DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306911442M
Compliance #: HL3069112613C

Date Concluded: February 17, 2023

Name, Address, and County of Licensee Investigated:
Brookdale Eden Prairie
7513 Mitchell Road
Eden Prairie, MN 55344
Hennepin County

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

Evaluator's Name: Michele R. Larson, RN
Special Investigator

Finding: Inconclusive

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

Initial Investigation Allegation(s):
The facility neglected the resident when they failed to provide supervision and safety checks during the night. Staff found the resident lying face down on the floor during morning shift change. The resident had been on the floor for an undetermined amount of time. It was reported the resident was not checked on during the overnight shift.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. Although staff failed to document they performed safety checks during the night she fell, the resident's progress note indicated unlicensed personnel (ULP) #1 said he checked on the resident around 5:40 a.m., and numerous staff stated safety checks were automatically performed for all residents.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator reviewed the resident's facility and hospital

records, and facility policies and procedures. Also, the investigator observed direct care staff performing resident cares during the onsite investigation.

The resident resided in a memory care assisted living facility for 10 days before the incident. The resident's diagnoses included dementia. The resident's record indicated the resident received assistance with escorts to and from meals and activities and assist with her activities of daily living (ADL's) as needed (PRN). The resident used a wheeled walker for mobility. The resident's assessment indicated the resident was vulnerable and unaware of her safety concerns.

The resident's record indicated the resident was found face down on her apartment floor by a ULP during shift change one early spring morning. The resident complained of right shoulder pain. Facility staff were unable to get the resident off the floor. Staff called 911 and the resident transported to a local hospital. The resident's family member was notified.

The resident's hospital record indicated the resident arrived at the hospital at 9:04 a.m. The resident was diagnosed with a fractured left shoulder. Emergency medical service (EMS) indicated the resident's bed was unmade and her pants were soiled. EMS indicated facility staff documented the resident was last checked at 8:00 p.m. the night before and thought the resident did not receive her nighttime medications. EMS noted there was an imprint on the resident's right side of her face. The resident was discharged to a local transitional care unit (TCU) facility for rehabilitation of her fractured left shoulder. The resident transferred to a long-term care facility after her discharge from the TCU.

A resident's progress note indicated ULP#1 stated he last checked on the resident at 5:40 a.m., and observed the resident was still in her bed.

Review of the resident's fall risk assessment indicated the resident was assessed as a high fall risk, based upon the resident's risk factors such as new admission, cognitive decline, vision deficits, incontinence, impaired hearing, previous history of falls, and diagnosis of osteoporosis.

Review of the resident's facility nurse assessment indicated the resident had two to five falls in the past 12 months and remained a high fall risk due to her history of falls. Staff were to encourage the resident's use of a call pendant cord for staff assistance.

The resident's service delivery record lacked evidence the resident received did not receive any safety checks and did not receive all her scheduled service as required in her service plan.

During an interview, an administrative staff person stated staff performed nightly safety checks at least every two hours, and more often if the resident was in isolation or quarantine. The administrative staff person stated although staff did document services, they did not document nightly safety checks because it was not required to do so. The administrative staff person

stated the resident was “very” independent, stating, “if she wasn’t in her room, she was out in the common area or dining room.”

During an interview, a facility nurse stated resident care plans were implemented on a daily sheet to alert ULP to resident care needs. The facility nurse stated resident ADL sheets were required to be signed by ULP before their shift ended but stated nurses did not check to see if ULP signed the ADL sheets. The facility nurse stated safety checks were supposed to be performed every two hours, stating, “it’s written in their care plans, it’s a standard for us.”

During an interview, ULP#1 stated not everybody documented services were completed, stating, “it’s hard sometimes when you are by yourself.” ULP#1 stated he checked on the resident around 5:00a.m., stating her lights were on and saw the resident wore street clothes while she laid in her bed.

During an interview, ULP#2 stated staff used to document services on a daily check off list but stated that stopped but was unsure when that occurred. ULP#2 stated resident cares were either brought up in stand-up meetings during shift change reports or written down. ULP#2 stated, “documenting was too time consuming, stating, “there are so many things you have to do.” ULP#2 stated there were resident “sheets” that were written out and “things” on resident care plans, but stated, “once you know them you really don’t look at them anymore.” ULP#2 stated she no longer looked at the resident sheets or care plans, stating, “you just learn.”

During an interview, an administrative nurse stated facility nurses performed fall risk management reports. The administrative nurse stated residents assessed as a high fall risk were not capable of moving safely on their own and required safety checks a minimum of every two hours. The administrative nurse stated ULP were supposed to document overnight safety checks on resident ADL sheets and initial the safety checks were performed every two hours. The administrative nurse stated it was difficult for ULP to manually document and check-off every service, stating, “it’s a compliance thing.” The administrative nurse stated a facility nurse needed to check resident ADL sheets and if there were spots not initialed the nurse needed to do constant reminders to the ULP. The administrative nurse stated it was more difficult for the facility since they used paper charting.

During an interview, the resident’s family member stated overall she was happy with the cares the resident received at the facility even though she was unsure if the resident received escort services.

During an interview, a family friend stated she would “pop” in to see the resident. The family friend stated there were a few times when she found the resident wandering in the hallway by herself. The family friend stated, “I would direct her to the dining room and help her with her meals. Sometimes I would find her unsure where the dining room was and unsure if she had eaten.”

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

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

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. Unable due to the resident's diagnosis of dementia.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not applicable.

Action taken by facility:
The facility immediately called 911 when they found the resident and immediately filed a MAARC report.

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

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

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

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

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30691	A. BUILDING: _____ B. WING _____	C 11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EDEN PRAIRIE	7513 MITCHELL ROAD EDEN PRAIRIE, MN 55344

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL306912613C/#HL306911442M On November 3, 2022, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 28 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL306912613C/#HL306911442M, tag identification 510, 1620, 1640.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that	0 510		

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0 510	Continued From page 1 complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observations, interview and record review, the facility failed to establish and maintain an effective infection control program that complied with accepted health care, medical and nursing standards per the Centers for Disease Control (CDC) guidelines. This had the potential to affect all 28 residents who resided in the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The CDC guideline titled, Environmental Cleaning Procedures, dated April 21, 2020, indicated ROUTINE CLEANING AND DISINFCTING RESIDENT SHARED AREAS	0 510		

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0 510	Continued From page 2 On November 3, 2022, at 9:40 a.m., the Minnesota Department of Health (MDH) investigator entered the facility. On November 3, 2022, at 9:59 a.m., an entrance conference was initiated with the director of nursing (DON)-A. DON-A stated there were 28 residents who resident in the assisted living facility with dementia care (ALFDC). The investigator handed DON-A a list of requested documents. On November 3, 2022, at 10:05 a.m., the MDH investigator and DON-A began a tour of the facility. DON-A stated resident's rooms contained bathrooms but no showers. DON-A stated there were two shower rooms for the 28 residents located in different areas of the facility. DON-A stated residents showered between two to three times per week, depending on the resident's level of care. DON-A stated resident's shower days alternated so residents did not all shower on the same days. During the tour, DON-A stated shower rooms were cleaned daily. On November 3, 2022, at 10:10 a.m., the MDH investigator requested to see a shower room. DON-A unlocked shower room #1's door which opened up into a large bathroom. The MDH investigator observed a toilet, sink, mirror, and a rattan vanity with four drawers that was placed next to the sink. The top of the vanity had partial pieces of paper towels. The MDH investigator observed the inside of the toilet bowl had a line of brown around the rim of the water. Debris of paper and dirt were scattered around the floor and around the base of the toilet. The investigator observed the entire mirror was covered with water stains.	0 510		

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0 510	Continued From page 3 On November 3, 2022, at 10:15 a.m., DON-A and the MDH investigator entered shower room #2. The investigator observed a wood shelving unit with five shelves. The top shelf had a plastic medication up that was tipped on its side. A washcloth was next to the cup. The MDH investigator observed the shelf below had a dirty hair comb that contained yellow hairs in between the teeth. The floor next to the shelves had a brown stain. The investigator observed debris and hair on the shower room floor. A white shower chair was in the shower. The investigator observed dried feces on the shower floor underneath the shower chair. DON-A stated, "we are in the process of hiring a housekeeper. We haven't had one in for two months. Staff try to clean when they can." The MDH investigator obtained 19 photos of shower room #1 and shower #2 as evidence for the facility's lack of proper cleaning and disinfecting of shared resident areas. On November 27, 2022, at 10:27 a.m., DON-A stated the facility did not have a cleaning schedule but tried to have staff "clean when they can." DON-A stated, "I agree, we need to do better." On November 3, 2022, at 2:43 p.m., the MDH investigator advised DON-A, licensed assisted living director (LALD)-B, and regional registered nurse (RN)-C, an infection control citation would be issued to the facility. The licensee policy titled, Infection Control, dated February 2018, indicated the licensee followed infection control practices for the surveillance, prevention, and control of disease and infection,	0 510		

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0 510	Continued From page 4 consistent with the federal Centers for Disease Control (CDC) prevention guidelines and the federal Occupational Safety and Health Administration (OSHA) bloodborne pathogens and regulations. TIME PERIOD TO CORRECT: Two (2) days.	0 510		
01620 SS=I	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the	01620		

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01620	Continued From page 5 licensee failed to ensure a registered nurse (RN) routinely assessed residents after falls for three of four residents (R2, R3, R4) with records reviewed. As a result, R2, R3, R4 were not assessed for causal fall factors and implement new fall interventions to prevent reoccurrences. 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). Findings Include: R2 R2's medical record was reviewed. R2 admitted to the facility on January 21, 2022. R2's diagnoses included Alzheimer's and Parkinson's disease. R2 was not always oriented to place or time and had difficulty communicating his needs and preferences verbally and non-verbally. R2's fall risk assessment dated June 14, 2022, at 3:15 p.m., indicated R2 was assessed as a high fall risk based upon three levels due to: 6 falls in past 12 months, incontinence; toileting assistance; difficulty walking and transferring; unsteadiness; Parkinson's disease; prescribed antidepressant; and cognitive decline. R2's fall assessment indicated he had not sustained injuries during his falls. R2's service plan dated October 19, 2022, indicated R2 received assistance with personal cares, medication management, toileting, meals,	01620		

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01620	Continued From page 6 and escorts. R2 required assistance from two staff persons for all transfers. R2 walked short distances using a four-wheeled walker and a manual wheelchair for mobility. R2's service plan indicated R2 was a high fall risk due to multiple falls since his admission to the facility. The facility implemented universal fall precautions for R2 and all residents of the facility which included, familiarizing R2 with the call system with a return demonstration. R2's service indicated R2 experienced falls in the past twelve months but did not sustain any injuries. Review of the facility's fall reports indicated between May 2, 2022, through October 26, 2022, R2 fell 11 times, including three with injuries. R2's fall report dated May 15, 2022, at 12:35 p.m. R2 had a laceration to his forehead, skin tear, and abrasion after he fell out of his wheelchair. R2 received outside treatment at an urgent care. R2's progress note dated May 15, 2022, at 3:09 p.m., completed by licensed practical nurse (LPN)-C, indicated R2 sustained a laceration above his left eyebrow after he had an unwitnessed fall off his wheelchair. LPN-C applied a steri-strip and obtained vital signs. R2's record lacked evidence an RN reassessed him after he fell on May 15, 2022. R2's fall report dated July 11, 2022, at 10:40 a.m., R2 was found on the floor inside apartment. R2 had an abrasion to skull. Nurse notified. R2 was treated at an outside facility. R2's progress note dated July 11, 2022, at 11:00 a.m., indicated R2 scraped his head on a wall as he fell to the floor. R2 denied pain.	01620		

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01620	Continued From page 7 R2's record lacked evidence an RN reassessed him after he fell on July 11, 2022. R3 R3's medical record was reviewed. R3 admitted to the facility on January 29, 2018. R3's diagnoses included unspecified dementia. R3 experienced difficulty with orientation to person, place, and time. R3's fall assessment dated July 12, 2022, at 11:51 a.m., indicated R3 was assessed as a high fall risk due to the following factors: difficulty with ambulation and transfers, unsteadiness when ambulating, prescribed anti-depressant/anxiety/psychotic medications, and cognitive decline. R3's fall risk assessment indicated she did not have a fall with injuries in the 12 months prior to July 12, 2022. Review of the facility's fall report indicated between May 6, 2022, and October September 14, 2022, R3 fell 13 times. R3's progress note dated August 25, 2022, at 2:25 p.m., written by LPN-C, indicated R3 lost her balance and fell. R3 sustained injuries to her ribs, right hip, and knee. R3 yelled out in pain when LPN-C tried to adjust her feet position, indicating, "she let out a huge yell, so maybe she is in pain." R3's record lacked evidence an RN reassessed him after she fell on August 24, 2022. R3's service plan dated October 10, 2022, indicated R3 received assistance with personal cares, laundry, housekeeping, and escorts. R3 used a manual wheelchair for mobility.	01620		

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01620	Continued From page 8 R3's 90- day assessment dated October 10, 2022, indicated R3 required physical assistance to and from the dining room and/or activities. R3's 90-day assessment inaccurately indicated R3 had two to five reported falls prior to October 10, 2022, and one fall that required a hospital stay. R3 had a fall mat on the floor next to her bed. R3's fall report dated October 16, 2022, at 11:55 a.m., and 2:40 p.m. indicated R3 had a bump noted on her forehead, skin tear, and redness/swelling to right hand, forehead, wrist. R3 was assessed by the hospice nurse. R3 received treatment at the hospital. R3's fall report dated October 26, 2022, at 11:45 a.m., indicated R3 had a head injury, and redness to her forehead. R3 was assessed by the hospice nurse. R4 R4's medical record was reviewed. R4 admitted to the facility on August 16, 2021. R4's diagnoses included unspecified dementia, history of falling, restlessness/agitation, and orthostatic hypotension. R4 experienced difficulty with person, place, and time. R4's assessment dated March 1, 2022, indicated R4 required physical assistance going to and from dining room. R4's assessment indicated R4 had two to five reported falls in the past 12 months. The box indicating, "fall with harm/injury with outside treatment" (urgent care, doctor's office, EMT) was unchecked. R4's fall report dated June 17, 2022, at 10:50 a.m., R4 had left forearm pain and a skin tear. R4 received treatment at a hospital.	01620		

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01620	Continued From page 9 R4's progress note dated June 17, 2022, at 1:17 p.m., indicated R4 sustained a large skin tear to his left forearm after he fell inside his apartment. R4's skin tear measured 7" (L) x 3" (NW). R4 complained of severe pain in his arms. R4 was transported to an emergency room (ER) for treatment. R4's record lacked an assessment following R4's fall on June 17, 2022 and return from the ER. R4's fall risk assessment dated June 27, 2022, indicated R4 was assessed as a high fall risk due to the following factors: incontinence, assistance with toileting, vision deficits, difficulty with ambulation and transfers, unsteadiness when ambulating, and cognitive decline. R4's fall risk assessment indicated R4 had 17 falls without injury and experienced a fall with injury on an unknown date in the past 12 months prior to June 27, 2022. Review of the facility's fall report indicated between May 6, 2022, and September 26, 2022, R4 fell 14 times. R4's record failed to include a 90-day assessment due September 27, 2022 and failed to include a review of multiple falls. Review of the facility's fall report indicated between September 30, 2022, and October 22, 2022, R4 fell 5 times. R4's record failed to include a RN assessment regarding R4's 5 falls in one month. R4's service plan dated November 28, 2022, indicated R4 received assistance with personal	01620		

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01620	Continued From page 10 cares, medication management, meals, and as needed (PRN) escorts. R4 used a four-wheeled walker and a manual wheelchair for mobility. On December 30, 2022, at 9:00 a.m., RN-H stated most RN duties focused on assessments, including admit, 14-day, 90-day, and change in condition. RN-H stated residents who were assessed as a high fall risk required transfer assistance and were not deemed capable of safely moving on their own. The licensee policy titled Evaluation Policy, updated August 2021, indicated an RN would reassess a resident as soon as possible after a change in condition that resulted in altered care needs. TIME PERIOD TO CORRECT: Seven (7) days.	01620		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan.	01640		

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01640	Continued From page 11 (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure three of four residents (R2, R3, R4) with records reviewed, received all scheduled services as indicated in their records. In addition, R2, R3, R4's service plans were not updated to include new fall preventions after numerous falls with 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings Include: R2 R2's medical record was reviewed. R2 admitted to the facility on January 21, 2022. R2's diagnoses included Alzheimer's and Parkinson's disease. R2 was not always oriented to place or time and had difficulty communicating his needs and preferences verbally and non-verbally. R2's fall risk assessment dated June 14, 2022, at 3:15 p.m., indicated R2 was assessed as a high fall risk due to the following factors: 6 falls in past 12 incontinence; toileting assistance; difficulty	01640		

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01640	Continued From page 12 ambulating and transferring; unsteadiness; Parkinson's disease; prescribed antidepressant; and cognitive decline. R2's fall assessment indicated he had not sustained injuries during his falls. Review of the facility's fall report indicated between May 2, 2022, and October 26, 2022, R2 fell 11 times, including three with injuries. R2's service plan dated October 19, 2022, indicated R2 received assistance with medication management and toileting, and as needed (PRN) assistance with escorts and transfers. R2 walked short distances using a four-wheeled walker and a manual wheelchair for mobility. R2's service plan included universal fall precautions implemented in all resident service plans. The universal fall precautions included, familiarizing residents with the call system with a return demonstration, but no individualized specific interventions. R2's record indicated R2's service plan was updated on the following dates: January 21, 2022 (initial), February 21, 2022, June, 14, 2022, and October 19, 2022. R2's service plan lacked evidence new fall interventions were implemented. R2's service delivery record indicated between May 2022, and November 2022, R2 did not receive all of his scheduled services. In addition, R2's November 2022 service delivery record indicated R3 did not receive any services. R2 received only two nighttime safety checks on June 4, 2022, and July 25, 2022. R3	01640		

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01640	Continued From page 13 R3's medical record was reviewed. R3 admitted to the facility on January 29, 2018. R3's diagnoses included unspecified dementia. R3 experienced difficulty with orientation to person, place, and time. R3's fall assessment dated July 12, 2022, at 11:51 a.m., indicated R3 was assessed as a high fall risk due to the following factors: difficulty with ambulation and transfers, unsteadiness when ambulating, prescribed anti-depressant/anxiety/psychotic medications, and cognitive decline. R3's fall risk assessment indicated she did not have a fall with injuries in the 12 months prior to July 12, 2022. Review of the facility's fall report indicated between May 2, 2022, and October 26, 2022, R3 fell 17 times, including five with injuries R3's 90- day assessment dated October 10, 2022, indicated R3 required physical assistance to and from the dining room and/or activities. R3's 90-day assessment indicated R3 had two to five reported falls prior to October 10, 2022, and one fall that required a hospital stay. R3 had a fall mat placed on the floor next to her bed. R3's service plan dated October 10, 2022, indicated R3 received total assistance with personal cares, medication management, laundry, housekeeping, toileting and escorts. R3 walked with the assist of one staff person and used a manual wheelchair for mobility. R3's service plan indicated R3 was a high fall risk due to multiple falls since his admission to the facility. R3's service plan included universal fall precautions included in all resident service plans. The universal fall precautions included, familiarizing residents with the call system with a	01640		

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01640	Continued From page 14 return demonstration. R3's service indicated R3 experienced falls in the past twelve months but did not sustain any injuries. R3's service plan was updated on the following dates: January 3, 2022, April 14, 2022, April 18, 2022, July 10, 2022, and October 10, 2022. R3's updated service plans included universal fall precautions the facility implemented for all residents, but no individualized specific interventions. R3's service plan lacked evidence new fall interventions were implemented. R3's service delivery record indicated between May 2022, and November 2022, R3 did not receive her required scheduled services of dressing/grooming, continence cares, and escorts, and received only one nighttime safety check on July 25, 2022. In addition, R3's November 2022 service delivery record indicated R3 did not receive any scheduled services. R4 R4's medical record was reviewed. R4 admitted to the facility on August 16, 2021. R4's diagnoses included unspecified dementia, history of falling, restlessness/agitation, and orthostatic hypotension. R4 experienced difficulty with person, place, and time. R4's assessment dated June 27, 2022, indicated R4 was assessed as required as needed (PRN) physical assistance with personal cares, toileting, and going to and from dining room. R4's assessment indicated R4 had two to five reported falls in the past 12 months since his March 1, 2022 assessment. The box indicating, "fall with harm/injury with outside treatment" (urgent care,	01640		

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01640	Continued From page 15 doctor's office, EMT) was unchecked. R4's fall risk assessment dated June 27, 2022, indicated R4 was assessed as a high fall risk due to the following factors: incontinence, assistance with toileting, vision deficits, difficulty with ambulation and transfers, unsteadiness when ambulating, and cognitive decline. R4's fall risk assessment indicated R4 had 17 falls without injury and no falls with injury in the past 12 months since June 27, 2022. Review of the facility's fall report indicated between May 2, 2022, and October 26, 2022, R4 fell 19 times, including three with injuries. R4's record indicated R4's service plan was updated on the following dates: March 1, 2022, June 27, 2022, and November 28, 2022. R4's service plan dated November 28, 2022, indicated R4 received PRN assistance with personal cares, meals, escorts, and rising from a sit-to-stand position. R4 received assistance with medication management, laundry, housekeeping, and toileting, R4 used a four-wheeled walker and a manual wheelchair for mobility. R4's service plan indicted he was independent with transfers but due to his increased falls during the night, staff would increase his overnight checks to insure he was toileted often. R4's service plan included universal fall precautions included in all resident service plans. The universal fall precautions included, familiarizing residents with the call system with a return demonstration, but no individualized specific interventions. R4's service plans lacked evidence new fall interventions were implemented.	01640		

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01640	Continued From page 16 R4's service delivery record indicated between May 2022, and November 2022, R4 did not receive his required services. R4 received only one nighttime safety check on June 4, 2022. On December 27, 2022, at 4:00 p.m., unlicensed personnel (ULP)-G stated the residents had sheets that were written out in addition to their care plans. ULP-G stated she no longer looked at the resident's care plans or service delivery records stating, "once you know them you don't really look at them anymore. We have meetings every day." On December 30, 2022, at 9:00 a.m., registered nurse (RN)-H stated the facility RN developed and updated service plans. RN-H stated facility RN's also conducted fall risk reports. RN-H stated a resident who was assessed as a high fall risk meant the resident required transfer assistance due to not being able to safely move on their own. RN-H stated high fall risk residents required safety checks every two hours at a minimum. RN-H stated it was difficult for ULP to manually check off every service for their residents, stating, "it's a compliance thing." RN-H stated the nurse needed to check resident's activities of daily living (ADL) sheets and look to see if there were spots that were not initialed. If there were, the nurse would need to do constant reminders. RN-H stated, "it's harder for this facility since it's all on paper. Other assisted living facilities have a tablet with them and check off services as they do it. Logs the exact time." On January 31, 2023, at 2:00 p.m., ULP-I stated there was a resident book located either in the laundry or break room. ULP-I stated services were checked off when they were completed but stated not everyone checked off the services.	01640		

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01640	Continued From page 17 ULP-I stated, "it's hard sometimes when you are by yourself." The licensee policy titled, Activities of Daily Living (ADL) Care Documentation, updated September 2022, indicated ADL cares would be documented daily per Minnesota state regulations. Daily ADL cares included assistance with eating, bathing, dressing, grooming, toileting, personal laundry, housekeeping, escorts to programs, mobility, ambulation, continence cares, verification of elimination patterns, and nightly safety checks. ADL cares would be documented on a daily basis for morning, evening, and nightly shift cares. ADL cares not performed would be reported to the manager-on-duty and to oncoming staff of the next shift. The licensee policy titled, Service Plan, updated August 2021, indicated service plans were revised as soon as possible after a change-in-condition that resulted in altered care needs. The original and most current service plan would be filed in the resident record and a copy would be kept in a central location to allow accessibility associates. TIME PERIOD TO CORRECT; Seven (7) days.	01640		