care and treatment of her injuries when the licensee took no action to assess R1's injuries, pain, or changes in function until 2 days later. The facility policy and procedure titled "Incident Report" dated August 1, 2024, indicated an incident report form should be completed to document any incident involving a resident, visitor, or staff. In the event of an accident, injury an incident report form must be turned into the Supervisor or Assisted Living Director. If a resident is involved in any incident, their responsible person must be notified to let them know of the occurrence. If the incident happens outside of business hours, the person completing the incident report must notify the responsible person and then notify the RN on-call and the Assisted Living Director, as appropriate. When in doubt of the severity of an incident or injury, call 911. All incident reports related to residents will be kept in their records. The incident report policy failed to include information on the process to notify triage of a resident incident, and what steps to take including when to assist the resident off the floor, what to report to triage, and who was responsible to document information in the resident record including assessment of the resident's injuries and direction given to staff.	02310		

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02310	Continued From page 19 The facility policy and procedure titled "Emergency 911" dated August 1, 2021, indicated 911 would be summoned for assistance and aid when handling emergency situations. The policy examples of events or circumstances which warrant notification of 911 included: - If the resident was bleeding severely - If a fracture was suspected - If the resident was unable to move one or more limbs The policy and procedure indicated if there was any doubt regarding the seriousness of the resident's condition, 911 would be called. The facility policy and procedure failed to direct staff to call triage vs. calling 911 in an emergency, and there was no direction to indicate 911 would not be called if a resident's family member could not be reached. The facility policy and procedure titled "Resident Record - Documentation" dated August 1, 2024, indicated staff would document in a resident record all medications, services, treatments, and therapies for each resident. PROCEDURE Indicated: 1. Staff providing assisted living services will document, daily, medications, services, treatments, or therapies provided to resident. 2. All documentation must include the signature and title of the person who performed the service or administered the medication, treatment or therapy. Initials may be used if there is a completed signature page included in the documentation. 5. All tasks not performed or administered must be reported and followed up on to meet the resident's needs. The facility policy titled "Resident Change in Condition or Need", dated January 1, 2024,	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35561	A. BUILDING: _____ B. WING _____	C 09/25/2024

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02310	Continued From page 20 indicated the licensee would conduct initial reviews and scheduled assessments and monitoring as required. And, when changes in condition or need are identified, a Registered Nurse would initiate a change in condition assessment. The assessment may be limited to only those issues where a change has been identified. The policy defined a change in condition as "A clinically important deviation from a patient's baseline in physical, cognitive, behavioral, or functional domains that is not defined as acute or is expected based on relevant diagnosis and history". A facility policy and procedure titled "Fall Incident and Procedure" dated March 8, 2023, indicated all occurrences of falls would be reported, assessed, documented, and investigated by a licensed nurse. A fall was defined as failure to maintain an appropriate lying, sitting, or standing position, resulting in an individual's abrupt, undesired relocation to a lower level. An episode in which a resident lost his/her balance and would have fallen, were it not for staff interventions, is also considered a fall. The procedure in the event of a fall as follows: Unlicensed Staff: 1. Do not move them. 2. Ask resident if they are hurt 3. Observe for: a. Responsiveness of client b. Any bleeding c. Head or neck injury d. Pain or discomfort 4. Check vital signs (blood pressure, temperature, respirations, pulse, oxygen saturation and blood sugar if diabetic) 5. Call the on-call nurse for direction: May consider using face time with on-call. If nurse	02310		

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02310	Continued From page 21 does not answer or call back within 10 min, complete the following: a. Check range of motion (ability to move upper and lower extremities). If they complain of pain or show nonverbal signs of pain during range of motion, STOP. b. If the client states they are not hurt, and no injury is visible, then the staff may assist client to location of their choice. c. Report the fall to the nurse on-site or on-call, and oncoming staff. d. If client states they are hurt, cannot stand or walk, the HHA will contact the nurse on-site for further directions. If the nurse is not on-site, then 911 will be activated, the on-call nurse to be notified, and HHA will contact the family if directed by license nurse. e. The HHA will document the fall on the communication board and complete an Fall incident report as completely as possible. Licensed Staff: 1. The nurse is responsible for completing an investigation of the fall, which includes: a. Comprehensive review of incident (what happened, where it happened; root cause analysis) b. Review medical diagnoses. c. Review current medications and medication changes d. Review H & P (is there a history of falls) No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	02310		
02360	144G.91 Subd. 8 Freedom from maltreatment	02360		

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02360	Continued From page 22 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		