Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL360217667M
Compliance #: HL360214421C

Date Concluded: January 16, 2024

Name, Address, and County of Licensee Investigated:
The Preserve of Roseville
2600 Dale Street North
Roseville, MN 55113
Ramsey County

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

Evaluator's Name: Brandon Martfeld, RN BSN
Special Investigator

Finding: Substantiated, facility responsibility

Nature of Investigation:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
The facility neglected a resident when the facility failed to follow the resident's plan of care, which resulted in the resident having falls with injuries over the course of three weeks, hospitalizations, a decline in health and was not able to return to the facility.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The resident sustained an unspecified number of falls over the course of one month, resulting in injuries and hospitalizations. The facility failed to provide documentation to assist in the investigation including incident reports, assessments, progress notes, care plans and/or service plans for the resident. There was no evidence the facility reassessed the resident following falls with injuries and implemented interventions to ensure the resident's safety and prevent future falls. The facility failed to provide accurate and complete staff contact information for previous staff so it could not be determined which staff were assisting the resident when the falls/injuries occurred.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also interviewed family members. The investigation included review of resident's medical records, facility schedules, hospital records, and facility policies. Also, the investigator completed a facility tour.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia, abnormalities of gait and mobility, and spondylosis (degeneration of bones and discs of the neck.) The resident's service plan provided by the facility was dated prior to the first fall with injury and included assistance with toileting, transfers, and wheelchair mobility. The resident's care plan indicated the resident was wheelchair bound and at high risk for falls.

The resident's hospital record indicated the resident was evaluated at the hospital after falling forward out of her wheelchair onto her face. The resident required a nose clamp for a bloody nose and returned to the facility the same day.

Approximately three weeks later, the resident's hospital record indicated the resident arrived at the hospital with left leg pain and an increased inability to transfer. The hospital record indicated the resident fell that same day when ambulating to the bathroom with staff. The resident complained of right and left leg pain following the fall. The hospital record also indicated the resident had multiple falls over two weeks and was unable to stand one day. The resident was diagnosed with both a right and left pelvic fractures. A non-surgical treatment plan was developed for the resident including physical therapy and the resident returned to the facility.

Two days after the resident was discharged from the hospital, the resident's hospital record indicated the resident arrived back at the hospital due to altered mental status, escalating behaviors, encephalopathy (group of conditions that caused brain dysfunction), and failure to thrive. The resident continued to decline during the hospital stay. Following eight days of hospitalization, the resident was transferred to a facility that provided a higher level of care.

Although requested, the facility failed to provide the investigator any information regarding the resident's falls including incident reports, a completed assessment following the resident's injuries and change in condition, updated fall interventions, and any care plan changes for the resident to ensure the resident's health and safety.

During an interview, unlicensed personnel (ULP) stated the resident required assistance from staff with dressing, toileting, and used a wheelchair for mobility. The ULP stated the resident often put her feet down on the ground when pushed in the wheelchair, to stop the wheelchair. The ULP stated staff were to use foot pedals when the resident was in the wheelchair for the resident's safety.

During an interview, another ULP stated the resident required two staff to assist with cares. The ULP stated one day the resident fell out of the wheelchair and the ULP assisted the resident following the fall. The ULP stated the resident was lying in the middle of the hallway, face down, bleeding from the nose. The ULP stated the staff member that cared for her, said the resident just stood up. The ULP stated the resident standing up did not sound right, because the resident took her time and would not just stand up quickly.

During an interview, a former nurse stated he completed an investigation following the resident's fall out of the wheelchair. The former nurse stated the resident fell forward out of the wheelchair when staff failed to use foot pedals on the resident's wheelchair. The former nurse stated the resident put her feet on the floor with the wheelchair in motion causing the fall out of the wheelchair. The staff member was suspended from the facility. The former nurse could not recall details of the falls that led to the resident's pelvic fracture.

During an interview, leadership stated she and the current nurse for the facility were hired after the resident's falls and they were not able to provide any documentation on the resident from that time.

During an interview, family members (FM)s stated one day facility staff contacted them and reported the resident fell out of the wheelchair. The FMs stated staff were to place foot pedals on the wheelchair when escorting the resident any distance. The FM stated without foot pedals, the resident placed her feet on the floor to stop the wheelchair. The FM stated, after the resident fell out of the wheelchair, the resident's knees hurt, and she did not walk any more. The FM stated approximately three weeks later, the facility called and stated when staff were assisting the resident to the bathroom, the resident did not want to walk and sat down on her butt. The following day, a family member visited the resident, and the resident was in a lot of pain. The FM stated the resident would not stand up to go to the bathroom. The resident was sent to the hospital and diagnosed with a pelvic fracture. The resident was sent back to the assisted living and continued to decline. The FM stated two days later, the facility arranged for the resident to be evaluated at a hospital.

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 able to due to cognition.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility sent the resident to the hospital.

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
Ramsey County Attorney
Roseville City Attorney
Roseville Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36021	A. BUILDING: _____ B. WING _____	C 11/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PRESERVE OF ROSEVILLE	2600 DALE STREET NORTH ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** HOME CARE PROVIDER/ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL360217507M/#HL360214095C #HL360217667M/#HL360214421C On November 27, 2023, 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 34 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL360217507M/#HL360214095C and #HL360217667M/#HL360214421C, tag identification 620, 720, 750, 1760, 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 License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.	
0 620 SS=D	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma (a) The assisted living facility must comply with	0 620		

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

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0 620	Continued From page 2 reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to submit a report within 24 hours to the Minnesota Adult Abuse Reporting Center (MAARC) for two of two residents (R1 and R2). The licensee failed to submit a MAARC report for R1, when R1 was not provided the medication Rivaroxaban (blood thinner) which resulted in R1 developing blood clots. In addition, the licensee failed to submit a MAARC report for R2, when R2 had multiple falls which resulted in injuries. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	0 620		

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0 620	Continued From page 3 The findings include: R1's face sheet dated June 23, 2022, indicated the resident's diagnoses included dementia, stroke and pulmonary embolism (blood clots of the lung). R1's service plan dated June 15, 2023, indicated R1 required assistance with medication administration. R1's assessment dated June 15 ,2023, indicated R1 had cognitive impairment. R1's July 2023, medication administration record (MAR) indicated the resident was to receive Rivaroxaban medication (blood thinner) 10 milligrams (mg) every evening. In the 24 days R1 was at the facility in July, 2023, R1 missed 20 doses of the medication. R1's hospital records dated July 25, 2023, indicated R1 arrived at the emergency room due to chest pain. R1's hospital record indicated R1 had pulmonary embolisms (blood clots) in both lungs and blood clots in both legs due to missed doses of Rivaroxaban. R1 was hospitalized for 35 days. During an interview on November 29, 2023, at 3:41 p.m., regional operations specialist-E stated she was aware R1 did not receive Rivaroxaban for a number of days because there was a delay in reordering the medication. No MAARC report was filed by the licensee for R1. R2's care plan dated June 17, 2023, and face	0 620		

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0 620	Continued From page 4 sheet indicated the resident's diagnoses included dementia, abnormalities of gait and mobility and spondylosis (term for wear and tear of the spinal disks), was wheelchair bound, and at high risk for falls. R2's service plan dated June 17, 2023, indicated R2 needed assistance with toileting, transfers, and wheelchair mobility. R2's hospital records dated June 30, 2023, indicated R2 sustained a bloody nose after falling forward from the wheelchair and required emergency medical services to clamp her nose. R1 required an evaluation at the hospital. R2 returned to the licensee on June 30, 2023. R2's hospital record indicated R2 returned to the hospital on July 23, 2023, due to left leg pain and an inability to stand. R2's hospital record indicated R2 had multiple falls over two weeks. R2 was diagnosed with right and left pelvic fracture and discharged from the hospital to the facility on July 25, 2023. R2's hospital records indicated on July 27, 2023, the resident arrived at the hospital due to altered mental status, escalating behaviors, encephalopathy (broad term for any brain disease that alters brain function or structure), and failure to thrive. On August 10, 2023, R2 discharged from the hospital to a different care facility that was able to provide a higher level of care. During an interview on December 22, 2023, at 12:34 p.m., RN-F stated when R2 fell out of her wheelchair, a facility investigation was completed. RN-F stated a staff member did not use the foot pedals on the wheelchair and the resident fell out of the wheelchair. The staff member was	0 620		

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0 620	Continued From page 5 suspended from the facility. No MAARC report was filed by the licensee for R2 falls with injuries. The licensee's Abuse/Neglect policy revised June 8, 2017, indicated the purpose of the policy was to ensure that all residents are treated with respect and dignity and live in a community that is free of abuse and neglect by any person. The policy indicated all allegations of abuse will be treated serious and will be investigated, documented, and reported as per State or Federal regulations, whichever is more stringent. The policy and procedure failed to address specific actions for staff in relation to neglect of a resident and the specific time frame to report maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). The licensee's Accidents and Incidents policy dated June 8, 2017, indicated the purpose of the policy was to establish guidelines for reporting, investigating and documenting incidents and accidents and to improve the quality of care and services by identifying causes. The policy indicated all incidents will be tracked and trended to assist in identify patterns or trends. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 620		
0 720 SS=F	144G.43 Subd. 2 Access to records The facility must ensure that the appropriate records are readily available to employees and contractors authorized to access the records.	0 720		

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0 720	Continued From page 6 Resident records must be maintained in a manner that allows for timely access, printing, or transmission of the records. The records must be made readily available to the commissioner upon request. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide requested records during a complaint investigation for two of two residents (R1 and R2) and for one of one employee, registered nurse (RN)-F reviewed. This failure had the potential to affect the health, safety, and welfare of all the residents. 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's face sheet dated June 23, 2022, indicated the resident's diagnoses included dementia, stroke and pulmonary embolism (blood clots of the lungs). R1's service plan dated June 15, 2023, indicated R1 required assistance with medication administration. R1's assessment dated June 15, 2023, indicated R1 had cognitive impairment.	0 720		

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0 720	Continued From page 7 Review of R1's July 2023, medication administration record (MAR) indicated R1 was to receive Rivaroxaban (blood thinner) medication 10 milligrams (mg) every evening. In the 24 days R1 was at the facility in July, R1 missed 20 doses of the Rivaroxaban. Documentation provided by family member (FM)-C, indicated Rivaroxaban was not available on July 17, 2023, and July 22, 2023. There was no further documentation as to why R1 missed doses of Rivaroxaban. R1's hospital records dated July 25, 2023, indicated R1 arrived at the emergency room due to complaints of chest pain. R1's hospital record indicated R1 had pulmonary embolisms (blood clots) in both lungs and blood clots in both legs due to missed doses of Rivaroxaban. R1 was hospitalized for 35 days. On November 27, 2023, at 9:15 a.m., all documents for R1 were requested through email from licensed assisted living director (LALD)-G. During an interview on November 29, 2023, at 3:41 p.m., regional operations specialist-E stated she was aware R1 did not receive Rivaroxaban for number of days because there was a delay in reordering the medication. The licensee did not provide R1's progress notes, incident report, internal investigation or documentation of why medication was not provided. R2's care plan dated June 17, 2023, and face sheet indicated R1's diagnoses included dementia, abnormalities of gait and mobility and spondylosis (term for wear and tear of the spinal	0 720		

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0 720	Continued From page 8 disks), was wheelchair bound, and a high risk for falls. R2's service plan dated June 17, 2023, indicated R2 required assistance with toileting, transfers, and wheelchair mobility. R2's hospital records dated June 30, 2023, indicated R2 sustained a bloody nose after falling forward from a wheelchair that required emergency medical services to clamp her nose and transport her to the emergency room. R2 returned to the facility. R2's hospital record indicated R2 returned to the hospital on July 23, 2023, due to left leg pain and an inability to stand. R2's hospital record indicated R2 had multiple falls over the past two weeks. R2 was diagnosed with right and left pelvic fractures and was discharged from the hospital on July 25, 2023. R2's hospital records indicated on July 27, 2023, R2 arrived back to the hospital due to altered mental status, escalating behaviors, encephalopathy (broad term for any brain disease that alters brain function or structure), and failure to thrive. On August 10, 2023, R2 discharged from the hospital to a different facility able to provide R2 with a higher level of care. During an interview on December 4, 2023, at 10:38 a.m., licensed assisted living director (LALD)-G stated her, and the nurse were hired after the resident's falls and injuries and had limited documentation on R2. The licensee failed to provide progress notes, incident reports or assessments following any of R2's falls with injury.	0 720		

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0 720	Continued From page 9 On November 30, 2023, at 7:04 a.m., RN-F's contact information, completed training, background study, and job description were requested by the investigator to the facility. The licensee failed to provide RN-F's employee records to include: - background study, - current job description, including qualifications, responsibilities, and identification of staff persons - all training documentation. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 720		
0 750 SS=D	144G.43 Subd. 5 Record retention Following the resident's discharge or termination of services, an assisted living facility must retain a resident's record for at least five years or as otherwise required by state or federal regulations. Arrangements must be made for secure storage and retrieval of resident records if the facility ceases to operate. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to maintain resident records for at least five years for two of two residents (R1 and R2) reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	0 750		

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0 750	Continued From page 10 cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On November 27, 2023, at 9:15 a.m., the investigator requested licensed assisted living director (LALD)-G to provide documentation for R1. The facility failed to provide the investigator with R1's progress notes, individual abuse prevention plan (IAPP), incident report, facility internal investigation, and documentation of rationale for medications not being given. On November 27, 2023, at 9:19 a.m., the investigator requested LALD-G to provide documentation for R2. The facility failed to provide the investigator R2's incident reports, assessment that was in effect for July of 2023, progress notes, and IAPP. During an interview on December 4, 2023, at 10:38 a.m. LALD-G stated all the documentation the investigator received was everything that could be found at the licensee. No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days.	0 750		
01760 SS=J	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the	01760		

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	36021	A. BUILDING: _____ B. WING _____	C 11/27/2023

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01760	Continued From page 11 resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure each medication was available and administered as prescribed for one of one resident's (R1) reviewed. The facility failed to administer R1's scheduled blood thinner medication, which caused R1 to have pulmonary embolisms in both lungs and blood clots in both legs. This practice resulted in a level four violation (a violation that results in serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's face sheet dated June 23, 2022, indicated the resident's diagnoses included dementia, stroke, and pulmonary embolism (blood clots of the lung). R1's service plan dated June 15, 2023, indicated	01760		

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01760	Continued From page 12 R1 required assistance with medication administration. R1's assessment dated June 15 ,2023, indicated R1 had cognitive impairment. R1's July 2023, medication administration record (MAR) indicated R1's provider order included Rivaroxaban (blood thinner) 10 milligrams (mg) medication every evening. The MAR indicated in the 24 days R1 was at the facility in July, 2023, R1 missed 20 doses of Rivaroxaban without an explanation for the missed doses. R1's hospital records dated July 25, 2023, indicated R1 arrived at the emergency room with complaints of chest pain. R1's diagnoses included blood clots in both lungs and legs. R1's provider contacted the facility questioning the development of blood clots when R1 was prescribed blood thinner medication. Facility staff reported to the provider that R1 had missed 10 doses of Rivaroxaban with no other additional information provided. R1 was diagnosed with pulmonary embolisms in both lungs and blood clots in both legs due to missed doses of Rivaroxaban. R1 required hospitalization for 35 days. During an interview on November 29, 2023, at 3:41 p.m., the regional operations specialist-E stated she was aware R1 did not receive Rivaroxaban for number of days because there was a delay in reordering the medication. During an interview on November 30, 2023, at 8:10 a.m. (FM)-C stated a doctor was concerned because R1 was on a blood thinner medication and should not have developed blood clots. FM-C stated the doctor called the facility, found out R1	01760		

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01760	Continued From page 13 had missed several doses of the blood thinner medication. The doctor told FM-C the error could have been fatal for R1. The licensee did not provide R1's progress notes, incident report, internal investigation or documentation of why medication was not provided. The licensee's policy titled Medication Management and Documentation dated March 4, 2020, indicated medication with a current, active order cannot be located in the medication cart/drawer, other areas of the medication cart, medication room, and community are searched. If the medication cannot be located after further investigation, the Health Service Director is contacted for additional instructions. The policy further indicated if a dose of regularly scheduled medication is withheld, refused, not available, or given at a time other than the scheduled time, the space provided on the front of the medication administration record (MAR) for that dosage administration is initialed and circled. An explanatory note is entered on the reverse side of the record or in the exception notes files of the electronic MAR. If medication doses are withheld, or not available the physician is notified. Document the notification and physician response. No further information was provided. Time period for correction: Seven (7) days	01760		
02310 SS=J	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted	02310		

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02310	Continued From page 14 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 care and services according to acceptable health care and medical, or nursing standards for one of one residents (R2) with records reviewed. The licensee failed to reassess and develop new interventions following falls with injury to prevent future falls and ensure the health and safety of R2. R2 suffered pelvic fractures due to the falls. This practice resulted in a level four violation (a violation that results in serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's care plan dated June 17, 2023, and face sheet indicated the resident's diagnoses included dementia, abnormalities of gait and mobility and spondylosis (term for wear and tear of the spinal disks), required a wheelchair for mobility, and at a high risk for falls. R2's care plan indicated the resident was wheelchair bound and a high risk for falls. R2's service plan dated June 17, 2023, indicated R2 required staff assistance with toileting, transfers, and wheelchair mobility.	02310		

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02310	Continued From page 15 R2's hospital records dated June 30, 2023, indicated R2 sustained a bloody nose after falling forward from the wheelchair and required emergency medical services to clamp her nose and transport to the emergency room. R2 returned to the licensee on June 30, 2023. R2's hospital record indicated R2 returned to the hospital on July 23, 2023, due to left leg pain with an inabilty to stand. R2's hospital record indicated R2 had multiple falls over two weeks. R2 was diagnosed with right and left pelvic fractures and was discharged from the hospital on July 25, 2023. R2's hospital records dated July 27, 2023, indicated R2 arrived at the hospital due to altered mental status, escalating behaviors, encephalopathy (broad term for any brain disease that alters brain function or structure), and failure to thrive. On August 10, 2023, R2 discharged from the hospital to a different care facility able to provide R2 with a higher level of care. During an interview on December 4, 2023, at 10:38 a.m., licensed assisted living director (LALD)-G stated both she and the nurse were hired after the resident's incidents and had limited amount of documentation on R2. During an interview on December 8, 2023, at 11:17 a.m., (FM)-H stated after R2 fell out of the wheelchair, R2's knees hurt, and she did not walk any more. FM-H stated approximately three weeks later, the facility called and stated R2 did not want to walk and sat down on her butt. The next day, the FM-H visited the R2 and found R2 in a lot of pain. R2 would not stand up to go to the bathroom. R2 returned to the hospital and was diagnosed with pelvic fractures. R2 returned to	02310		

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02310	Continued From page 16 the assisted living, refused to eat and required an evaluation at the hospital two days later. R2 discharged from the hospital to a different facility. During an interview on December 22, 2023, at 12:34 p.m., registered nurse (RN)-F stated documentation was completed by paper. RN-F stated the facility did not use electronic documentation at that time. RN-F stated when R2 fell out of her wheelchair, a facility investigation was completed. RN-F stated a staff member did not use the foot pedals on the wheelchair and the resident fell out of the wheelchair. The staff member was suspended from the facility. RN-F could not recall details of R2's falls that led to the pelvic fracture. The licensee failed to provide progress notes, incident reports and assessments following any of R2's falls with injuries to include interventions developed to ensure R2's health and safety. The licensee's policy titled Fall Risk dated June 8, 2017, indicated all memory care residents will have their risk evaluated on intervals per the state regulations and interventions implemented and placed on their individualized service plan. The policy further indicated when a resident falls staff were to: 1. Administer first aid and take the resident's vitals 2. notify the medical doctor and family 3. place the resident on alert charting and on the 24-hour report 4. complete an incident report 5. assess for a need in change of status 6. implement fall prevention interventions and interim service plan No further information was provided.	02310		

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02310	Continued From page 17 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: The facility failed to ensure two of two resident reviewed (R1 and R2) were free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		