Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL265859722M
Compliance #: HL265859201C

Date Concluded: April 24, 2025

Name, Address, and County of Licensee Investigated:

Edgewood Sartell
577 Brianna Drive
Sartell, MN 56377
Stearns 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 she fell outside during severe cold weather and sustained frostbite injuries to her hands and fingers. Then, the facility failed to provide ordered wound care resulting in hospitalization and treatment for her wounds.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The resident had recurring falls outside by her car, however, the facility failed to implement care planned fall interventions to ensure the residents safety. The resident fell again going to her car during extreme cold, but the facility failed to timely assess the resident for injuries and failed to report changes in the resident's condition after blisters, pain, swelling, and necrosis (dead tissue) developed on the residents' fingers. Although the resident record indicated wound care was provided to the resident's frostbite on her fingers; date/time stamped photographs showed the residents wounds thickly imbedded with

dirt and debris around the time wound care was documented as completed. The resident was hospitalized and treated for frostbite of her fingers.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family members, and witnesses to the incident. The investigation included review of the resident record(s), hospital records, emergency department (ED) records, clinic records, therapy records, facility incident reports, staff schedules, law enforcement reports, and related facility policy and procedures. Also, the investigator observed resident's and staff in the facility and the area where the fall incidents occurred.

Local weather reports from the day of the incident indicated severe cold warnings and school closures were in effect with temperature recordings of -20 degrees around the time of the incident and windchill of -48 degrees Fahrenheit possible.

The resident resided in an assisted living facility with diagnoses including Parkinson's disease, dementia, memory loss, closed head injury with altered mental status, hypotension, and cerebral meningioma (non-cancerous brain tumor that can cause cognitive changes, memory loss, confusion, and difficulty with balance/coordination).

The resident's service plan included escort assistance 3 times daily, assistance with showering, and medication management services.

The resident's assessment and plan of care prior to the incident identified the resident was at a high risk for falls but failed to indicate the resident needed escort assistance as indicated in the resident's service plan. The assessment and plan of care indicated the resident was independent with ambulation using a 4 wheeled walker, and had fall interventions including encouraging the resident to use her walker at all times especially when outside in the snow, keep her cell phone/pendant call light within reach when going outside, and in bad weather the resident was not to go outside without another person. The assessment identified the resident had moderate cognitive impairment related to dementia with impaired judgment, but indicated the resident was able to make her needs known and utilized a pendant call light.

A review of the resident's fall incident reports indicated the resident had 6 recurring falls in the last 60 days with 2 of them occurring while going outside to her car during snowy conditions without her walker prior to the incident. After the falls occurred the resident record lacked documentation to indicate the facility had implemented the resident's plan of care for fall interventions including providing the resident with encouragement to use her walker, have her cell phone, pendant call light, and someone with her when going outside in bad weather to ensure the resident's safety. The resident record lacked any documentation of resident refusal or non-compliance with assessed fall interventions as indicated in the resident's plan of care.

12 days later at 9:33 a.m. a progress note indicated the resident's provider was notified the resident had another fall outside while going to her car.

- At 10:00 a.m. a fall incident report indicated the resident left her walker inside the building and was found on the ground by her car by a visitor who helped the resident up, but the resident got into her car and left before staff could check on her.
- At 12:15 p.m. the same day another fall incident report indicated the resident had another unwitnessed fall in her room by her recliner chair. The incident report indicated although the resident was back in the facility, and a nurse was notified the resident had another fall, there was no indication the resident was assessed for possible injuries after either fall occurred.

The following day at 10:19 a.m. a progress note indicated unlicensed personnel (ULP) staff reported to the facility registered nurse (RN) the resident had blisters on all of her fingers on both hands. The progress note indicated when the RN looked at the residents fingers she noted large blisters on the 2nd, 3rd, and 5th finger on the left hand and blisters on the 1st, 2nd, 4th and 5th finger on her right hand. The note indicated the resident was unaware the blisters were there, or how they occurred. The RN documented 2 of the blisters on the right hand were open, and the rings on multiple fingers appeared tight. The RN documented updating the resident's family who agreed to bring the resident to the ED and questioned if the blisters were frost bite.

- At 12:13 p.m. a progress note indicated the RN interviewed staff who stated they noticed blisters on the resident's hands and fingers the previous evening at 8:00 p.m. the day of the incident. The record indicated staff did not report the change of condition to nursing when blisters developed until about 14 hours after they were first observed.
- At 1:43 p.m. the resident returned from the ED with the diagnosis of frostbite on both hands. The ED provided no orders for dressing changes or wound care at that time. The note indicated the family member planned to have the resident seen at the clinic for a follow up the next day.
- At 2:32 p.m. a post fall event progress note identified the resident had 6 falls in the last 60 days and was at a risk for falls related to Parkinson's and an unsteady gait. The note indicated the resident had a large bruise on her left hip but failed to include the frost bite injuries.

The following day a progress note at 1:02 p.m. indicated the RN checked on the resident's blisters and noted most were open, some were weeping, and some were open and bloody looking. The resident reported more pain, appeared to be lethargic, and needed assistance with dressing. Another progress note later that day indicated the resident was seen at the clinic by her provider who debrided loose dead skin from the wounds and ordered the facility to provide Epsom salt soaks 3 times daily to the residents fingers.

The resident's clinic record indicated the resident had extensive blistering on both hands, and indicated the resident's exposure to cold was likely prolonged. A bilateral hand exam revealed the resident's fingertips had frost bite with flaps of dead skin hanging from the fingertips on multiple fingers, with blisters along the left fifth finger. The record included orders to soak the

resident’s fingers in warm Epsom salt water for 15 minutes 3-4 times daily, keep areas clean and dry, protect hands from cold exposure, eliminate smoking, and observed for signs of infection including redness, and symptoms of fever, chills, or sweats.

A review of the resident’s service delivery of care record for wound care indicated although Epsom salt hand soaks were scheduled 3 times daily, they were not completed timely as scheduled, and the resident refused one time with no indication staff reapproached or reported the refusal to nursing or the resident’s provider.

The resident record lacked direction to ULP staff to monitor and report changes in the resident’s wounds including increased pain, swelling, signs of infection, and black necrotic tissue.

Four days later, at 10:50 a.m. the RN documented in a progress note the resident’s frostbite injuries, previously blistered, were now black in color, swollen, and the resident had increased pain in her fingers. The progress notes indicated the resident’s provider and family were updated and family brought the resident back to the emergency department. The resident was admitted to the hospital for wound management of the frostbite.

The resident’s ED/Hospital record indicated the resident was admitted with frost bite injuries. The record indicated the resident initially presented to the ED the day after falling outside during subzero temperatures and sustained frost bite injuries. The resident returned to the ED 5 days later with necrosis (dead tissue) and significant discomfort in her fingers requiring morphine for pain management. The resident’s ED/Hospital record indicated, “wound care was apparently not provided by the facility 3-4 times daily as ordered due to the wounds being observed quite dirty with matted fuzz imbedded in the wounds.” The ED record included photographs that verified the wound findings. The resident was admitted to the hospital for wound management, wound care, and dressing changes.

When interviewed the visitor who assisted the resident off the ground stated the resident was not dressed appropriately for the weather that day and described the resident dressed in a light coat with a gown and sweatpants on. The visitor stated the resident’s walker was left by the door of the facility and was not with the resident at the time of the fall. The visitor stated he helped the resident get up, she got into her car, started it, and was sitting in her car when he left the facility a while later.

When interviewed facility leadership stated the resident always left her walker with her pendant call light in it inside the building and then walked to her car unassisted. During email communication leadership indicated the resident was independent with ambulation, and they had no documentation of staff implementing fall interventions on the resident’s care plan or documentation of the resident’s refusal or non-compliance with fall interventions.

When interviewed a RN stated the day the incident occurred the resident left before nursing could assess for injuries, and indicated staff did not report the blisters on the resident's fingers later that night, or changes in the resident's wounds including pain, swelling, and black tissue over the weekend and they should have. The RN indicated when she observed the resident's wounds Monday morning (4 days later), they were swollen, painful, with black dead tissue, so the resident was brought back to the ED and admitted to the hospital. The RN denied the resident's wounds were soiled or imbedded with debris as shown in the ED photographs, and stated she observed the resident's wounds to be clean prior to leaving the facility for the ED.

Another nurse stated she knew the resident had fallen outside by her car but indicated the resident left before nursing could assess the resident for possible injuries. The nurse was asked if the resident was assessed when she returned later that day, or after staff documented reporting to her the resident had fallen again in her room, but the nurse denied being aware another fall occurred that day or that the resident had returned to the facility before the end of her shift. The nurse denied being aware the resident was at a risk for falls, or had fall interventions in place and stated the resident was independent with ambulation and always left her walker inside then walked to her car unassisted. The nurse stated staff did not intervein or provide encouragement for the resident to use her walker or have her pendant call light with her while going outside as indicated on her plan of care.

Multiple ULP staff interviewed indicated the resident kept her pendant call light in her walker and left her walker inside the facility then walked to her car unassisted many times per day. Staff interviewed were unaware the resident was at a risk for falls, or had fall interventions in place, and indicated they did not provide encouragement for the resident to use her walker, have her pendant, or someone with her during times of bad weather as indicated in the resident's plan of care.

When interviewed 2 of the resident's family members stated the facility had not provided Epsom salt hand soaks as ordered because they had observed the resident's wounds filthy, black, and imbedded with dirt and fuzzy debris 2 days in a row prior to the resident being admitted to the hospital.

A review of family provided date and time stamped photographs of the resident's wounds at the facility, showed the wounds visibly soiled and thickly imbedded with debris about 2 hours after staff documented wound care was provided, and around the same time the RN documented observing the resident's wounds in a progress note.

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:
The day after blisters developed on the resident’s hands following a fall outside in subzero temperatures for an unknown amount of time, the facility sent the resident to the ED for evaluation and treatment of her injuries. Then, 4 days later the facility notified the family of a change in the resident’s condition, and the resident was brought back to the ED and admitted 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
Stearns County Attorney
Sartell City Attorney
Sartell Police Department
St. Cloud Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26585	A. BUILDING: _____ B. WING _____	C 03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD SARTELL LLC	677 BRIANNA DRIVE SARTELL, MN 56377

(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: #HL265859722M/#HL265859201C On March 13, 2025, 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 43 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL265859722M/#HL265859201C, tag identification 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.	
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services	02310		

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02310	Continued From page 1 (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 facility failed to ensure one of one resident (R1), was assessed to ensure the appropriate level of care required. R1 was harmed when she had recurring falls outside in the snow, but the facility failed to implement R1's plan of care with fall interventions, R1 fell again outside in subzero temperatures for an unknown amount to time and sustained frost bite injuries on her hands and fingers. Then, facility failed to timely assess the resident for injuries, and failed to timely report a change in R1's condition after blisters developed. In addition, the facility failed to ensure wound care was provided as ordered, and failed to timely report a change of condition when R1's wounds developed increased pain, swelling, and necrosis. The resident was hospitalized and treated for her wounds. 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: On March 20, 2025, https://bringthenews.com	02310		

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02310	Continued From page 2 website indicated extreme cold weather conditions with school closures in effect the day of the incident occurred with wind chills of -45 degrees Fahrenheit possible. On March 24, 2025, www.weatherspark.com a website reviewed for weather on the day and the time of the incident indicated severe cold recordings of -20 degrees Fahrenheit. R1 was admitted to the licensee on July 14, 2023, with diagnoses including Parkinson's disease, dementia, memory loss, closed head injury with altered mental status, hypotension, and cerebral meningioma (non-cancerous brain tumor that can cause cognitive changes, memory loss, confusion, and difficulty with balance/coordination). R1's admission service plan included escort assistance 3 times daily, assistance with showering, and medication management services. R1's assessment and plan of care prior to the incident dated February 7, 2025, identified R1 was at a high risk for falls but failed to indicate R1 needed escort assistance as indicated in R1's service plan. The assessment and plan of care indicated R1 was independent with ambulation using a 4 wheeled walker, and had fall interventions including encouraging R1 to use her walker at all times especially when outside in the snow, keep her cell phone/pendant call light within reach when going outside, and in bad weather R1 was not to go outside without another person. The assessment identified R1 had moderate cognitive impairment related to dementia with impaired judgment, but indicated R1 was able to make her needs known and	02310		

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02310	Continued From page 3 utilized a pendant call light. R1's fall incident reports indicated R1 had 6 recurring falls in the last 60 days with 2 of them occurring while going outside to her car during snowy conditions without her walker prior to the fall incident resulting in frost bite injury. On December 21, 2024, at 5:15 p.m. one fall incident report indicated R1 fell outside and was found on her hands and knees. R1 was not using her walker at the time the fall occurred. R1 went out to her car to smoke and was found in the snow. A fall follow up note on December 22, at 11:33 a.m. indicated R1's pendant and walker were inside when R1 fell outside in the snow by her car. R1's care plan was updated on December 23, for the licensee to keep pathways clear. The report indicated no post fall root cause analysis was completed, and had no indication any action was taken to prevent recurring falls. On February 6, 2025, at 10:30 a.m. another fall incident report indicated R1 fell again outside while it was cold and snowing trying to get to her car and was found kneeling on the ground beside her car in 4-5 inches of snow. The report indicated fall interventions in place included R1's walker. The report indicated action taken to prevent recurring falls was to talk to R1 about walking outside in the snow. On February 6, 2025, at 10:46 a.m. a fall follow up note indicated R1 had 4 falls in the last 90 days, R1 was at a risk for falls related to antihypertensives medications, and an unsteady gait related to Parkinson's. The note indicated R1's care plan was updated The care plan was updated to encourage R1 to have her walker, cell phone, pendant on when going outside, and indicated R1 was not to go outside during bad weather without	02310		

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02310	Continued From page 4 another person. There was no indication what staff were to do if R1 was observed going outside in severe cold, or snowy weather conditions without her walker, pendant call light, or another person. On February 18, 2025, at 9:33 a.m. (12 days later) a progress note indicated R1's provider was notified the resident had another fall outside while going to her car. - At 10:00 a.m. a fall incident report indicated R1 fell outside but did not use her emergency call pendant to summon assistance. The report indicated R1 left her walker inside the building and was found on the ground by her car by a visitor who assisted R1 up, but R1 got into her car and left before staff could check on R1. The incident report indicated no post fall assessment for injuries was completed. - At 11:40 a.m. a progress note indicated another resident reported finding R1 on the ground by her car. The other resident's son assisted R1 up and she left in her car before staff could check on her. - At 12:15 p.m. another fall incident report the same day indicated R1 had another unwitnessed fall in her room by her recliner chair. The incident report indicated although R1 was back in the facility, and a nurse was notified the resident had another fall, there was no indication R1 was assessed for possible injuries after either fall occurred. After the falls occurred R1's record lacked documentation to indicate the facility had implemented the plan of care for fall interventions including providing R1 with encouragement to use her walker, have her cell phone, pendant call light, and someone with her when going outside in bad weather to ensure R1's safety. R1's record lacked any documentation of refusal or	02310		

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02310	Continued From page 5 non-compliance with assessed fall interventions as indicated in R1's plan of care. On February 19, 2025, at 10:19 a.m. the following day a progress note indicated staff (unknown) reported R1 had blisters on all her finger of both hands. The note indicated registered nurse case manager (RNCM)-I looked at R1's fingers and noted large blisters on the 2nd, 3rd, and 5th finger on the left hand and blister on the 1st, 2nd, 4th and 5th finger on her right hand. The note indicated R1 was unaware of how the blisters occurred and was unaware that the blisters were there, and R1 did not recall burning herself. RNCM-I noted there was a heating pad without a cover on it beside where R1 was sitting, and R1 had rings on multiple fingers that appeared tight. RNCM-I documented sending pictures to and notifying family member (FM)-F and R1's provider. FM-F agreed to send R1 to the emergency department (ED) and questioned if the injury was frost bite. - At 12:13 p.m. another progress note indicated RNCM-I interviewed staff that worked the previous evening shift who noticed blisters on R1's fingers at 8:00 p.m. the day of the incident. The record indicated staff did not report the change of condition to nursing when blisters developed until about 14 hours after they were first observed. - At 1:43 p.m. R1 returned from the ED with the diagnosis of frostbite on both hands. The ED provided no orders for dressing changes or wound care at that time. The note indicated the family member planned to have R1 seen at the clinic for a follow up the next day. - At 2:32 a post fall event progress note identified R1 had 6 falls in the last 60 days and was at a risk for falls related to Parkinson's and an unsteady gait. The note indicated R1 had a large	02310		

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02310	Continued From page 6 bruise on her left hip but failed to include the frost bite injuries. On February 20, at 1:02 p.m. progress note indicated the RNCM-I checked on R1's blisters and noted most were open, some were weeping, and some were open and bloody looking. R1 reported more pain, appeared to be lethargic, and needed assistance with dressing. Another progress note later that day indicated R1 was seen at the clinic by her provider who debrided loose dead skin from the wounds and ordered Epsom salt soaks 3 times daily. R1's clinic record from the February 20, 2025, indicated R1 had extensive blistering on both hands. A bilateral hand exam revealed R1's fingertips had frost bite with flaps of dead skin hanging from the fingertips on multiple fingers. R1 had blisters along the left fifth finger, and the record indicated R1's exposure to the cold was likely prolonged. The record included instructions to soak R1's fingers in warm Epsom salt water 15 min 3-4 times daily, keep areas clean and dry, protect hands from cold exposure, eliminate smoking, and observed for signs of infection including redness symptoms of fever chills or sweats. A review of R1's service delivery of care record for wound care indicated although Epsom salt hand soaks were scheduled 3 times daily, they were not completed timely as scheduled. - On February 21, 2025, wound care scheduled at 7:00 a.m. was not completed until 10:06 a.m., and wound care scheduled at 12:00 p.m. was refused due to increased pain. The record failed to indicate staff re-approached R1, or reported the refusal or R1's report of increased pain to nursing.	02310		

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02310	Continued From page 7 - On February 22, 2025, wound care scheduled at 7:00 a.m. was not completed until 10:50 a.m., wound care scheduled at 12:00 p.m. was not completed unit 2:07 p.m., and wound care scheduled at 7:00 p.m. was not completed until 8:22 p.m. - On February 23, 2025, wound care scheduled at 7:00 a.m. was not completed until 12:01 p.m., and wound care scheduled at 12:00 p.m. was completed at 1:33 p.m. 1 hour and 32 minutes after the previous wound care was provided. - On February 24, 2025, wound care scheduled at 7:00 a.m. was not completed until 8:57 a.m. In addition, R1's service delivery of care record for wound care included instructions to soak R1's hands in 15 milliliters (mL) of Epsom salt water for 10 minutes, remove and allow to air dry by resting on a towel. The record lacked direction to unlicensed personnel (ULP) staff to monitor and report changes in R1's wounds including increased pain, swelling, signs of infection, and black eschar tissue. There was no indication ongoing wound monitoring was completed. As a result, concerns with R1's wounds were not identified, reported, or addressed until 4 days later. On February 24, 2025, at 10:50 a.m. (4 days later) the RNCM-I documented in a progress note R1's frostbite injuries, previously blistered, were now black in color, swollen, and the R1 was complaining of increased pain in her fingers. R1's provider and family were updated, who brought R1 back to the ED, and R1 was admitted to the hospital. R1's ED/Hospital record indicated R1 was admitted with frost bite injuries. The record indicated R1 initially presented to the ED the day	02310		

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	26585	A. BUILDING: _____ B. WING _____	C 03/13/2025

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02310	Continued From page 8 after falling outside during subzero temperatures and sustained frost bite injuries. R1 returned to the ED 5 days later with necrosis (dead tissue) and significant discomfort in her fingers requiring morphine for pain management. R1's ED/Hospital record indicated "wound care was apparently not provided by the facility 3-4 times daily as ordered due to the wounds being observed quite dirty with matted fuzz imbedded in the wounds." The ED record included photographs that showed the wounds visibly soiled as documented in the ED record. R1 was admitted to the hospital for wound management, wound care, and dressing changes. On March 13, 2025, at 11:53 a.m. during an entrance conference facility leadership included RNCM-I, Registered Nurse Clinical Services Director (RNCSD)-J, Executive Director (ED)-K. Leadership staff stated R1 commonly left her walker with her pendant call light in it inside the building, then walked to her car unassisted. On March 13, 2025, at 11:53 a.m. and 2:52 p.m. RNCM-I stated the day the incident occurred R1 left before nursing could assess for injuries, and indicated staff did not report the blisters on R1's fingers later that night, or changes in R1's wounds including pain, increased swelling, and black tissue over the weekend and indicated the should have. Then, when she observed R1's wounds Monday morning (4 days later), they were more swollen, painful, and appeared black with dead tissue. R1 was brought back to the ED and admitted to the hospital. RNCM-I stated R1 left the facility for the ED around noon and she observed R1's wounds prior to leaving the facility for the ED, and they were clean. The RNCM-I adamantly denied the wounds were soiled or imbedded with debris as shown in the ED	02310		

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02310	Continued From page 9 photographs. On March 13, 2025, at 1:28 p.m. ULP-A stated R1 usually had her pendant hanging from her walker or in the walker basket. ULP-A indicated R1 would frequently go out to her car to smoke and left her walker inside the lobby. ULP-A denied being aware R1 was a risk for falls or had any fall interventions in place. ULP-A stated she had observed R1's wounds dirty and covered with food debris, but indicated R1 denied pain and said she was fine. On March 13, 2025, at 1:43 p.m. ULP-B stated she had provided Epsom salt hand soaks to R1, and indicated R1 would not keep her fingers in the water but dunked them in and out. ULP-C stated some of R1's fingers were turning black and had scabs on them but she did not report it because they basically looked the same when she saw them. ULP-C stated R1 would come and go frequently to her car, and left her pendant call light and walker by the reception desk at the facility entrance then walked to her car unassisted. ULP-C stated R1 had fallen previously in the snow going to her car without her walker, and was not steady to ambulate without the use of her walker, but indicated it was R1 choice if she wanted to use her walker or not. ULP-C indicated she did not intervene if R1 was observed going outside without her walker. On March 13, 2025, at 2:18 p.m. ULP-C stated R1 frequently left the facility and went to her car about 20 feet away from the facility doors without her walker. ULP-C denied being aware R1 was at a risk for falls or had fall interventions in place. On March 18, 2025, at 4:06 p.m. during email communication RNCSD-J indicated R1 was	02310		

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02310	Continued From page 10 independent with ambulation, and they had no documentation of fall interventions implemented on R1's care plan including documentation of R1's refusal or non-compliance with fall interventions. On March 18, 2025, at 11:29 a.m. FM-F and FM-G stated the facility had not provided Epsom salt hand soaks as ordered because they had observed R1's wounds filthy, black, and imbedded with dirt and fuzzy debris 2 days in a row prior to (R1) being admitted to the hospital. A review of family provided wound photographs at the facility dated and time stamped February 24, 2024 at 11:54 a.m. showed R1's wounds at the facility visibly soiled and thickly imbedded with debris about 2 hours after staff documented completing wound care/Epsom salt hand soaks, and around the same time the RNCM-I documented observing R1's wounds in a progress note. As a result, there was no indication wound care was provided as ordered/documented, and showed R1's wounds were not clean when R1 left the facility as stated by the RNCM-I On March 19, 2025, at 1:47 p.m. FM-D who assisted R1 off the ground on February 18, 2025, stated R1 was not dressed appropriately for the severe cold, she wore a light coat with a gown and sweat pants, and indicated R1's walker was left by the door of the facility and was not with R1 at the time of the fall. The FM-D stated he helped R1 get up, then she got into her car, started it, and was still sitting in her car when he left the facility a few minutes later. On March 19, 2025, at 10:46 a.m. Licensed Practical Nurse (LPN)-E stated she knew R1 had fallen outside by her car but indicated R1 left	02310		

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02310	Continued From page 11 before nursing could assess for possible injuries. LPN-E was asked if R1 was assessed when she returned later that day, after staff documented reporting to her R1 had fallen again in her room around noon, but LPN-E denied being aware another fall occurred that day or that R1 had returned to the facility before the end of her shift. LPN-E denied being aware R1 was at a risk for falls, or had fall interventions in place and stated R1 was independent with ambulation and always left her walker inside then walked to her car unassisted. LPN-E indicated staff did not intervene or provide encouragement for R1 to use her walker or have her pendant call light with her while going outside as indicated on her plan of care. On March 20, 2025, at 2:15 p.m. ULP-H stated she observed blisters on R1's hands the evening of the incident but failed to report the change because she planned to do it i the morning. ULP-H stated she should report any changes in the resident condition immediately. ULP-H stated R1 was unsteady with ambulation at times and always left her pendant call light in her walker, and left her walker inside the facility then went to her car without it. ULP-H denied R1 was at a risk for falls or had fall interventions in place and indicated they did not intervene or provide reminders to R1 to encourage her to have her pendant call light or walker when going outside as indicated on her plan of care. A facility policy and procedure titled "Service Planning/Care Planning Coordination of Care", dated January 2025, indicated the Service Plan/Care Plan was used to identify resident care issues, how staff should monitor/observe for them, and interventions for each resident that staff can apply if necessary. Because it is a	02310		

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02310	Continued From page 12 primary health record, other documentation about a resident ' s care should coordinate with and through the Service Plan/ Care Plan. A facility policy and procedure titled "Fall Reduction Policy", dated January 2025, The Community strives to reduce falls, and promote resident safety by focusing on assessment and education, medication management, environmental modifications, and exercise to maximize effectiveness, yet allow for resident autonomy and choice. The Community assesses each resident for his or her fall risk, designs a service plan, and implements procedures to minimize falls and/or injury. A fall is an unintended landing on a floor or lower position. A fall can be inferred if the fall is witnessed, if the resident is found on the floor, or if the resident states that a fall has occurred. High risk fall reduction strategies included additional interventions that may be used on residents identified as fall risk include: i. Conducting resident rounds more frequently. ii. Considering physical therapy and balance training for residents who have gait instability, functional limitations, or a fall within the prior 30 days (with physician ' s order). iii. Evaluate resident for placement to a higher level of care. a. Additional safety precautions and interventions may include: i. Encouraging the resident to ask for help when rising. ii. Emphasizing to family members that they should call the staff instead of trying to help an unsteady resident themselves. 3. Periodic evaluations of the service plan and effectiveness of reduction strategies include: d. Environmental hazards (clutter, spills on floor, location of cords and wires, etc.).C. Intervention 1. If a resident falls, the following steps should be taken: a. Post fall evaluation may include: i. Vital signs (pulse, temperature, respirations, and blood pressure,	02310		

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02310	Continued From page 13 presence or absence of pain). ii. Inspection for bruises, swelling, and lacerations. vi. Monitor the resident ' s condition. vii. Implement Fall Reduction Strategies. viii. Update the resident ' s Service Plan/Care Plan. Documentation 1. Document all falls, including objective and factual statements regarding: a. Circumstance at the time of the fall. i. For an un-witnessed fall, the record should reflect the resident ' s statement with quotes. ii. For an un-witnessed fall, notes should indicate the resident ' s condition and location upon staff arrival. iii. For a witnessed fall, notes should indicate the resident ' s activity prior to the fall and other precipitating factors. B. Results of assessment and condition of the resident. c. Care rendered. d. Notification of physician and family. e. Physician orders. f. Reduction strategies implemented to prevent reoccurrence. 2. For a suspected resident injury notify the nurse (or Executive Director where applicable). 3. Complete an Incident Report. 4. Document all interactions with resident and resident ' s family/representative, related to the incident. E. Education 1. Staff training at new hire orientation and during annual in-services is provided, reviewing both intrinsic and environmental factors that contribute to increased risk of falls. 2. Fall reduction strategies are reviewed with all staff, including the method and frequency of assessing effectiveness. 3. Upon admission and/or when a resident is identified as a fall risk following admission, education should be conducted. The facility policy and procedure titled "Initial Assessment - Resident", dated January 2025, indicated the Service Plan and must be revised with any significant change in conditions or when observations indicate it necessary to revise. The community must implement and provide all	02310		

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02310	Continued From page 14 services required by the current Service Plan. Based on the assessment the RN shall provide direction for each delegated task, documented in the resident record (Service Plan, Care Plan, MAR), with a list of parameters, specific and unique to the resident, which indicate action to take, when, whom to notify, and/or other appropriate information. The RN or designee responsible for delegation shall conduct routine reviews of resident care needs to confirm their continued applicability. This should be done at least annually or per state requirement and with any significant change in the resident ' s condition. The resident record should contain documentation of ongoing assessment and continued needs. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	02310		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: Based on interviews and document review, the licensee failed to ensure one of one residents (R1) reviewed was free from maltreatment Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred,	02360		

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02360	Continued From page 15 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		