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 #: HL315573643M
Compliance #: HL315573992C

Date Concluded: June 5, 2024

Name, Address, and County of Licensee Investigated:
Farmstead Care of Moorhead
3200 28th Street South
Moorhead, MN 56560
Clay County

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

Evaluator's Name: Barbara Axness, 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 facility neglected the resident when the registered nurse (RN) failed to assess a newly developed open area and failed to contact the resident's primary care provider. As a result, the resident developed into a stage three pressure ulcer.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The resident had a history of skin breakdown, and nursing staff failed to assess the resident's risk and implement interventions to prevent further skin breakdown. Facility staff identified a new open area, but the nurse did not assess the wound until nine days later and the primary care provider (PCP) was not updated until 17 days after the wound was first observed. By the time the PCP was updated, the wound had progressed to a stage three pressure ulcer (full thickness skin loss that extends into the fatty tissue layer).

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted the resident's case worker and primary care provider. The investigation included review of the resident's records, facility internal investigation documentation, facility incident reports, staff schedules, and related facility policies and procedures. Also, the investigator observed care and services provided in the facility and the resident's pressure ulcer.

The resident resided in an assisted living facility. The resident's diagnoses included hemiplegia and hemiparesis affecting the right dominant side (right sided weakness). The resident's service plan included assistance with dressing, bathing, toileting, and transfers with a mechanical lift. The resident's assessment lacked documentation related to refusals of care or a history of skin breakdown. The assessment indicated the resident's only skin integrity issue was edema to his legs. The resident had a preference to sleep in his recliner, but the assessment failed to identify the resident's preference of sleeping in a recliner and the risk of developing pressure ulcers or other skin breakdown. The resident's care plan indicated the resident was toileted eight times per day. The resident was noted to have a history of abusing others and had a history of verbal aggression with staff. Unlicensed personnel (ULP) were to check the resident's bottom for open/new sores every other day and "make observations for this." If the resident refused to have his incontinence product changed or refused to be toileted after two attempts, ULP were to ask another staff member to help him and document the refusal. Staff were to provide the resident with two choices on when to change his incontinent product and to come back in 15 to 20 minutes. Repositioning assistance was removed from the resident's care plan per his request but was later updated to include "due to wounds on buttock. Offer reposition every 3 hours, document refusals" at an unidentified date.

The resident's medical record indicated the resident had a recurring pressure ulcer on his buttocks that would heal and reopen. Two days after it recently healed over, the area reopened. ULP documented the "sore on his left buttock reopened today. Writer applied barrier cream to the area, will continue to monitor." The next note was completed five days later when ULP noted the area was still open and barrier cream was being used. Two days later, the ULP documented that the resident's sore was still open but was now bleeding. The ULP wrote she cleansed the area and applied barrier cream and would "continue to monitor."

Nine days after the wound reopened, the nurse assessed the area. The nurse noted it to be a stage 2 pressure ulcer on the right buttock. The nurse applied barrier cream but failed to contact the PCP. Three days after the assessment, the nurse documented "no changes to [the resident's] open area from earlier this week. Still open, no active bleeding. [Brand name] barrier cream applied." The nurse failed to contact the PCP.

17 days after the wound first opened, the nurse documented the wound was now a stage 3 pressure ulcer and was noted to be bleeding. The nurse applied barrier cream and noted a "pinpoint open area to right buttock." The nurse faxed the PCP about the open sore on the left buttock. The resident refused to go to an appointment with his PCP that day and two days later

the PCP was updated that the facility had filed a report related to self-neglect that resulted in the development of a pressure ulcer. Four days after the fax was sent, the nurse contacted the PCP to request a referral to a wound clinic. The PCP responded later that day with an order for a referral to a wound clinic and interventions that included the use of a pressure relieving cushion in the resident's wheelchair. Despite the order for the referral to the wound clinic, the facility never made an appointment. The resident refused to be seen by the wound clinic and the facility did not update the PCP of the resident's refusal. The facility failed to ensure the resident utilized the pressure relieving cushion and failed to notify the PCP that the resident refused the intervention.

At the time of the onsite visit, the investigator observed the open area on the resident's buttocks. A small open area was observed on the resident's left buttock and the entirety of the resident's buttocks was leathery and dark purple with some non-blanchable (skin does not turn white when pressure is applied, indicative of anlack of blood flow) areas. A pressure relieving cushion was observed on the resident's dining room table. The resident's room did not have a bed, only a recliner. The resident stated that he slept in the recliner and preferred to sleep in the recliner verses the bed.

During an interview, the administrative nurse stated that the facility's current process included for unlicensed personnel (care coordinators) to conduct skin assessments. The administrative nurse felt it was appropriate for care coordinators to complete skin assessments because they were certified nursing assistants and she had trained them on how to complete a skin assessment. The administrative nurse stated that the care coordinators had been monitoring the resident's pressure ulcer but once it started to bleed, she got involved with the resident's care. The administrative nurse stated that once the pressure ulcer worsened to a stage 3, she updated the provider. The administrative nurse acknowledged the resident's history of skin breakdown and noncompliance were not included on the assessment as the nurse consultant had told the facility to include only the current skin status and not the history. The administrative nurse also acknowledged that interventions were attempted but were not documented. The nurse confirmed that the referral for the wound clinic consultation was not completed as the resident refused. The nurse thought that the provider had been updated about the refusal and stated they were waiting from a response from the provider.

During an interview, the care coordinator (unlicensed personnel) stated that in her role, she worked as a lead caregiver and helped the nurses by training other unlicensed staff, worked with the nurses to inventory medications, completed dressing changes, skin assessments, and documented intake and output, among other duties. The care coordinator felt it was within her scope of duties to complete skin assessments since the nurse had trained her on how to do them. The care coordinator indicated she was trained by a previous registered nurse (RN) at the facility but couldn't recall what was covered in the training. The care coordinator also stated that any time she entered a progress note about a skin condition, she emailed the nurse to make sure she was aware of any changes to the resident's skin.

During an interview, facility administrative staff stated they were not aware of the delay in assessment of the wound or update to the resident's provider. The administrative staff stated they were not sure why the nurse failed to address the wound timely and as far as she was aware, the wound got worse due to the resident's non-compliance. The administrative staff stated that the resident admitted to the facility with a history of pressure ulcers and routinely developed them, so she was not sure why this was not addressed in the resident's assessment.

During an interview, the resident's primary care provider (PCP) stated he was not previously informed of the delay in assessment of the wound or delay in contacting his office. The PCP indicated that the facility made it sound like it was self-neglect since the resident wouldn't listen to them about wound care. The PCP stated that given the resident was wheelchair bound, he should have been notified within a few days of the wound reopening. The PCP stated barrier cream would be an appropriate treatment for a stage one pressure ulcer but would not be the recommended treatment for a stage three pressure ulcer. The PCP stated he was not aware that the resident was sleeping in a recliner. The PCP stated that the resident should be using a special cushion in his wheelchair since he had hip contractures that affected his positioning. The PCP stated the day they received the first fax from the facility, they immediately scheduled an appointment for the resident to be seen in the clinic that day. The appointment was cancelled by the resident, and they did not hear anything further from the facility.

During an interview, the resident's case manager stated the facility updated them of the report of self-neglect, but the facility did not disclose information about a delay in care. The case manager stated that a nurse reached out to set up a care conference regarding the resident and she had replied that she would like to attend but has not heard anything back from the facility in a few weeks.

During an interview, the resident stated he didn't refuse care but "we don't seem to be on the same page…that's the word they're using.. but I don't refuse care, I want things done a certain way."

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: Yes
Family/Responsible Party interviewed: Yes, case manager
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
No action taken.

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

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Clay County Attorney
Moorhead City Attorney
Moorhead Police Department
Minnesota Board of Executives for Long Term Services and Supports
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31557	A. BUILDING: _____ B. WING _____	C 05/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FARMSTEAD CARE OF MOORHEAD LP	3200 28TH STREET SOUTH MOORHEAD, MN 56560

(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: #HL315573643M/#HL315573992C On May 21, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 97 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL315573643M/#HL315573992C, tag identification 1410, 1620, 2320, 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	

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0 000	Continued From page 1	0 000	ISSUED PURSUANT TO 144G.81 SUBDIVISION 1-3.	
01410 SS=F	144G.62 Subd. 2 Delegation of assisted living services (a) A registered nurse or licensed health professional may delegate tasks only to staff who are competent and possess the knowledge and skills consistent with the complexity of the tasks and according to the appropriate Minnesota practice act. The assisted living facility must establish and implement a system to communicate up-to-date information to the registered nurse or licensed health professional regarding the current available staff and their competency, so the registered nurse or licensed health professional has sufficient information to determine the appropriateness of delegating tasks to meet individual resident needs and preferences. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide appropriate care and services subject to appropriate Minnesota practice acts when the registered nurse (RN) delegated unlicensed personnel (ULP) to conduct skin assessments on a resident who had a worsening pressure ulcer. 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	01410		

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01410	Continued From page 2 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The Nurse Practice Act, Minnesota Statute Section 148.171, dated August 1, 2013, indicated the registered nurse (RN) scope of practice included implementing interventions delegated, ordered, or prescribed by a licensed health care provider. The same document indicated "delegation" means the transfer of authority to another nurse or competent, unlicensed assistive person to perform a specific nursing task or activity in a specific situation. The same document indicated "supervision" means guidance means guidance by the RN including the initial direction, setting expectations, directing activities and course of action, evaluating, and changing a course of action. Based on the National Guidelines for Nursing Delegation, developed by the American Nurses Association (ANA) effective April 29, 2019, the licensed nurse cannot delegate any activity which requires clinical reasoning, nursing judgment, or critical decision making. R1's diagnoses included hemiplegia and hemiparesis following cerebral infraction affecting right dominant side (weakness on the right side caused by a stroke) R1's care plan dated February 24, 2020, indicated the resident was toileted eight times per day. R1 was noted to have a history of abusing others and had a history of verbal aggression with staff. Unlicensed personnel were to check the resident's bottom for open/new sores every other day and make observations for this.	01410		

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01410	Continued From page 3 R1's unsigned service plan dated May 13, 2024, indicated the resident received assistance with toileting, showers, activities of daily living, repositioning every three hours, and medication administration. Unlicensed personnel were to check the resident's bottom for new/open sores every other day. R1's assessment dated April 8, 2024, indicated R1's only skin concern was edema to his bilateral lower legs. R1 was noted to be incontinent and needed to be toileted every three hours. The assessment indicated R1 had behaviors of verbal aggression. R1's progress notes contained the following: -March 6, 2024, ULP noted a small open sore to the resident's left buttock. Barrier cream was applied. -March 11, 2024, ULP noted a small area on the resident's buttock was almost healed. -March 18, 2024, ULP noted the "left buttock sore is healed over, staff applied barrier cream to prevent it from opening again. Will continue to monitor." -March 20, 2024, ULP noted the resident's bottom remained healed over. -April 4, 2024, Clinical Nurse Supervisor/Registered Nurse (CNS)-A documented she attempted to do the resident's 90 day assessment but he refused. -April 12, 2024, ULP documented "no new changes to his bottom. Area is healed over." -April 14, 2024, ULP documented "resident's sore on his left buttock reopened today. Writer applied barrier cream to the area. Will continue to monitor." -April 19, 2024, ULP documented "resident has an open sore on his left buttock. Area was not	01410		

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01410	Continued From page 4	01410		

actively bleeding when writer assessed the area. Barrier cream was applied. Will continue to monitor." The RN failed to assess the resident's wound.
-April 22, 2024, ULP documented "resident's sore on his left buttock is open and actively bleeding at this time. Writer cleaned the area and applied barrier cream. Will continue to monitor."
-April 23, 2024, CNS-A assessed the wound and wrote "Resident has a stage 2 pressure sore to right buttock that measures 2 centimeters (cm) by 1 cm without any depth ..."
-April 24, 2024, ULP documented "sore on his left buttock is open, and not actively bleeding at this time ..."
-April 26, 2024, CNS-A wrote, "No changes to [R1's] open area from earlier this week. Still open, no active bleeding. Tena barrier cream applied ..."
-April 29, 2024, ULP documented the resident's sore on his left buttock was still open but not actively bleeding.
-May 1, 2024, CNS-A assessed the wound again and documented "Resident has a stage 3 pressure ulcer measuring 2.75 cm in length x 2.25 cm in width x 0.1 millimeters (mm) in depth. Wound tissue is dark red, and vascular with bleeding. Wound was cleansed and Tena barrier cream applied. Resident has a pinpoint open area to right buttock. Area cleansed and Tena barrier cream applied."
-May 3, 2024, ULP documented the resident continued to have an open sore on his left buttock.
-May 9, 2024, CNS-A measured the resident's wound again and it was noted to be a stage 3 pressure ulcer that was 10 mm in length by 5 mm wide and 4 mm in depth.

Care coordinator/unlicensed personnel (CC/ULP)-G's job description for the position of

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01410	Continued From page 5 care coordinator dated May 7, 2024, indicated the care coordinator served as the lead caregiver in addition to providing nursing care to the residents of Farmstead Living. The care coordinator worked alongside licensed nurses to directly impact the resident's quality of life by assisting with their activities of daily living (ADLs). Responsibilities of the position included training caregivers, contributing to the resident's plan of care, updating paper copies of care plans for each unit, communicating with the pharmacy regarding medication orders, faxing providers regarding medication reorders, fall reports, etc., assisting residents with activities of daily living, maintained resident's records daily in a timely manner and in accordance with company policies and procedures, document medication distribution as applicable, leisure activities, incidents, and observations, report any changes in resident's physical condition and/or behavior, observes and reports the health and emotional condition of each resident, and promptly report all changes to the nurse or other appropriate supervisor, lead shift report, and follow proper procedures in emergency situations and respond promptly and positively to resident requests for assistance. Nursing tasks the care coordinator was to perform included, taking and recording vital signs, reviewing blood pressure, monitoring pain, exchanging medications, dressing changes, skin care, nail care, weight management, monitoring food intakes for those with feeding tubes, monitor output of urine for those with catheters, perform catheter flushes, track bowel movements, and transfer, position, and turn residents. Qualifications included experience in long term care, memory care, or assisted living and a certified nursing assistant (CNA) was preferred, but not required.	01410		

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01410	Continued From page 6 On May 21, 2024, at 10:10 a.m., clinical nurse supervisor (CNS)-A stated the facility's current process was that unlicensed personnel, called care coordinators, were responsible for conducting skin assessments. CNS-A stated she felt the care coordinators were appropriate to complete skin assessments because they were certified nursing assistants and she had trained them on how to complete a skin assessment. CNS-A stated the care coordinator had been monitoring the pressure ulcer but once it started to bleed, she got involved with the resident's care. On May 21, 2024, at 11:10 a.m., care coordinator/unlicensed personnel (CC/ULP)-G stated in her role, she worked as a lead caregiver and also helped the nurses by training ULP on some things, working with the nurses to inventory medications, do dressing changes, skin assessments, and document intakes and output, among other duties. CC/ULP-G stated she felt it was within her scope of duties to complete skin assessments since the nurse had trained her how to do them. CC/ULP-G was asked what the training included or when it was done. CC/ULP-G stated it was done by a prior RN and she couldn't recall what all was covered in the training. On May 21, 2024, at 12:18 p.m., licensed assisted living director (LALD)-C confirmed via email that it would not be within the care coordinator's scope of practice to perform skin assessments. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01410		

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01620	Continued From page 7	01620		
01620 SS=G	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed assessments as required for one of one residents (R1) with a worsening wound. The RN failed to assess a new open area, until nine days after it was first observed. The RN also did not update the primary care provider until 17 days after the wound was first noted. During that time, the wound worsened to a stage 3 pressure ulcer.	01620		

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01620	Continued From page 8 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). The findings include: The RN failed to monitor skin integrity status and failed to monitor and assess R1's wounds. R1's diagnoses included hemiplegia and hemiparesis following cerebral infraction affecting right dominant side (weakness on the right side caused by a stroke). R1's care plan dated February 24, 2020 indicated the resident was toileted eight times per day. R1 was noted to have a history of abusing others and had a history of verbal aggression with staff. Unlicensed personnel were to check the resident's bottom for open/new sores every other day and make observations for this. If the resident refused to have his incontinence product changed or to be toileted after two attempts, ULP were to ask another staff member to help him and document. R1 was to be given two choices on when to change his incontinence product when he refuses and to come back in 15 to 20 minutes to allow him to make a decision. Repositioning was removed from the resident's care plan at his request but "due to wounds on buttock. Offer reposition every 3 hours, document refusals" was added back to the care plan at an unidentified date.	01620		

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01620	Continued From page 9 R1's individual abuse prevention plan (IAPP) dated April 16, 2024, included a section for falls or frequent bruising and had "open areas" handwritten in the section. The vulnerability was "resident will often get open areas to buttocks due to refusal to reposition and toileting" Interventions included staff reporting refusals to the nurse and staff reporting open areas to the nurse. The IAPP failed to identify any individualized interventions related to his refusals. The resident was noted to be at risk for self abuse due to refusing "repositioning often and toileting, especially weekends, causing skin breakdown." Interventions included staff to monitor resident for concerns of self-abuse and report promptly to the nurse. The IAPP failed to identify any individualized interventions related to his refusals. R1's unsigned service plan dated May 13, 2024, indicated the resident received assistance with toileting, showers, activities of daily living, repositioning every three hours, and medication administration. Unlicensed personnel were to check the resident's bottom for new/open sores every other day. R1's assessment dated April 8, 2024, indicated the resident did not have any emotional conditions like behavioral disorders, depression, or anxiety. The resident did not have any symptoms of mental health conditions or behavioral expressions of concern. A section for skin integrity indicated the only skin concern was edema to his bilateral lower legs. The resident was noted to be incontinent and needed to be toileted every three hours. The assessment indicated the resident had behaviors of verbal aggression. The assessment failed to identify the resident's preference of sleeping in a recliner	01620		

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01620	Continued From page 10 instead of a bed and how that could increase his risk of developing pressure ulcers or other skin breakdown. R1's progress notes contained the following: -March 6, 2024, ULP noted a small open sore to the resident's left buttock. Barrier cream was applied. -March 11, 2024, ULP noted a small area on the resident's buttock was almost healed. -March 18, 2024, ULP noted the "left buttock sore is healed over, staff applied barrier cream to prevent it from opening again. Will continue to monitor." -March 20, 2024, ULP noted the resident's bottom remained healed over. -March 26, 2024, ULP documented "resident has been in a negative/argumentative mood all day today ...resident's biggest complaint to this staff was about being late as he normally gets up in the 6:00 hour and staff showed up to his room at 7:15. Then when resident pages, it's when this writer is attending to another residents needs and cannot leave them unsupervised. Resident has been incontinent of bowel two times, once in the morning and once this afternoon. In the afternoon, he had a full change of clothing due to the incontinence. Resident stated "if you would've just done your job and came on time, we wouldn't be in this mess. Resident only becomes more upset when you attempt to reason with him. -April 4, 2024, the clinical nurse supervisor (CNS)-A documented she attempted to do the resident's 90 day assessment but he refused. -April 5, 2024, an administrative staff member met with the resident to discuss various concerns. "I asked if he ever refuses services from [ULP] and he said no. He also said they should know to put the cream on his bottom and be checking for soars (sic) as he can't do this on	01620		

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01620	Continued From page 11 his own. When checking his care plan it does show that nursing does this Monday, Wednesday, Friday. We told him we would follow up with him next week ..." -April 11, 2024, the CNS documented she came to the resident's room after a ULP reported he was having behaviors. "When writer entered resident's room, resident was having verbal aggression towards [ULP] and this writer. Resident had called [ULP] an asshole and told her that they should have came to them right away. [ULP] had already once told the resident they were in giving another resident a shower when they had paged to use the restroom and they couldn't leave them. Resident continued to yell at [ULP] saying "you should have not even taken the other resident to do a shower until I buzzed. I always go to the bathroom some time after lunch, I come first." This writer then told the resident that [ULP] cannot wait all afternoon for them to use the bathroom as other residents are scheduled for their showers at a certain time. [R1] then began to yell at this writer "I had to wait" Writer then told resident -April 12, 2024, ULP documented "no new changes to his bottom. Area is healed over." -April 14, 2024, ULP documented "resident's sore on his left buttock reopened today. Writer applied barrier cream to the area. Will continue to monitor." The RN failed to assess the resident's wound. -April 19, 2024, ULP documented "resident has an open sore on his left buttock. Area was not actively bleeding when writer assessed the area. Barrier cream was applied. Will continue to monitor." The RN failed to assess the resident's wound. -April 22, 2024, ULP documented "resident's sore on his left buttock is open and actively bleeding at this time. Writer cleaned the area and applied	01620		

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barrier cream. Will continue to monitor." The RN failed to assess the resident's wound.
-April 23, 2024, CNS-A assessed the wound and wrote "Resident has a stage 2 pressure sore to right buttock that measures 2 centimeters (cm) by 1 cm without any depth. This writer cleansed the area thoroughly with warm, soapy water. Patted dry, then applied Tena barrier cream. This writer provided education to resident that the best way to prevent the pressure sores from recurring or worsening is by ensuring that they are not sitting in a soiled, wet brief, and that they are following their repositioning schedule. Resident replied with "I have heard this all before." Writer did let resident know that they will be measuring their sore every week to see if it is worsening, stable, or improving. Resident was agreeable to this ..." The RN failed to update the resident's primary care provider following the assessment.
-April 24, 2024, ULP documented "sore on his left buttock is open, and not actively bleeding at this time ..."
-April 26, 2024, CNS-A wrote, "No changes to [R1's] open area from earlier this week. Still open, no active bleeding. Tena barrier cream applied. This writer attempted to talk to resident about toileting and repositioning. Resident stated "I have already been told this before." Writer will reapproach the resident on the subject tomorrow when they are in facility ..." The RN again failed to update the resident's primary care provider.
-April 28, 2024, CNS-A documented the resident refused toileting twice between 2:00 p.m. and 4:00 p.m. Resident was noted to have not been toileted since 10:30 a.m. "This writer then let resident know that since he refusing to be toileted or repositioned, Farmstead is going to have to file a report of self neglect on him due to their open sores. Resident became agitated, raising his voice saying "you file whatever reports you need

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01620	Continued From page 13 to do to make you sleep at night, when all you want to do is waste my time and take away from me watching TV." This writer tried to explain to resident that we are trying to prevent his sores from getting worse or infected. Resident again yelled at writer while waiving his hands in writers face saying just leave, go. Writer then got up and walked away as to not agitate the resident any further." The RN again failed to update the resident's primary care provider on the open wound. Later that same day, CNS-D documented when staff went to change the resident at 8:00 p.m., the resident was soiled with urine and stool and his open area was bleeding. The area was cleaned and barrier cream was applied. -April 29, 2024, CNS-D documented the resident had behaviors after staff didn't respond to his light immediately. CNS-D wrote, "will continue to monitor for ongoing behaviors." CNS-D failed to identify any interventions or take action to address the resident's ongoing behaviors and refusals of care. Later that day, ULP documented the resident's sore on his left buttock was still open but not actively bleeding. In another progress note from that day, CNS-D wrote she "filed a MAARC report against the resident due to self neglect. No care plan changes made at this time." CNS-D failed to notify the resident's primary care provider. -May 1, 2024, CNS-D assessed the wound again and documented "Resident has a stage 3 pressure ulcer measuring 2.75 cm in length x 2.25 cm in width x 0.1 millimeters (mm) in depth. Wound tissue is dark red, and vascular with bleeding. Wound was cleansed and Tena barrier cream applied. Resident has a pinpoint open area to right buttock. Area cleansed and Tena barrier cream applied." CNS-D sent a fax to the resident's primary care provider "regarding the open sore on left buttock." The resident was	01620		

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scheduled to be seen in the clinic that day, however the resident cancelled his appointment.
-May 3, 2024, ULP documented the resident continued to have an open sore on his left buttock. Later that day, licensed practical nurse/director of resident care (LPN/DRC)-A sent a fax to R1's primary care provider to advise a MAARC report was filed "due to constant refusals of toileting and repositioning causing his sore on his buttock to become larger. Did inform PCP that education has been provided regarding risks and benefits of toileting and repositioning ..."
-May 7, 2024, CNS-A sent a fax to the PCP requesting a referral to the wound clinic. A referral was placed and CNS-A updated the resident. The resident told CNS-A "I would like a 24 hour notice before anything gets sent to my provider regarding my care. I know my wound is bad, but this decision needs to be made between my doctor and I, and not this facility." ...Resident is resistant to wound clinic and PT/OT at this time until speaking to their provider." Later that day, LPN/DRC-A "spoke with [R1] about his Roho cushion for his wheelchair as he has not been using it. [R1] states he did not want to use it today but will consider using it next week. Writer contacted PT [physical therapy] to see if PT could assist with proper air pressure and placement of the cushion ..."
-May 9, 2024, CNS-A measured the resident's wound again and it was noted to be a stage 3 pressure ulcer that was 10 mm in length by 5 mm wide and 4 mm in depth. "This writer and staff member attempted to switch resident's wheelchair cushion for Roho cushion. Resident refused. Writer educated resident on the benefits of the Roho cushion and how it helps distribute weight and that [PCP] has recommended they start to use it due to the increase in size in pressure ulcer. Resident stated they have had the

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01620	Continued From page 15 Roho cushion for three years and they would like to read up on it prior to using it as they have not used it yet ..." R1's record contained a fax dated May 1, 2024, from CNS-A which read, "Resident has a stage 3 pressure ulcer ...wound tissue is dark red, and vascular with bleeding. Wound was cleansed, and Tena barrier cream applied. Resident has a pinpoint open area to right buttock. Area cleansed and Tena barrier cream applied. Resident refuses to let staff change or reposition him for 8 hours or more on the weekend, which causes sore to get worse. Can we please get a referral to the wound clinic or a prescription for wound?" The response back from the PCP dated May 2, 2024, was "wound clinic consult. PT/OT assessment, Roho cushion for wheelchair." The fax was resent to the PCP on May 6, 2024, and received back at the facility on May 7, 2024. On May 16, 2024, at 9:55 a.m., the investigator entered R1's room with ULP-F. R1 was sitting on the toilet and connected to a mechanical lift. ULP-F showed the investigator the open area on R1's buttocks. A small open area was observed on the resident's left buttock. The entirety of the resident's buttocks was leathery and dark purple with some non-blanchable areas. R1 was transferred back to his wheelchair. A Roho cushion was observed on the resident's dining room table. The resident's room did not have a bed, just a recliner. R1 stated he sleeps in the recliner and prefers to sleep in it over a bed. On May 16, 2024, at 10:10 a.m., R1 stated it's not that he refused cares but "we don't seem to be on the same page ...that's the word they're using but I don't refuse care, I want things done a certain way."	01620		

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01620	Continued From page 16 On May 20, 2024, at 10:10 a.m., R1's PCP stated he was not previously aware of the delay in assessing the wound or contacting his office and that the facility had made it sound like it was self-neglect since the resident wouldn't listen to them about wound care. The PCP stated given the resident is wheelchair bound, he should have been notified within a few days of the wound reopening. The PCP stated barrier cream would be appropriate for a stage one pressure ulcer but would not be the recommended treatment for a stage three pressure ulcer. The PCP stated he was not aware the resident was sleeping in a recliner. The PCP stated the resident was to be using a special cushion in his wheelchair since he had hip contractures that caused him to sit in a weird position. The PCP stated the day they received the first fax, they immediately scheduled the resident to be seen in person in the clinic and got him an appointment that day. The appointment was canceled by the resident and they did not hear anything further from the facility. On May 20, 2024, at 10:35 a.m., resident's case manager stated that the licensed practical nurse (LPN) updated them of the MAARC report for self-neglect, but the facility did not disclose the delay in care. The case manager stated the LPN reached out to set up a care conference regarding the resident and she replied that she would like to attend but hasn't heard anything back in a few weeks. On May 20, 2024, at 11:45 a.m., licensed practical nurse/director of resident care (LPN/DRC)-B stated she was not previously aware of the delay of the RN assessing the wound or updating the provider and that their process would be to address wounds as soon as	01620		

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01620	Continued From page 17 they're noticed. On May 20, 2024, at 12:10 p.m., licensed assisted living director (LALD)-C stated she was not previously aware of the delay in assessment of the wound or updating the resident's provider. LALD-C stated she was not sure why the RN failed to address the wound timely and as far as she was aware, the wound got worse due to the resident's non-compliance. LALD-C stated the resident admitted to the facility with a history of pressure ulcers and he routinely developed them so she was not sure why this was not addressed in the resident's assessment. On May 21, 2024, at 10:10 a.m., clinical nurse supervisor (CNS)-A stated the facility's current process was that unlicensed personnel called care coordinators were responsible for conducting skin assessments. CNS-A stated she felt the care coordinators were appropriate to complete skin assessments because they were certified nursing assistants and she had trained them on how to complete a skin assessment. CNS-A stated the care coordinator had been monitoring the pressure ulcer but once it started to bleed, she got involved with the resident's care. CNS-A was asked why the provider was not updated when the pressure ulcer first developed and stated, "It usually closes back up within a week so that's why the provider wasn't notified. It usually reopens on weekends because he sits on one end of the building and doesn't allow staff to toilet him or do anything." CNS-A stated once the pressure ulcer worsened to a stage three, she updated the provider. CNS-A was asked why the resident's skin assessment did not include his history of skin breakdown and noncompliance and if that would be relevant to include in an assessment. CNS-A stated their consultant had	01620		

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told them to only include how the resident's skin is currently and the assessment only focused on the resident's current status, not their history, although she added they would include a history of their allergies. CNS-A was asked why interventions were not developed to reflect the resident's history of noncompliance and why there was no documentation showing what interventions had been tried. CNS-A stated they had tried things like offering the resident free cable TV in his room and offering a choice of if he wants to change his incontinence product in 15 or 30 minutes. CNS-A confirmed the referral for wound clinic consultation was not done and the resident refused so it would not be happening. CNS-A was asked if the provider had been updated and she thought they had updated him. CNS-A was asked if she was aware the provider sent a fax back to the facility on May 2nd and confirmed she did not know but they had reached out to the provider again on May 7th after they hadn't heard anything back.

On May 21, 2024, at 11:10 a.m., care coordinator/unlicensed personnel (CC/ULP)-G stated in her role, she worked as a lead caregiver and also helped the nurses by training ULP on some things, working with the nurses to inventory medications, do dressing changes, skin assessments, and document intakes and output, among other duties. CC/ULP-G stated she felt it was within her scope of duties to complete skin assessments since the nurse had trained her how to do them. CC/ULP-G was asked what the training included or when it was done. CC/ULP-G stated it was done by a prior RN and she couldn't recall what all was covered in the training. CC/ULP-G stated any time she entered a note about a skin condition, she would send an email to CNS-A as well to make sure she was aware of

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01620	Continued From page 19 any changes to R1's skin. CC/ULP-G stated she would have sent emails to CNS-A on April 14, April 19, and April 22nd. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
02320 SS=F	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to notify the registered nurse on call with a change in condition. The licensed practical nurse (LPN) provided medical advice while serving as the on-call nurse, outside the scope of practice for a LPN. This had the potential to affect all residents receiving assisted living services. 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	02320		

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02320	Continued From page 20 a large portion or all of the residents). The findings include: The licensee's nurse on call schedule indicated a licensed practical nurse (LPN) was the nurse on call for 21 of 31 days in March, 20 of 30 days in April, and 20 of 31 days in May, 2024. In the corner of the calendar, information for the 24/7 registered nurse (RN) on-call was listed. Licensed practical nurse/director of resident care (LPN/DRC)-B's job description for the position of Director of Resident care, dated March 20, 2024, indicated the position was responsible for providing nursing care to residents, including medication and treatment administration, documentation, and other therapeutic interventions under the direction of the RN. The Director of Resident Care plans nurse staffing schedules, coordinated treatment plans, and assisted, supervised, coached members of the care team as needed. Additional responsibilities included monitoring residents to assess the effectiveness of their medication and care plans, possible unintended side effects, and negative medicine interactions, respond to emergency and specialized resident care situations, evaluate facility care practices, and communicate to appropriate personnel, residents, and/or responsible party information regarding the resident. The position was also on the nurse on-call assignment on a rotating basis with the nursing team, in compliance with the nurse on-call policy. Able to troubleshoot and assist within scope of practice. Qualifications included being a LPN or RN in the state of Minnesota. Licensed practical nurse/director of resident care (LPN/DRC)-H's job description for the position of	02320		

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02320	Continued From page 21 Director of Resident care, dated March 20, 2024, indicated the position was responsible for providing nursing care to residents, including medication and treatment administration, documentation, and other therapeutic interventions under the direction of the RN. The Director of Resident Care plans nurse staffing schedules, coordinated treatment plans, and assisted, supervised, coached members of the care team as needed. Additional responsibilities included monitoring residents to assess the effectiveness of their medication and care plans, possible unintended side effects, and negative medicine interactions, respond to emergency and specialized resident care situations, evaluate facility care practices, and communicate to appropriate personnel, residents, and/or responsible party information regarding the resident. The position was also on the nurse on-call assignment on a rotating basis with the nursing team, in compliance with the nurse on-call policy. Able to troubleshoot and assist within scope of practice. Qualifications included being a a LPN or RN in the state of Minnesota. Emails including a summary of calls received by the on-call nurse included the following instances of the LPN triaging and assessing a resident change in condition without immediately notifying the RN: -May 12, 2024, the on-call nurse, LPN/DRC-H, was notified of a resident complaining of chest pain with a blood pressure of 187/78. LPN/DRC-H directed staff to administer as needed nitro [medication] and failed to immediately notify the RN. The RN was notified of the issue via email on May 13, 2024 at 6:47 a.m. -May 11, 2024, the on-call nurse, LPN/DRC-H, was notified a resident pulled out a feeding tube at 5:00 a.m., and was sent to the hospital via	02320		

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02320	Continued From page 22	02320		

ambulance. LPN/DRC-H failed to immediately notify the RN. The RN was notified of the issue via email on May 12, 2024, at 9:12 a.m.
-May 6, 2024, the on-call nurse, LPN/DRC-H was notified of a resident having abdominal pain and chest pain at 8:30 p.m. The resident was noted to have high blood pressure and oxygen ranging from 88% to 96%. LPN/DRC-H directed staff to administer Tylenol and Tums. Later that night at 10:48 p.m., the resident pulled out a feeding tube and was sent to the emergency room via ambulance. The resident returned to the facility at 1:15 a.m. and pulled out his tube again at 6:25 a.m., and was sent back to the emergency room. The RN was notified of the issue via email on May 7, 2024, at 6:46 a.m., and replied at 8:55 a.m. writing, "Thank you for the update...[the resident] was just leaving this morning when I pulled up for work."
-May 4, 2024, the on-call nurse, LPN/DRC-B was notified of a resident who had dizziness, increased blood pressure, and sudden onset of swelling in her lower legs. The resident was sent to the emergency room. Another resident fell and was noted to have low oxygen. LPN/DRC-B directed staff to recheck and monitor oxygen, which continued to be low. The resident's family declined going to the emergency room for further evaluation. The RN was notified of the issue via email on May 5, 2024, at 9:02 a.m.

On May 16, 2024, at 7:15 a.m., unlicensed personnel (ULP)-I stated when the on-call nurse is the LPN, the LPN usually answers all their questions and provides nursing guidance. ULP-N stated she did not recall any instances where the LPN directed them to contact the RN.

On May 16, 2024, at 7:20 a.m., ULP-J stated when the on-call nurse is the LPN, the LPN

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02320	Continued From page 23 usually answers all their questions and provides nursing guidance. ULP-N stated she did not recall any instances where the LPN directed them to contact the RN. On May 16, 2024, at 8:05 a.m., ULP-K stated when the on-call nurse is the LPN, the LPN usually answers all their questions and provides nursing guidance. ULP-N stated she did not recall any instances where the LPN directed them to contact the RN. On May 27, 2024, at 2:10 p.m., licensed practical nurse/director of resident care (LPN/DRC)-B wrote for the resident with chest pain, "The RN was notified the morning of 5/13/24 by email. This resident has a history of chest pain and an established order for nitro which he uses frequently. This was not a change of condition for him. The RN was notified in the morning [of May 6 and May 11] of [the resident] pulling his tube out. The LPN notified his sister and she decides if she wants him sent by ambulance or if she will transport. [The May 4, 2024 calls], The LPN handled these calls, the RN was notified in the morning of these calls except for [resident], the RN was notified at the time [resident] was sent into the ER via text message." In addition, LPN/DRC-A wrote, "As far as the on-call questions, the LPN can and does answer within his/her scope of practice. Staff, including LPN's, have access to an on-call RN 24/7 (which is what the language of 144G states). When the LPN gets the phone call from the staff, the LPN will only answer questions within his/her scope of practice and if it is not within the scope, the RN will be called. The staff always have the option to call the RN on call if they don't feel comfortable with calling the LPN."	02320		

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02320	Continued From page 24 Minnesota Statute 148.171 subdivision 14 indicated the practice of practical nursing included conducting a focused assessment of the health status of an individual patient through the collection and comparison of data to normal findings and the individual patient's current health status, and reporting changes and responses to interventions in an ongoing manner to a registered nurse or the appropriate licensed health care provider for delegated or assigned tasks or activities, participating with other health care providers in the development and modification of a plan of care, determining and implementing appropriate interventions within a nursing plan of care or when delegated or assigned by a registered nurse, implementing interventions that are delegated, ordered, or prescribed by a licensed health care provider, assigning nursing activities or tasks to other licensed practical nurses (LPNs), assigning and monitoring nursing tasks or activities to unlicensed assistive personnel, providing safe and effective nursing care delivery, promoting a safe and therapeutic environment, advocating for the best interests of individual patients, assisting in the evaluation of responses to interventions, collaborating and communicating with other health care providers; Minnesota Statute 148.171 subdivision 15 indicated the practice of professional nursing included providing a comprehensive assessment of the health status of a patient through the collection, analysis, and synthesis of data used to establish a health status baseline and plan of care, address changes in a patient's condition, collaborating with the health care team to develop and coordinate an integrated plan of care, developing nursing interventions to be integrated with the plan of care, implementing nursing care	02320		

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02320	Continued From page 25 through the execution of independent nursing interventions, implementing interventions that are delegated, ordered, or prescribed by a licensed health care provider, delegating nursing tasks or assigning nursing activities to implement the plan of care, providing safe and effective nursing care, promoting a safe and therapeutic environment, advocating for the best interests of individual patients, evaluating responses to interventions and the effectiveness of the plan of care, and collaborating and coordinating with other health care professionals in the management and implementation of care within and across care settings and communities. The licensee's 24/7 Registered Nurse Availability/On-Call Staff policy dated March 12, 2024, indicated One or more licensed practical nurses is designated as on-call, and is readily available to be contacted by telephone, electronic messaging, or in person by Farmstead Living staff when questions regarding resident care or status arise that are within the scope of practice for licensed practical nurses pursuant to the Minnesota Nurse Practice Act (Minn Stat 148.171-148.285). If topics or questions arise that are readily identifiable as or are arguably outside of the licensed practical nurse's scope of practice, the licensed practical nurse will immediately contact the on-call registered nurse. The licensed practical nurse would also send a report by email to the RN to review and follow up if needed. The email would be printed off and placed in a logbook. The email would be audited daily by the clinical nurse supervisor to ensure compliance with the Minnesota Nurse Practice Act and Minnesota Statutes Chapter 144G. No further information was provided.	02320		

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02320	Continued From page 26 TIME PERIOD FOR CORRECTION: Seven (7) days	02320		
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 one of one residents reviewed (R1) was 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	No plan of correction is required for this tag.	