Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL202016685M
Compliance #: HL202012620C

Date Concluded: October 24, 2023

Name, Address, and County of Licensee Investigated:
Lakewood Manor
222 5th Street NE
Staples, MN 56479
Todd County

Facility Type: Assisted Living Facility (ALF)

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 after staff failed to report, monitor, and assess a change in condition. The resident was noted to have not felt well for several days and had purple extremities. The resident was admitted to the hospital.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The resident had two unwitnessed falls and two days later began to complain of weakness and was unable to bear weight on her legs. The resident complained of worsening pain and numbness/loss of sensation in her lower limbs for 17 days before she was sent to the emergency room. The RN failed to reassess the resident after she went from being independent with transfers to requiring the use of a mechanical lift. The RN failed to update the resident's provider. The resident was admitted to the hospital and later admitted to a nursing home.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted the case manager and the resident's primary care provider. The investigation included review of facility medical records including the care plan, service plan, assessments, and progress notes, as well as hospital records. At the time of the onsite visit, the investigator observed provision of cares and medication administration.

The resident resided in an assisted living facility. The resident's diagnoses included hypertension (high blood pressure), chronic obstructive pulmonary disease (COPD), stress fractures, and malignant neoplasm (cancer) of the pelvic bones, sacrum, and coccyx. The resident's service plan included assistance with bathing and medication management. The resident's assessment indicated the resident was independent with walking but was not ambulatory and would self-propel with her wheelchair. The resident was independent with dressing, grooming, and required assistance from staff twice per day to use the bathroom. The resident required assistance from one staff member and a transfer belt PRN (as needed, not on a regular basis).

Progress notes indicated approximately 23 days before the resident was admitted to the hospital, the resident fell out of bed. Three days later, the resident experienced another fall and 911 was called to help get the resident off the floor.

Three days after her second fall, unlicensed personnel (ULP) documented the resident had a hard time transferring and the resident reported she couldn't move her leg. Staff began using a mechanical lift to transfer the resident. The registered nurse (RN) failed to reassess the resident after her transfer status changed. Over the next 17 days, the resident continued to complain of worsening pain, numbness in her legs and feet, and increased difficulty with transferring. The resident was eventually not able to use the mechanical lift because she couldn't move her legs to put them on the platform or grab on to the lift due to pain in her hands and wrist. The resident began to require more assistance with activities of daily living and assistance with supplemental oxygen. During this time, the RN failed to update the resident's primary care provider, failed to reassess the resident, failed to update the resident's service plan, and failed to seek further care for the resident's change of condition.

About a week before the resident went to the hospital, a physical therapy assistant documented the resident's oxygen saturation was staying at 80% (normal oxygen saturation levels are 95%-100%) even with recovery breathing and "patient stated she feels the good Lord is taking her home and that she is feeling like it's her time to go." Therapy exercises were not performed due to the resident's low oxygen levels. The note indicated "nursing staff made aware of patient's low O2 [oxygen] and that patient is currently on supplemental O2." After starting supplemental oxygen, the resident's oxygen saturation level went up to 93%. The physical therapy assistant documented they "left on O2 with nursing staff notified. The resident was scheduled to discharge from therapy services due to her decline.

The resident's hospital admission assessment indicated the resident had become much weaker over the past few weeks and required assistance with all activities of daily living and transfers. The resident was diagnosed with a chordoma (a rare type of tumor that occurs along the spine), which was attributed to her loss of mobility. The hospital documentation indicated the facility would not take the resident back due to her transfer status.

During investigative interviews, several unlicensed personnel (ULP) stated the resident declined to the point she needed a mechanical lift for transfers. ULP stated they had communicated to the registered nurse (RN) about the resident's decline and entered progress notes detailing her decline but did not get any kind of response from the RN regarding their concerns. ULP stated the RN did not provide any guidance on changes in the resident's transfer status and the unlicensed staff had implemented the use of the mechanical lift. One ULP stated they "assumed if I was documenting it, she'd [the RN] be handling it." The ULP stated the resident had previously managed her oxygen on her own but as she declined, staff had to provide assistance with oxygen. The ULP stated the RN did not update the resident's service plan and did not provide any additional guidance to staff. One ULP stated the resident went from being able to transfer on her own and within a few weeks, lost the use of her legs. The ULP stated she and several staff members reported their concerns to the RN but didn't feel like it was given priority or taken seriously. The ULP stated she and other caregivers "documented and documented" their concerns with the resident's decline and nothing happened, and the nurse did not take action until the resident's daughter came in and raised concerns.

During an interview, the RN stated the last couple of weeks the resident resided at the facility, "she'd have good days and bad days." The RN could not recall when she was first updated of the decline and change in transfer status for the resident but remembered visiting with the resident on a Monday. The RN stated she did not document that assessment with the resident and could not recall if she documented anything regarding the resident needing to use a mechanical lift. The RN could not recall if staff had updated her on the resident's change in condition, but she would read progress notes "on and off and honestly we were transitioning from one program to another, so I probably didn't read them as often as I usually do." The RN stated she updated the provider and the resident was sent to the emergency room that same day, but the RN was not sure if the provider had been updated over the course of the past two weeks when she began to decline.

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: Not available for interview.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
No action taken.

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
Todd County Attorney
Staples City Attorney
Staples Police Department
Minnesota Board of Nursing
Minnesota Board of Executives for Long Term Services and Supports

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20201	A. BUILDING: _____ B. WING _____	C 09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD MANOR	222 5TH STREET NE STAPLES, MN 56479

(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: #HL202016685M/#HL202012620C #HL202018565M/ #HL202015919C On September 22, 2023, through September 28, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 27 residents receiving services under the provider's Assisted Living license. The following immediate correction orders were issued on September 22, 2023. The following immediate correction orders are issued for #HL202018565M/ #HL202015919C, tag identification 1880, 2310, 2350. The following correction orders are issued that were not issued at the time of immediate correction orders.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	

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0 000	Continued From page 1 The following correction orders are issued for #HL202018565M/ #HL202015919C, tag identification 0250, 0430, 0470, 0620, 0630, 0680, 1060, 1070, 2360. The following correction orders are issued for #HL202016685M/#HL202012620C, tag identification 0250, 0470, 0620, 1620, 2360.	0 000		
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman	0 250		

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0 250	Continued From page 2 access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a	0 250		

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0 250	Continued From page 3 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 22, 2023, at 12:15 p.m., licensed assisted living director (LALD)-A confirmed the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent RN-A, identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat.	0 250		

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0 250	Continued From page 4 chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license.	0 250		

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0 250	Continued From page 5 - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page six was electronically signed by authorized agent LALD-A on May 23, 2023. The licensee had an assisted living license reissued on June 1, 2023, with an expiration date of May 31, 2024. The licensee failed to ensure the following policies and procedures were developed and/or implemented: -requirements in section 626.557, reporting of maltreatment of vulnerable adults As a result of this survey, the following orders	0 250		

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0 250	Continued From page 6 were issued 0430, 0470, 0620, 0630, 0680, 1060, 1070, 1620, 1880, 2310, 2350, 2360, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on interview and record review, the	0 430		

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0 430	Continued From page 7 licensee failed to ensure the uniform checklist disclosure of services (UDALSA) accurately reflected services provided by the licensee. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee's UDALSA, last updated March 18, 2023, included a section for dementia care services available, which pertained only to assisted living with dementia care licensed facilities. Section 1 on page three indicated the facility did not offer a secured unit or building for wandering or exit-seeking behavior but checked a box indicating it offered individualized digital/alarm monitoring for wandering or exit-seeking behavior through a wander guard pendant. The facility indicated it was not prepared to manage challenging behaviors by leaving the section unchecked. Page 11 included a section on Security & Monitoring services offered by the licensee. Daily and every two hour safety checks were marked as a service that was available, but sections for hourly, every 30 minute, and every 15 minute safety checks were unmarked, indicating it was not a service that was offered. A wander alert system at facility exits was checked as a service available. R1's updated assessment dated September 23, 2023, indicated staff would provide one to one	0 430		

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0 430	Continued From page 8 care as a behavioral intervention. Staff were to check on the resident "every half hour until resident is reassessed by nurse and determined safe or until other placement (sic)." On September 26, 2023, at 10:30 a.m., licensed assisted living director (LALD)-A was asked about the facility providing services not offered per their UDALSA. LALD-A stated "doing 30 minute checks isn't something we generally do." LALD-A stated it was only for the emergency situation and is not a service usually provided and confirmed it was not listed on their UDALSA as something they were able to offer. In addition, the licensee's UDALSA indicated there was a licensed assisted living director on site full time. A review of the Board of Executives for Long Term Services and Supports on September 26, 2023, indicated LALD-A had a shared director license and worked at a second location operated by the licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans	0 470		

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0 470	Continued From page 9 on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the required staffing plan was developed, implemented, and evaluated for appropriateness of staffing levels as required, potentially affecting all of the current residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 470		

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0 470	Continued From page 10 On September 22, 2023, at 3:50 p.m., the licensee's staffing plan was requested. On September 26, 2023, at 8:30 a.m., the licensee's staffing plan was requested. The licensee's staffing schedule and staffing policy were provided. The staffing plan was requested again. On September 26, 2023, at 12:58 p.m., LALD-A emailed a document titled Lakewood Health System Assisted Living Contingency staffing plan. The plan indicated the objective was to reduce the overall impact of an emergency/disaster on employees, patients/residents, partners, and stakeholders to decrease the time it takes to restore full operational capacity. The plan was last updated August 24, 2020. The licensee's UDALSA, last updated March 18, 2023, included a section on Security & Monitoring services offered by the licensee. Daily and every two hour safety checks were marked as a service that was available, but sections for hourly, every 30 minute, and every 15 minute safety checks were unmarked, indicating it was not a service that was offered. R1's updated assessment dated September 23, 2023, indicated staff would provide one to one care as a behavioral intervention. Staff were to check on the resident "every half hour until resident is reassessed by nurse and determined safe or until other placement (sic)." The licensee's staffing policy did not address how the facility would staff in situations where a behavioral resident required additional care and services. The licensee's Staffing and Scheduling policy	0 470		

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	20201	A. BUILDING: _____ B. WING _____	C 09/28/2023

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0 470	Continued From page 11 dated August 1, 2021, indicated the clinical nurse supervisor would develop and implement a written staffing plan that provides an adequate number of qualified direct care staff to meet the resident's needs 24-hours a day, seven days a week. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 620 SS=E	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the	0 620		

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0 620	Continued From page 12 previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment for two of two	0 620		

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0 620	Continued From page 13 residents (R1, R2) reviewed for an elopement and a change in condition. 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 The licensee failed to report suspected neglect after the resident eloped from the building. The resident was not reassessed and interventions were not reevaluated or implemented. R1's diagnoses included dementia, weakness, and type two diabetes. R1's service plan dated October 28, 2022, indicated the resident received assistance with dressing, grooming, bathing, toileting, and transfers. R1's progress notes contained the following entries: -June 6, 2023, RN-C documented she completed a 90 day review. The resident remained independent with supports of nail care, bathing, cognitive support, scheduling of appointments and transportation, housekeeping, laundry, and meals.	0 620		

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0 620	Continued From page 14 -June 17, 2023, at 9:25 a.m., a unlicensed personnel (ULP) documented the resident came to the dining room with a pair of pants in her lap. The ULP later "found the resident outside in the middle of the street. Writer went and got resident and asked what she was doing." The resident claimed she was saving some chickens from getting hurt. The resident became combative with the ULP. The on-call registered nurse, (RN)-B, was notified but no immediate interventions were documented by the RN and the incident was not reported to MAARC. RN-B directed staff to place a wander guard but failed to complete an assessment to ensure the wander guard was appropriate. -June 17, 2023, at 8:56 p.m., a ULP documented the resident had behaviors throughout the shift and redirection was not successful. The resident attempted to elope "multiple times over the course of the next four hours." -June 19, 2023, RN-B wrote she "instructed staff to put a roam alert pendant on resident wheelchair due to exiting the building without staff knowledge and resident unaware of own safety in doing this." -September 1, 2023, RN-B documented she met with the resident for a 90 day review of services and noted the resident has "remained independent with supports of nail care, showers, cognitive support, pericare, housekeeping, laundry, meals, and emergency pendant...resident reports good appetite, sleeping well at night, and normal urination and bowel movements." -September 14, 2023, a ULP documented the resident came downstairs in her wheelchair with	0 620		

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0 620	Continued From page 15 just a shirt and a brief on. The resident exhibited verbal behaviors including thinking the devil was coming to get her. The ULP documented the resident was hitting the front door button with her walker and setting off the wander alarm. Redirection attempts were not successful. R1's care plan did not address the resident's history of elopement and no interventions were implemented to prevent further elopements. R1's care plan indicated the resident had mild/moderate/severe memory loss and required reminders for activities and meals and frequent hygiene checks. Behaviors noted were behaviors of disrobing, taking things belonging to others, wandering aimlessly, showing anger, provocation, verbal abuse, or other extreme or erratic behavior patters. It was noted the resident hits out at staff and thinks people are taking things from her. R1's most recent assessment, dated September 1, 2023, indicated the resident was disoriented to time, place, and situation. The resident was noted to have a history of elopements and was at risk for elopement. No interventions were documented. On September 22, 2023, at 4:50, licensed assisted living director (LALD)-A stated she felt the facility was able to meet R1's needs and had appropriately assessed the resident's behaviors. On September 25, 2023, at 1:40 p.m., RN-C stated she had not been on call when the resident eloped and when she came back that Monday, she had visited with the resident but did not document any assessments or identify if any other interventions were needed. RN-C stated she wasn't sure if a MAARC report had been filed and thought LALD-A might have filed one.	0 620		

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0 620	Continued From page 16 On September 28, 2023, at 1:00 p.m., RN-B confirmed she had been on call and was notified by staff that R1 eloped on June 17, 2023. RN-B stated she had not considered filing a MAARC report at that time but agreed if a resident left the building, it would be a reportable event. R2 The licensee failed to report suspected neglect after the resident experienced a change in condition and the RN failed to reassess the resident. The resident had a fall and later began to experience severe pain over the next 17 days and required a mechanical lift for transfers after she was no longer able to independently transfer herself due to pain. R2's diagnoses included hypertension (high blood pressure), chronic obstructive pulmonary disease (COPD), stress fractures, and malignant neoplasm (cancer) of pelvic bones, sacrum and coccyx. R2's service plan dated January 19, 2023, indicated the resident received assistance with bathing and medication management. R2's most recent assessment, dated April 20, 2023, but signed by LALD-A on May 8, 2023, indicated the resident was independent with walking but was not ambulatory and would self propel with her wheelchair. The resident was independent with dressing and grooming, required assistance from staff twice per day to use the bathroom. The resident required assistance from one staff member and a transfer belt PRN (as needed, not on a regular basis). R2's care plan, dated April 20, 2023, indicated the	0 620		

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0 620	Continued From page 17 resident was not ambulatory and required occasional assistance to get in and out of the bed or chair. Staff were to report any changes in ability to transfer to the nurse. R2's progress notes contained the following entries: -April 23, 2023, a ULP documented the resident slid out of bed. The RN entered a note the following day indicating a silk bedspread was removed from the resident's room. -April 26, 2023, the RN documented the resident had an unwitnessed fall and was found laying on the floor. 911 was called for lift assistance to get the resident off the floor. -April 29, 2023, a night shift ULP documented the resident was having a difficult time transferring and unable to bear weight on her legs. The resident's upper body strength was noted to be weak and "it was very hard for resident to push up off the bed to get into a standing position and difficult for resident to turn and get into the wheelchair." -April 29, 2023, an evening shift ULP documented the resident had "a hard time transferring with assistance using gait belt. [resident] told writer she cannot move her leg. Writer went to AL [assisted living] storage and brought PAL lift (type of mechanical lift) assist machine and used for toileting after supper. [resident] was much easier to move around and toilet with PAL lift. [Resident] told writer she was glad to have this machine. Writer will relay to staff location of PAL lift assistance for [resident] transfers." -May 1, 2023, a ULP documented the resident	0 620		

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0 620	Continued From page 18 was transferred with the PAL lift three times during the evening shift for toileting. The ULP wrote the resident was "unable to move either leg and needs assistance to lift them to the PAL platform for standing. [Resident] told writer her feet and legs are numb. [resident] was also assisted to bed with PAL machine and legs were lifted by writer onto bed as [resident] cannot lift her legs..." -May 5, 2023, a ULP documented the resident was now using a PAL lift assist for toileting and transfers. -May 9, 2023, a ULP documented the resident was unable to help with lifting either leg and told the writer "I can't lift either one, they are too heavy for me." -May 11, 2023, a ULP documented the resident "started to wheeze and cough a little, and seemed to be out of breath. Writer asked [resident] if she is ok [resident] said yes." Later when the resident came down for supper, it was noted the tenant was out of breath and had no strength to push herself to the table. -May 13, 2023, a ULP documented the resident was transferred with a PAL lift and had trouble putting her legs straight. The resident reported to the ULP her legs were weak. -May 15, 2023, a ULP documented the resident reported she was "numb from her lower back down, with no voluntary motor control below her waist. She states that while in bed, her "better" right leg bends involuntarily which keeps her away...Resident states she has no voluntary control or sensation of bowels or bladder. Resident also complained of pain and numbness	0 620		

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0 620	Continued From page 19 in hands." -May 16, 2023, a night shift ULP documented the "resident was unable to use the lift to go to the bathroom." The ULP had difficulty getting the resident to a sitting position and she was not able to hold onto the lift "because her left hand and wrist were too painful." The resident was given Tramadol, a pain medication, and staff tried to help straighten her legs "but they kept bending back up." -May 16, 2023, the RN documented the resident "states she has no feeling in bilateral lower extremities, is unable to feel if she needs to urinate or have a BM (bowel movement)." The resident's primary care provider was notified and the resident was sent to the emergency room for further evaluation. -May 18, 2023, the RN documented the resident had been admitted to the hospital with compression fractures. The resident was admitted to a nursing home due to requiring a higher level of care. On September 25, 2023, at 10:00 a.m., ULP-E stated R2 became "more and more disabled, you could put her in bed and two hours later she couldn't move her arms." ULP-E stated they had communicated the resident's decline to the nurse with progress notes and emails but was not aware of any response from the nurse on their concerns. ULP-E stated she didn't recall the nurse ever providing any direction to staff on what to do for the resident's change in transfer status. On September 25, 2023, ULP-D stated he remembered updating RN-C about the resident's increasing difficulty with transfers but didn't recall	0 620		

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0 620	Continued From page 20 the nurse ever providing any specific instruction or formally updating the staff of the resident's transfer status. ULP-D stated he knew other staff besides himself reported the resident's numbness to RN-C. ULP-C stated he would enter progress notes about the resident's decline and "assumed if I was documenting it, she'd [RN-C] be handling it." On September 25, 2023, at 1:45 p.m., RN-C stated the last couple of weeks R2 resided at the facility, "she'd have good days and bad days." RN-C could not recall when she first was updated of the decline and change in transfer status for R2, but remembered visiting with the resident on a Monday. RN-C stated she did not document that assessment with the resident and could not recall if she documented anything regarding the resident needing to use a mechanical lift. RN-C could not recall if staff had updated her on the resident's change in condition but she would read progress notes "on and off and honestly we were transitioning from one program to another so I probably didn't read them as often as I usually do." RN-C stated she updated the provider and the resident was sent to the emergency room that same day [on May 16, 2023] but RN-C was not sure if the provider had been updated over the course of the past two weeks when she began to decline. On September 26, 2023, at 12:38 p.m., LALD-A provided records to show R2's change in condition had been appropriately addressed over the 17 days in question. The attached records included the following: R2 was seen by her primary care provider on May 2, 2023, for a face to face visit for the resident to obtain an electric wheelchair. The record did not	0 620		

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0 620	Continued From page 21 contain any documentation that would indicate the provider was updated of any specific concerns besides the need for an electric wheelchair. R2 was receiving home health physical and occupational therapy services for strengthening and received therapy on May 3, May 6, May 8, May 9, and May 10. On May 10, 2023, a physical therapy assistant documented the resident's oxygen was staying at 80% (normal oxygen saturation levels are 95% to 100%) even with recovery breathing and "patient stated she feels the good Lord is taking her home and that she is feeling like it's her time to go." Therapy exercises were not performed due to the resident's low oxygen levels. The note indicated "nursing staff made aware of patient's low O2 [oxygen] and that patient is currently on supplemental O2." After starting supplemental oxygen, the resident's oxygen came up to 93%. The physical therapy assistant documented they "left on O2 with nursing staff notified. Patient is declining in status and signed notice for discharge on 5/17." A home care nurse visited the resident on May 11, 2023, and documented the resident continued to need more assistance with ADLs and toileting due to being in a wheelchair. Her oxygen was noted to be 93% on room air and at times 90%. The records lacked evidence the provider had been notified of a change in condition and lacked evidence the RN appropriately responded to reports of low oxygen levels. On September 28, 2023, at 9:05 a.m., ULP-G stated R2 went from being able to transfer on her	0 620		

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0 620	Continued From page 22 own and within a few weeks, lost the use of her legs. ULP-G stated she and several staff members reported their concerns to RN-C but didn't feel like it was given priority or taken seriously. ULP-G stated as the resident declined, they had to provide more assistance with the resident's oxygen as she was not able to manage it independently anymore. ULP-G stated she and other caregivers "documented and documented" their concerns with the resident's decline and nothing happened and the nurse did not take action until the resident's daughter came in and raised concerns. The licensee's Vulnerable Adult Maltreatment-Prevention & Reporting policy, updated August 1, 2022, indicated staff who suspect maltreatment of a resident would take immediate action to keep the resident safe, call 911 if needed, and contact the clinical nurse supervisor and assisted living director. If the assisted living director or clinical nurse supervisor confirmed the suspicion of maltreatment, they would contact the Minnesota Adult Abuse Reporting Center (MAARC). Such report must be made no later than 24 hours after the maltreatment was first suspected. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
0 630 SS=G	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the	0 630		

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0 630	Continued From page 23 person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was updated to include specific measures to minimize the risk of vulnerabilities for one of one resident (R1) reviewed for an elopement and behaviors. 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: R1's diagnoses included dementia, weakness, and type two diabetes. R1's service plan dated October 28, 2022, indicated the resident received assistance with dressing, grooming, bathing, toileting, and transfers. R1's careplan did not address the resident's history of elopement and no interventions were	0 630		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 630	Continued From page 24 implemented to prevent further elopements. R1's care plan indicated the resident had mild/moderate/severe memory loss and required reminders for activities and meals and frequent hygiene checks. Behaviors noted were behaviors of disrobing, taking things belonging to others, wandering aimlessly, showing anger, provocation, verbal abuse, or other extreme or erratic behavior patters. It was noted the resident hits out at staff and thinks people are taking things from her. R1's most recent assessment, dated September 1, 2023, indicated the resident was disoriented to time, place, and situation. The resident was noted to have a history of elopements and was at risk for elopement. No interventions were documented. ELOPEMENT R1's progress notes contained the following entries: -June 6, 2023, RN-B documented she completed a 90 day review. The resident remained independent with supports of nail care, bathing, cognitive support, scheduling of appointments and transportation, housekeeping, laundry, meals." -June 17, 2023, a ULP documented the resident came to the dining room with a pair of pants in her lap. The ULP later "found the resident outside in the middle of the street. Writer went and got resident and asked what she was doing." The resident claimed she was saving some chickens from getting hurt. The resident became combative with the ULP. No immediate interventions were documented and the resident was not reassessed. -June 17, 2023, a ULP documented the resident	0 630		

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	20201	A. BUILDING: _____ B. WING _____	C 09/28/2023

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0 630	Continued From page 25 had behaviors and redirection was not successful. The resident attempted to elope "multiple times over the course of the next four hours." -June 19, 2023, RN-B wrote she "instructed staff to put a roam alert pendant on resident wheelchair due to exiting the building without staff knowledge and resident unaware of own safety in doing this." The RN failed to reassess the resident after implementing a roam alert pendant. -September 1, 2023, RN-B documented she met with the resident for a 90 day review of services and noted the resident has "remained independent with supports of nail care, showers, cognitive support, pericare, housekeeping, laundry, meals, and emergency pendant...resident reports good appetite, sleeping well at night, and normal urination and bowel movements." -September 14, 2023, a ULP documented the resident came downstairs in her wheelchair with just a shirt and a brief on. The resident exhibited verbal behaviors including thinking the devil was coming to get her. The ULP documented the resident was hitting the front door button with her walker and setting off the wander alarm. Redirection attempts were not successful. The RN did not document any follow up taken after the resident attempted to elope. On September 22, 2023, at 4:50, LALD-A stated she felt the facility was able to meet R1's needs and had appropriately assessed the resident's behaviors. -September 23, 2023, RN-B documented the resident was sent to the emergency room for	0 630		

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0 630	Continued From page 26 increased behaviors and increased exit seeking. RN-B wrote she had a conversation with the emergency room staff about the resident being unsafe at the assisted living due to her increased exit seeking, aggression, and refusing of cares. The resident was diagnosed with a urinary tract infection and sent back to the facility. An updated assessment was completed on September 23, 2023. The assessment indicated the resident was at risk for elopement and had a roam alert (wander guard) on her wheelchair. -September 25, 2023, LALD-A documented she spoke with the resident's power of attorney to inform her of escalated behaviors, exit seeking, and refusal of cares. -September 25, 2023, RN-B documented "per writer's nursing assessment of resident it is determined that resident is not appropriate for this assisted living facility due to her diagnosis of dementia, cognitive status, exit seeking, is undirectable most of the time which causes a concern for her safety. Resident refuses to abide by rules indicated in the tenant [resident] handbook and lease to keep apt [apartment] kept in a clean manner so as not to attract insects...nurse clinical judgment from assessment is that resident is no longer safe for this AL [assisted living] and AL staff are unable to meet her needs. It is advised to seek other placement in a memory care unit or behavioral health. LALD has been updated and involved." On September 26, 2023, at 7:50 a.m., R1's wander guard was not observed on her wheelchair. On September 26, 2023, at 8:30 a.m., ULP-F	0 630		

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0 630	Continued From page 27 verified she was not able to find the resident's wander guard on her wheelchair. On September 26, 2023, at 10:00 a.m., the investigator requested LALD-A show where R1's wander guard would be placed. LALD-A stated "they had just been talking about it" after a ULP reported they couldn't find it this morning. LALD-A and ULP-F returned to R1's room with the investigator and confirmed the wander guard was not on the resident's wheelchair. LALD-A stated R1's power of attorney (POA) might have brought home the wheelchair with the wander guard on it over the weekend but wasn't sure how she would have been able to get the wander guard out of the building. LALD-A stated the prior shift had documented the wander guard was in place so she was not sure how long it had been missing for. On September 26, 2023, at 10:30 a.m., LALD-A was asked about R1's history of elopements and the lack of interventions identified on her IAPP. LALD-A stated "I guess I wasn't aware of an elopement on her, I know she had attempts but my understanding is staff are able to redirect her." LALD-A waas not able to identify any other interventions besides redirecting the resident. On September 25, 2023, at 10:00 a.m., ULP-E stated R1 had left the building once looking for her chickens and was out in the road for a few minutes. ULP-E stated the process staff follow if a resident leaves the building is to try get them to come back in but "we can't force her to come in, this is an assisted living and she has her rights." ULP-E thought the nurse had been updated the resident left the building but didn't recall hearing any specific interventions to use if she attempts to elope again, other than the nurse putting a	0 630		

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0 630	Continued From page 28 wander guard on her. On September 25, 2023, ULP-D stated the resident had a lot of behaviors and she would frequently refuse cares and go as long as 16 plus hours without changing her brief, despite being saturated with urine. ULP-D stated he had identified a few interventions to use with R1 that were successful like showing the resident he's happy to help and she isn't a burden to staff or find ways to make her comfortable before initiating cares but added "I haven't gotten any practical tips on dealing with her from the nurse [RN-B and RN-C]. We use our general training on dementia to approach her but as far as a specific plan, there isn't one we're just doing the best we can with her." ULP-D confirmed he didn't think his interventions were on the resident's care plan as neither RN-B nor RN-C sought feedback from staff on interventions. On September 25, 2023, at 1:45 p.m., RN-C stated she knew the resident eloped one time and she put a wander guard on her. RN-C confirmed an assessment was not completed to ensure the wander guard was appropriate and not a restraint, and confirmed an incident report or MAARC report was not completed for the elopement. RN-C stated she wasn't the on call nurse over the weekend R1 left the facility and she had assumed LALD-A filed a report and did not follow up with her to ensure one was completed. RN-C was asked about interventions implemented for R1's behaviors and how staff had been educated to approach the resident. RN-C stated, "I did a lot of verbal teaching and I didn't document as much as I should have." RN-C was asked why R1's care plan lacked specific, individualized, and person-centered interventions and RN-C stated she had put in the	0 630		

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0 630	Continued From page 29 assessments and care plans "as quickly as possible just to get something in as we got the new program and I was going to add stuff back in later." BEHAVIORS The licensee's UDALSA, last updated March 18, 2023, included a section for dementia care services available, which pertained only to assisted living with dementia care licensed facilities. Section 1 on page three indicated the facility did not offer a secured unit or building for wandering or exit-seeking behavior but checked a box indicating it offered individualized digital/alarm monitoring for wandering or exit-seeking behavior through a wander guard pendant. The facility indicated it was not prepared to manage challenging behaviors by leaving the section unchecked. Page 11 included a section on Security & Monitoring services offered by the licensee. Daily and every two hour safety checks were marked as a service that was available, but sections for hourly, every 30 minute, and every 15 minute safety checks were unmarked, indicating it was not a service that was offered. A wander alert system at facility exits was checked as a service available. R1's progress notes contained the following entries: -May 25, 2023, a ULP documented the resident "sat in the commons area talking about how the water is going to kill everyone and we should not be washing clothing or showering." The resident refused to go back to her room and wanted to "sit there and make sure everyone know that the water is going to kill them and that it is all Trump's doing." -May 28, 2023, a ULP documented the resident	0 630		

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0 630	Continued From page 30 "refused to let writer help change her incontinence products at 4:40 a.m. even though her briefs were saturated..." -May 31, 2023, a ULP documented the resident refused cares overnight. -June 2, 2023, a ULP documented the resident refused 5:00 a.m. cares. -June 6, 2023, RN-B documented she completed a 90 day review. The resident remained independent with supports of nail care, bathing, cognitive support, scheduling of appointments and transportation, housekeeping, laundry, meals." -June 8, 2023, a ULP documented the resident was in front of an elevator not allowing other residents to use it. The resident was redirected back to her room. -June 13, 2023, a ULP documented the resident refused toileting all shift and was in bed sleeping. -June 17, 2023, a ULP documented the resident came to the dining room with a pair of pants in her lap. The ULP later "found the resident outside in the middle of the street. Writer went and got resident and asked what she was doing." The resident claimed she was saving some chickens from getting hurt. The resident became combative with the ULP. -June 17, 2023, a ULP documented the resident had behaviors and redirection was not successful. The resident attempted to elope "multiple times over the course of the next four hours."	0 630		

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0 630	Continued From page 31 -June 19, 2023, RN-B wrote she "instructed staff to put a roam alert pendant on resident wheelchair due to exiting the building without staff knowledge and resident unaware of own safety in doing this." -June 20, 2023, a ULP documented the resident refused overnight cares. -June 27, 2023, a ULP documented the resident was sitting at her door, yelling out. -June 29, 2023, a ULP documented the resident was yelling out at 7:00 a.m. needing to use the bathroom. The resident sat on the toilet for 1.5 hours. -July 3, 2023, a ULP documented the resident came downstairs in just a shirt and a brief and asked to use the bathroom. "She was agitated and stated there is nobody around here to help her that she had to come downstairs and look for help. I explained to her that I'm the only one working. I was busy at the time. She continued to be upset when I brought her back to her room." -July 4, 2023, a ULP documented the resident was unwilling to let staff change her brief and became combative. -July 5, 2023, a ULP documented the resident came down to the dining room and was upset someone stole a small plate. -July 11, 2023, a ULP documented the resident was uncooperative with evening cares and would not allow staff to put a brief on. -July 12, 2023, a ULP documented they tried three times to get the resident to put a brief on or	0 630		

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0 630	Continued From page 32 go to the bathroom but the resident refused. The ULP "removed two meals from the resident's room that had been sitting there since 10 p.m. Resident did not eat any of those meals." -July 21, 2023, a ULP documented the resident refused toileting or incontinence product changes "but reluctantly complied at 5:00 a.m. when very soaked." -July 23, 2023, a night shift ULP documented the resident was combative about changing her soaked brief. -July 23, 2023, a ULP documented she reapproached the resident after she refused cares all day. The resident was eventually cooperative and put on a dry brief, but "kneed the writer in the jaw." -July 23, 2023, a ULP documented the resident was agitated and tired and did not get up all day long. The resident was noted to have not eaten. -August 2, 2023, a ULP documented the resident was yelling in her doorway at 4 a.m. -August 17, 2023, the resident refused to change her brief on the overnight shift. The resident had soaked her bedsheets with urine but refused to allow them to be changed. The ULP placed a dry absorbent pad on the bed. -August 19, 2023, a ULP documented the resident refused toileting and would not let staff change her brief. -August 20, 2023, a ULP documented the resident refused her lunch as she thought it was poison.	0 630		

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0 630	Continued From page 33 -August 21, 2023, a ULP documented the resident refused toileting and refused her supper. -August 22, 2023, a night shift ULP documented the resident refused toileting on the overnight shift. The ULP removed the resident's uneaten supper from her room. -August 22, 2023, a ULP documented the resident refused to use the bathroom or let her change the bed. -August 24, 2023, a ULP documented the resident came to the dining room "with no bottoms on and seemed agitated." -August 25, 2023, a ULP documented they checked on the resident and she was not wearing a brief. The resident refused to put one on. -August 28, 2023, RN-B documented she assessed the resident after a fall. -August 29, 2023, a ULP documented the resident refused to get up and use the bathroom. "She was soaked in urine through her brief and her chuck pads. I was able to get the soaked pads off of her and then she was kicking and hitting me. She screamed at me that I was wasting her briefs, I explained to her it was all wet." The resident refused to put the dry brief on and went to bed without one on. -September 1, 2023, a ULP documented the resident refused to get up for toileting or allow for the staff member to change her brief. -September 1, 2023, RN-B documented she met with the resident for a 90 day review of services	0 630		

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0 630	Continued From page 34 and noted the resident has "remained independent with supports of nail care, showers, cognitive support, pericare, housekeeping, laundry, meals, and emergency pendant...resident reports good appetite, sleeping well at night, and normal urination and bowel movements." -September 2, 2023, a ULP documented the resident was out by the elevator and noted she needed her brief changed. The ULP offered to help and the resident was "calling writer names and said she was going to get the police cause the facility was keeping her here like an animal." -On September 7, 2023, a night shift ULP documented the resident refused toileting but allowed her to change her brief. The ULP noted she removed an uneaten meal from the resident's room. -September 7, 2023, a ULP documented the resident had been in bed sleeping all day. The resident refused attempts to change her brief. The ULP wrote, "I explained to her brief is soaking wet and she told me it will eventually dry out. I told her she is going to get sore if she doesn't let me change and she said she don't care and the world is ending." -September 10, 2023, a ULP documented the resident had been in bed sleeping all day and "had not eaten anything or let me check on her. She refused to get up to the bathroom. She told me to leave her alone and just cover her up with her blanket. I've tried a couple times and she keeps refusing." -September 14, 2023, a ULP documented the resident came downstairs in her wheelchair with	0 630		

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0 630	Continued From page 35 just a shirt and a brief on. The resident exhibited verbal behaviors including thinking the devil was coming to get her. The ULP documented the resident was hitting the front door button with her walker and setting off the wander alarm. Redirection attempts were not successful. -September 17, 2023, a ULP documented the resident refused toileting or to have her brief changed on the night shift, telling the ULP, "No get away! I don't want it changed." -September 19, 2023, a ULP documented the resident refused scheduled cares on the night shift and "held onto her brief not allowing writer to change her." -September 21, 2023, a night shift ULP documented the resident refused cares at the first attempt but accepted help at 3:15 a.m. -September 21, 2023, a ULP documented the resident refused toileting all day. "She told me she just wants to die and to leave her alone. I've tried multiple times. I asked her to change her in bed and she yelled no. She ate breakfast in bed but refused her lunch." On September 22, 2023, at 3:50 p.m., LALD-A stated she knew the resident would refuse cares at times but didn't think it was significant and the resident would have the right to refuse cares. LALD-A was asked at what point would refusals lead to health and safety concerns and LALD-A stated, "I guess I'd have to leave that up to the nurse." LALD-A stated the resident usually wouldn't go through an entire shift without receiving some cares and she had not observed some of the concerns noted by the investigator. LALD-A stated interventions for the resident that	0 630		

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0 630	Continued From page 36 worked included redirection and reapproaching. -September 23, 2023, a ULP documented the resident refused to allow staff to change her incontenence products. On the overnight shift, the resident came downstairs looking for her plants. The resident became upset and told the staff member she was going to "get justice and destroy the building with a wrecking ball." The resident went from one end of the building to the other, repetitively pressing the elevator button for approximately two hours and "refused any type of redirection or conversation." A few hours later, it was noted the resident threw all her bedding and pillows in the stair well. The ULP attempted to get the resident to allow her to change her wet incontenence product and the resident refused. -September 23, 2023, RN-B documented the resident was sent to the emergency room for increased behaviors and exit seeking. The resident was diagnosed with a urinary tract infection and returned to the facility. RN-B entered a separate progress note that read, "before resident was sent to ER, writer called ER and talked to nurse to stress the fact that resident was unsafe at this time at the AL [assisted living] due to multiple exit seeking, increased agitation, and refusing cares to maintain health. Writer again called and told ER nurse this before she was discharged." -September 24, 2023, a ULP documented the resident was toileted and in a cooperative mood. -September 25, 2023, a night shift ULP documented the resident was toileted once on her shift and refused the rest. The resident started kicking and telling the ULP to "get the hell out of there and that the only place she was going	0 630		

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0 630	Continued From page 37 to was the cemetery. She was reapproached one more time and told [ULP] to go to hell." -September 25, 2023, a day shift ULP documented they tried to get the resident to change her clothes but the resident "ripped off the clothes and said she didn't have to have clothes on and that she won't do it. Staff then went to go get tenant [resident] breafkast, she was completely naked and threatened to throw eggs at the staff. Staff then left her alone in her apartment, then staff was out in the hallway when tenant [resident] came out of her apartment completely naked..." -September 25, 2023, the resident refused her antibiotic for her urinary tract infection as she "thinks it's poison." -September 25, 2023, RN-B documented an assessment note indicating she reassessed the resident after she was in the hallway completely nude and yelling at staff earlier. The resident refused cares from RN-B and her primary care provider. An additional progress note from RN-B indicated the resident was not appropriate for the facility due to her diagnosis of dementia, cognitive status, exit seeking, and was undirectable most of the time which causes a concern for safety. It was noted the resident "will not let staff most of the time help her with hygiene cares, she is unable to do this for herself, she would save wet products and try to dry and reuse it if staff did not manage this. She will kick, hit, and yell at staff at thimes when they try to assist. She will put her feet down on the floor when staff try to push her in wheelchair, she will not use or leave the footrests on. Resident has been noted on several occasions to sit in the hallway with shirt and brief on and a small towel covering her midsection,	0 630		

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	20201	A. BUILDING: _____ B. WING _____	C 09/28/2023

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0 630	Continued From page 38 she will sit and elevator (sic) and keep pressing the button so other residents can't use it, she sits at the front door and does the same thing and makes it hard for incoming residents to get around her, this is interferring with other residents daily lives. Nurse clinical judgement from assessment is that resident is no longer safe for this AL and AL staff are unable to meet her needs. It is advised to seek other placement in a memory care unit or behavioral health..." -September 25, 2023, the resident was started on an antidepressant. An updated assessment completed on September 25, 2023, indicated the resident had behaviors including verbal abuse and hitting staff. An intervention was "do not ask if she's ready for bed, bath, or pericare or other ADLs, SAY LET'S GO, it's time for, etc..." On September 25, 2023, at 10:00 a.m., ULP-E stated she didn't know anything about the resident's diagnoses but thought she had a bit of dementia and paranoia. ULP-E stated sometimes the resident will go all day and night without allowing staff to change her wet brief. ULP-E stated the resident sometimes comes out of her apartment naked but other than redirecting the resident was not aware of any other interventions to try. ULP-E stated the resident had her stove shut off after the resident set a brief on fire when she tried drying out wet briefs in the oven so she could use them again. On September 25, 2023, at 1:45 p.m., RN-C stated it was very common for R1 to refuse cares and some staff had better luck with approaching the resident and getting her to agree to cares.	0 630		

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0 630	Continued From page 39 On September 26, 2023, at 7:50 a.m., ULP-F entered R1's room and asked her if she wanted to go to the bathroom. R1 stated no. ULP-F left the room and stated she would try again later. On September 26, 2023, at 8:30 a.m., ULP-F entered R1's room and asked her if she wanted to go to the bathroom. R1 stated no. R1 eventually wheeled herself to the bathroom and sat on the toilet. R1 agreed to put on a dry brief but pericares were not offered to R1. ULP-F asked R1 if she wanted to brush her teeth. R1 stated no, she already brushed her teeth. ULP-F asked R1 if she wanted to put on clean clothes, R1 stated no. ULP-F left the resident's room. On September 26, 2023, at 8:50 a.m., ULP-F stated she had not been educated on any interventions specific to R1 but did have a card on her name badge that gave general interventions to use for residents with behaviors. ULP-F stated residents had the right to refuse care. ULP-F stated if the resident refused anything, she would reapproach her later. On September 28, 2023, at 9:05 a.m., ULP-G stated staff had never been provided with any specific interventions on how to work with R1's behaviors and management never sought feedback from staff on what approaches worked for the resident's behaviors. ULP-G stated the only thing they were ever told was just to redirect the resident and the guidance around that was limited and no specifics on how to redirect were provided. ULP-G stated many other staff members have been voicing concerns about R1 "for a long time." ULP-G stated R1 was often wearing a saturated, urine soaked incontenence product and it was clear cares hadn't been completed. ULP-G stated she and other staff had	0 630		

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0 630	Continued From page 40 raised concerns about the resident's safety and that they didn't feel her care needs could be met at the facility as she needed more one on one care but they felt their concerns were not taken seriously by management. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule.	0 680		

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0 680	Continued From page 41 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living director and clinical nurse supervisor reviewed the missing resident plan at least quarterly and document any changes to the plan. This had the potential to affect all residents receiving services under the assisted living license, staff and visitors. 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the investigation, the investigator requested to review the licensee's Missing Resident plan. The licensee's Missing Client policy had only been reviewed twice since it was implemented October 10, 2011. The policy was revised on June 27, 2016, and reviewed on April 6, 2023. The policy did not specify how often it would be reviewed or who would review it. On September 26, 2023, at 10:30 a.m., licensed assisted living director (LALD)-A stated she did not know how often the Missing Resident plan was supposed to be reviewed but thought it was annually. No further information was provided.	0 680		

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0 680	Continued From page 42 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter	01060		

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01060	Continued From page 43 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation for one or one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included dementia, weakness, and type two diabetes. R1's service plan dated October 28, 2022, indicated the resident received assistance with dressing, grooming, bathing, toileting, and transfers. R1's progress notes dated September 30, 2023,	01060		

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01060	Continued From page 44 indicated the licensee sent R1 to the emergency room after the resident refused several attempts to change a wet incontinence product. The on call registered nurse (RN)-J advised staff to "please call 911 and tell them this resident is neglecting of self-cares and any attempt for staff to fulfill those cares, as well as, hitting, kicking, punching staff. Patient was transferred by ambulance at approximately 1:20 a.m." The resident remained admitted in the hospital as of October 10, 2023. On October 9, 2023, at 10:13 a.m., the investigator requested evidence an emergency relocation notice was completed and also sent to the Office of Ombudsman for Long-Term Care. On October 9, 2023, at 2:24 p.m., a Notification of Emergency Relocation was sent to the investigator. The notice indicated the date of the emergency relocation was September 30, 2023. The reason for the relocation was due to altered mental status. The notification indicated it was provided to R1's power of attorney and the Ombudsman for LTC on October 9, 2023. A progress note from October 9, 2023, at 1:45 p.m., indicated licensed assisted living director (LALD)-A "provided resident and POA with the emergency relocation notification." R1's record lacked a written notice that contains, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care;	01060		

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01060	Continued From page 45 - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, R1's record lacked notification to the Office of Ombudsman for Long-Term Care with in four days that R2 had been relocated and had not returned to the facility. As of October 10, 2023, the Office of Ombudsman for Long-Term Care had not received the written notice. On October 12, 2023, at 11:45 a.m., registered nurse (RN)-J confirmed the resident was transferred to the emergency room due to behaviors and that an emergency relocation notice was not issued to the family or the Office of the Ombudsman for Long-Term Care. RN-J stated LALD-A would have been the one who was responsible for ensuring that was completed. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days.	01060		
01070 SS=D	144G.52 Subd. 10 Right to return If a resident is absent from a facility for any reason, including an emergency relocation, the facility shall not refuse to allow a resident to return if a termination of housing has not been effectuated.	01070		

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01070	Continued From page 46 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to allow the return of one of one residents (R1) after they were sent to the emergency room, although the licensee had not issued a notice of termination of services or housing. The licensee failed to offer any option for R1 to return as a housing-only resident with the necessary services provided by another agency. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings include: R1's diagnoses included dementia, weakness, and type two diabetes. R1's service plan dated October 28, 2022, indicated the resident received assistance with dressing, grooming, bathing, toileting, and transfers. On September 22, 2023, at 3:50 p.m., licensed assisted living director (LALD)-A stated she knew the resident would refuse cares at times but didn't think it was significant and the resident would have the right to refuse cares. LALD-A was asked at what point would refusals lead to health and safety concerns and LALD-A stated, "I guess I'd	01070		

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01070	Continued From page 47 have to leave that up to the nurse." LALD-A stated the resident usually wouldn't go through an entire shift without receiving some cares and she had not observed some of the concerns noted by the investigator. LALD-A stated interventions for the resident that worked included redirection and reapproaching. -September 23, 2023, registered nurse (RN)-B documented the resident was sent to the emergency room for increased behaviors and exit seeking. The resident was diagnosed with a urinary tract infection and returned to the facility. RN-B entered a separate progress note that read, "before resident was sent to ER, writer called ER and talked to nurse to stress the fact that resident was unsafe at this time at the AL [assisted living] due to multiple exit seeking, increased agitation, and refusing cares to maintain health. Writer again called and told ER nurse this before she was discharged." The facility did not issue a notice of termination, despite documentation indicating the resident's needs were not able to be met by the facility. -September 25, 2023, RN-B documented an assessment note indicating she reassessed the resident after she was in the hallway completely nude and yelling at staff earlier. The resident refused cares from RN-B and her primary care provider. An additional progress note from RN-B indicated the resident was "not appropriate for the facility due to her diagnosis of dementia, cognitive status, exit seeking, and was undirectable most of the time which causes a concern for safety." It was noted the resident "will not let staff most of the time help her with hygiene cares, she is unable to do this for herself, she would save wet products and try to dry and reuse it if staff did not manage this. She will kick, hit, and yell at staff at	01070		

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01070	Continued From page 48 thimes when they try to assist. She will put her feet down on the floor when staff try to push her in wheelchair, she will not use or leave the footrests on. Resident has been noted on several occasions to sit in the hallway with shirt and brief on and a small towel covering her midsection, she will sit and elevator (sic) and keep pressing the button so other residents can't use it, she sits at the front door and does the same thing and makes it hard for incoming residents to get around her, this is interferring with other residents daily lives. Nurse clinical judgement from assessment is that resident is no longer safe for this AL and AL staff are unable to meet her needs. It is advised to seek other placement in a memory care unit or behavioral health..." The facility did not issue a notice of termination, despite documentation indicating the resident's needs were not able to be met by the facility. -September 25, 2023, licensed assisted living director (LALD)-A documented she spoke with the resident's POA "again informing her of her escalated behaviors, exit seeking and refusal of cares...POA also agreed to trying a medication per the providers order and agreed to a transfer to a higher level of care/secured unit and or behavioral health unit." The facility did not issue a notice of termination, despite documentation indicating the resident's needs were not able to be met by the facility. -September 25, 2023, RN-J documented the resident was having delusions thinking staff were killing her neighbor. RN-J documented unlicensed staff were "informed to call 911. 1.Delusional thoughts of harming neighbor and babies 2. Unable to calm without one on one 3. unable to give one on one due to staffing/resident ratio 4. Unsafe environment." The facility did not issue a	01070		

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01070	Continued From page 49 notice of termination, despite documentation indicating the resident's needs were not able to be met by the facility. -September 30, 2023, RN-J documented unlicensed staff called after they were unable to get the resident to cooperate with any cares. RN-J requested staff make three attempts to provide cares, 30 minutes apart. The resident continued to refuse. RN-J wrote "Writer stated we need to care for resident, so please call 911 and tell them this resident is neglecting of self-cares and any attempt for staff to fulfill those cares, as well as, hitting, kicking, punching staff. Patient was transferred by ambulance at approximately 1:20 a.m." The facility did not issue a notice of termination, despite documentation indicating the resident's needs were not able to be met by the facility. Documentation from emergency medical responders indicated emergency services were called on September 30, 2023, for a resident "being combative with staff." Documentation indicated the resident had not been changed in 11 hours and "staff said she called her nurse and the nurse said she needed to go in and that she would probably not be able to return, patient does suffer from chronic dementia according to staff." Hospital documentation indicated the resident had a longstanding diagnosis of dementia which was slowly worsening and "no longer to safely live at assisted living any long (sic)" The note indicated the social worker was working on placement, either geripsych placement or long term care placement. A progress note from the hospital physician entered on October 1, 2023, indicated the resident would "likely need placement." A progress note from October 6,	01070		

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01070	Continued From page 50 2023, indicated social services was "involved in finding placement as patient is unable to care for herself in her home." The facility did not issue a notice of termination. On October 11, 2023, at 4:50 p.m., the resident's POA's representative stated right after R1 admitted to the hospital, "it was very clear [from facility staff] she couldn't return there." The representative stated facility staff repeatedly communicated they "couldn't handle [R1] and didn't have enough staff" but never issued any termination notice or mentioned discharging, but were clear the resident wouldn't be able to return. The representative stated it made things very confusing and uncertain and at times the staff seemed like they were backpedaling on if the resident could or couldn't return. The representative stated they finally had a meeting on October 10, 2023, after he asked them if they had discharge papers or what they would be doing for the resident's return, and it was mutually agreed the resident should move somewhere with higher care. The representative stated it was very frustrating and like they were "being told two different stories" where they'd say she couldn't return but wouldn't issue discharge paperwork or outright say she couldn't return. The representative stated the resident was paying out of pocket for the assisted living facility so if she wasn't going to be able to return, they shouldn't have to continue to pay for it. On October 12, 2023, at 11:45 a.m., RN-J stated a termination notice wasn't issued as they were "waiting for what the doctor thought of the resident's current condition." No further information was provided.	01070		

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	20201	A. BUILDING: _____ B. WING _____	C 09/28/2023

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01070	Continued From page 51 TIME PERIOD FOR CORRECTION: Seven (7) days.	01070		
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 observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) reassessed one of one resident with change of condition (R2). This practice resulted in a level three violation (a	01620		

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01620	Continued From page 52 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: R2's diagnoses included hypertension (high blood pressure), chronic obstructive pulmonary disease (COPD), stress fractures, and malignant neoplasm (cancer) of pelvic bones, sacrum and coccyx. R2's service plan dated January 19, 2023, indicated the resident received assistance with bathing and medication management. R2's most recent assessment, dated April 20, 2023, but signed by LALD-A on May 8, 2023, indicated the resident was independent with walking but was not ambulatory and would self propel with her wheelchair. The resident was independent with dressing and grooming, required assistance from staff twice per day to use the bathroom. The resident required assistance from one staff member and a transfer belt PRN (as needed, not on a regular basis). R2's care plan, dated April 20, 2023, indicated the resident was not ambulatory and required occasional assistance to get in and out of the bed or chair. Staff were to report any changes in ability to transfer to the nurse. R2's progress notes contained the following entries:	01620		

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01620	Continued From page 53 -April 23, 2023, a ULP documented the resident slid out of bed. The RN entered a note the following day indicating a silk bedspread was removed from the resident's room. -April 26, 2023, the RN documented the resident had an unwitnessed fall and was found laying on the floor. 911 was called for lift assistance to get the resident off the floor. -April 29, 2023, a night shift ULP documented the resident was having a difficult time transferring and unable to bear weight on her legs. The resident's upper body strength was noted to be weak and "it was very hard for resident to push up off the bed to get into a standing position and difficult for resident to turn and get into the wheelchair." -April 29, 2023, an evening shift ULP documented the resident had "a hard time transferring with assistance using gait belt. [resident] told writer she cannot move her leg. Writer went to AL [assisted living] storage and brought PAL lift (type of mechanical lift) assist machine and used for toileting after supper. [resident] was much easier to move around and toilet with PAL lift. [Resident] told writer she was glad to have this machine. Writer will relay to staff location of PAL lift assistance for [resident] transfers." The RN failed to reassess the resident's change of condition requiring the use of a mechanical lift or update the resident's service plan and care plan. -May 1, 2023, a ULP documented the resident was transferred with the PAL lift three times during the evening shift for toileting. The ULP wrote the resident was "unable to move either leg and needs assistance to lift them to the PAL	01620		

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01620	Continued From page 54 platform for standing. [Resident] told writer her feet and legs are numb. [resident] was also assisted to bed with PAL machine and legs were lifted by writer onto bed as [resident] cannot lift her legs..." -May 5, 2023, a ULP documented the resident was now using a PAL lift assist for toileting and transfers. -May 9, 2023, a ULP documented the resident was unable to help with lifting either leg and told the writer "I can't lift either one, they are too heavy for me." -May 11, 2023, a ULP documented the resident "started to wheeze and cough a little, and seemed to be out of breath. Writer asked [resident] if she is ok [resident] said yes." Later when the resident came down for supper, it was noted the tenant was out of breath and had no strength to push herself to the table. The RN failed to reassess the resident or take action to address the newly noted wheezing and coughing. -May 13, 2023, a ULP documented the resident got a laceration on her elbow after hitting it on a screw on her wheelchair. -May 13, 2023, a ULP documented the resident was transferred with a PAL lift and had trouble putting her legs straight. The resident reported to the ULP her legs were weak. -May 15, 2023, a ULP documented the resident reported she was "numb from her lower back down, with no voluntary motor control below her waist. She states that while in bed, her "better" right leg bends involuntarily which keeps her away...Resident states she has no voluntary	01620		

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01620	Continued From page 55 control or sensation of bowels or bladder. Resident also complained of pain and numbness in hands." The RN failed to reassess the resident's newly noted numbness. -May 16, 2023, a night shift ULP documented the "resident was unable to use the lift to go to the bathroom." The ULP had difficulty getting the resident to a sitting position and she was not able to hold onto the lift "because her left hand and wrist were too painful." The resident was given Tramadol, a pain medication, and staff tried to help straighten her legs "but they kept bending back up." -May 16, 2023, the RN documented the resident "states she has no feeling in bilateral lower extremities, is unable to feel if she needs to urinate or have a BM (bowel movement)." The resident's primary care provider was notified and the resident was sent to the emergency room for further evaluation. -May 18, 2023, the RN documented the resident had been admitted to the hospital with compression fractures. The resident was admitted to a nursing home due to requiring a higher level of care. On September 25, 2023, at 10:00 a.m., ULP-E stated R2 became "more and more disabled, you could put her in bed and two hours later she couldn't move her arms." ULP-E stated they had communicated the resident's decline to the nurse with progress notes and emails but was not aware of any response from the nurse on their concerns. ULP-E stated she didn't recall the nurse ever providing any direction to staff on what to do for the resident's change in transfer status.	01620		

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01620	Continued From page 56 On September 25, 2023, ULP-D stated he remembered updating RN-C about the resident's increasing difficulty with transfers but didn't recall the nurse ever providing any specific instruction or formally updating the staff of the resident's transfer status. ULP-D stated he knew other staff besides himself reported the resident's numbness to RN-C. ULP-C stated he would enter progress notes about the resident's decline and "assumed if I was documenting it, she'd [RN-C] be handling it." On September 25, 2023, at 1:45 p.m., RN-C stated the last couple of weeks R2 resided at the facility, "she'd have good days and bad days." RN-C could not recall when she first was updated of the decline and change in transfer status for R2, but remembered visiting with the resident on a Monday. RN-C stated she did not document that assessment with the resident and could not recall if she documented anything regarding the resident needing to use a mechanical lift. RN-C could not recall if staff had updated her on the resident's change in condition but she would read progress notes "on and off and honestly we were transitioning from one program to another so I probably didn't read them as often as I usually do." RN-C stated she updated the provider and the resident was sent to the emergency room that same day but RN-C was not sure if the provider had been updated over the course of the past two weeks when she began to decline. On September 28, 2023, at 9:05 a.m., ULP-G stated R2 went from being able to transfer on her own and within a few weeks, lost the use of her legs. ULP-G stated she and several staff members reported their concerns to RN-C but didn't feel like it was given priority or taken seriously. ULP-G stated as the resident declined,	01620		

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01620	Continued From page 57 they had to provide more assistance with the resident's oxygen as she was not able to manage it independently anymore. ULP-G stated she and other caregivers "documented and documented" their concerns with the resident's decline and nothing happened and the nurse did not take action until the resident's daughter came in and raised concerns. On September 26, 2023, at 12:38 p.m., LALD-A provided records to show R2's change in condition had been appropriately addressed over the 17 days in question from the first report of using a mechanical lift on April 29, 2023, through May 16, 2023. The records did not contain any documentation from the facility to the clinic or primary care provider updating them of the resident's change of condition. The attached records included the following: R2 was seen by her primary care provider on May 2, 2023, for a face to face visit for the resident to obtain an electric wheelchair. The record did not contain any documentation that would indicate the provider was updated of any specific concerns besides the need for an electric wheelchair. R2 received home health physical and occupational therapy services for strengthening and received therapy on May 3, May 6, May 8, May 9, and May 10. On May 10, 2023, a physical therapy assistant documented the resident's oxygen was staying at 80% (normal oxygen saturation levels are 95% to 100%) even with recovery breathing and "patient stated she feels the good Lord is taking her home and that she is feeling like it's her time to go." Therapy exercises were not performed due to the	01620		

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01620	Continued From page 58 resident's low oxygen levels. The note indicated "nursing staff made aware of patient's low O2 [oxygen] and that patient is currently on supplemental O2." After starting supplemental oxygen, the resident's oxygen came up to 93%. The physical therapy assistant documented they "left on O2 with nursing staff notified. Patient is declining in status and signed notice for discharge on 5/17." The resident's record did not contain documentation the RN took action on the low oxygen levels or reassessed the resident. A home care nurse visited the resident on May 11, 2023, and documented the resident continued to need more assistance with ADLs and toileting due to being in a wheelchair. Her oxygen was noted to be 93% on room air and at times 90%. The resident's record did not contain documentation the RN took action on the low oxygen levels or reassessed the resident. The records lacked evidence the provider had been notified of a change in condition and lacked evidence the RN appropriately responded to reports of low oxygen levels. On September 27, 2023, at 11:39 a.m., LALD-A wrote in an email to the investigator, "The PTA [physical therapy assistant] was who noticed the low oxygen level. Our RN was not notified of this. There is the potential the PTA informed a universal worker [ULP] but we are unsure. Our process is they should communicate with the RN..." R2's hospital admission assessment from May 16, 2023, indicated the resident had become much weaker over the past few weeks and has required assistance with all activities of daily living and transfers. The resident was diagnosed with a chordoma (a rare type of tumor that occurs along the spine), which was attributed to her loss of	01620		

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01620	Continued From page 59 mobility. The hospital documentation indicated the facility would not take the resident back due to her transfer status. The resident was eventually admitted to a skilled nursing facility. The licensee's Resident Change in Condition or Need policy, dated August 1, 2022, indicated when changes in condition or need are identified, a Registered Nurse will initiate a change in condition assessment. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
01880 SS=G	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the licensee failed to ensure safe storage of medications for one of one resident (R1) reviewed. This resulted in an immediate order on September 22, 2023. 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	01880		

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01880	Continued From page 60 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On September 22, 2023, at 12:00 p.m. a Minnesota Department of Health (MDH) investigator entered the facility on a complaint investigation. An entrance conference was conducted with the licensed assisted living director (LALD)-A at 12:15 p.m. On September 22, 2023 between 12:15 - 12:50 p.m., the MDH investigator conducted observations of the facility's second floor and noted a strong urine smell. During the observation period of the second floor, the MDH investigator knocked on R1's door and asked permission to enter. Upon entering the room, the investigator observed R1 laying in the middle of the bed. R1 had white sneakers on, no pants on but had an incontinent product on, and was wrapped in a fleece blanket on top of a fitted sheet. R1's head was on top of rags and there was no pillow, and no additional sheets or blankets were observed on or around the bed. R1 was laying on top of a disposable soaker pad in the middle of the bed. The pad was saturated with urine and several flies were observed around R1. A fly swatter was observed near R1's right side on top of the saturated soaker pad. R1 provided her name to the investigator. The investigator asked R1 is she was comfortable and R1 replied " I don't know." The investigator asked R1 if she needed to use the bathroom or if her pad or sheets were wet and R1 replied "I suppose, it always is I don't know, I don't care." Upon further observation of R1's room, various	01880		

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01880	Continued From page 61 medications were noted throughout the room and bathroom including Vitamin D3, a multivitamin, several bottles of Mylanta, milk of magnesia, cough syrup, and stool softeners that expired in 2011. R1's table was cluttered with pills, old food, and melted ice cream. On September 22, 2023, at 1:50 p.m. the investigator requested the facility registered nurse (RN)-B to observe R1 and R1's room. RN-B confirmed R1 kept medications in her room and stated R1 had been assessed as able to self administer medications. On September 22, 2023, at 3:30 p.m. the investigator again went to R1's room. Medications pointed out to RN-B at 1:50 p.m. remained on the counter and in bathroom. On September 22, 2023, at 4:20 p.m., RN-B returned to R1's room with the investigator. RN-B was asked about the medications in R1's room, including one that had expired in 2011, as well as toilet cleaner on the counter next to a drinking cup and a variety of additional liquid medications. RN-B stated the resident could have access to cleaner since it was her apartment and staff had trouble removing things from her room due to her behaviors. The MDH investigator requested R1's medical record for review. R1's diagnoses included dementia, weakness, and type two diabetes. R1's service plan dated October 28, 2022, indicated the resident received assistance with dressing, grooming, bathing, toileting, and transfers. R1 received no medication	01880		

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01880	Continued From page 62 management by the facility. R1's most recent assessment, dated September 1, 2023, indicated the resident was disoriented to time, place, and situation. The assessment did not assess the resident's ability to self-administer medication. A Self-Med Assessment dated October 18, 2021, was provided to the investigator. The assessment indicated the resident did not take any prescribed medications and only takes milk of magnesia over the counter. The resident was determined to be able to self administer her own milk of magnesia. No additional medications were included. The assessment did not include information on R1's storage of medications. R1's care plan indicated the resident had mild/moderate/severe memory loss and required reminders for activities, meals, and frequent hygiene checks. The resident needed assistance to use the toilet and maintain bladder continence. Behaviors noted were behaviors of disrobing, taking things belonging to others, wandering aimlessly, showing anger, provocation, verbal abuse, or other extreme or erratic behavior patters. It was noted the resident hits out at staff and thinks people are taking things from her. The care plan did not include an assessment of the resident's ongoing refusals to change her brief or use the bathroom. The care plan lacked specific interventions for staff to use when the resident exhibited behaviors or refusals. R1's care plan also did not address R1's self administration of medications, medication stored in R1's room. A medication storage policy, medication assessment policy, or medication self-administration policy was not provided.	01880		

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01880	Continued From page 63 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days On September 28, 2023, the immediacy of correction order 1880 was removed, however non-compliance remained at a level three isolated scope (G).	01880		
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the licensee failed to ensure appropriate care and services were provided based on the resident's needs, an up-to-date service plan, and according to accepted health care standards for one of one resident (R1). This resulted in an immediate order on September 22, 2023. 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).	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20201	A. BUILDING: _____ B. WING _____	C 09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD MANOR	222 5TH STREET NE STAPLES, MN 56479

(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
02310	Continued From page 64 The findings include: On September 22, 2023 at 12:00 p.m. a Minnesota Department of Health (MDH) investigator entered the facility on a complaint investigation. An entrance conference was conducted with the licensed assisted living director (LALD)-A at 12:15 p.m. On September 22, 2023 between 12:15 - 12:50 p.m., the MDH investigator conducted observations of the facility's second floor and noted a strong urine smell. During the observation period of the second floor, the MDH investigator knocked on R1's door and asked permission to enter. Upon entering the room, the investigator observed R1 laying in the middle of the bed. R1 had white sneakers on, had no pants on but did have an incontinent product on, and was wrapped in a fleece blanket laying on top of a fitted sheet. R1's head was on top of rags and there was no pillow, and no additional sheets or blankets were observed on or around the bed. R1 was laying on top of a disposable soaker pad in the middle of the bed. The pad was saturated with urine and several flies were observed around R1. A fly swatter was observed near R1's right side on top of the saturated soaker pad. R1 provided her name to the investigator. The investigator asked R1 is she was comfortable and R1 replied " I don't know." The investigator asked R1 if she needed to use the bathroom or if her pad or sheets were wet and R1 replied "I suppose, it always is I don't know, I don't care." Upon further observation of R1's room, the investigator observed several white Styrofoam cups of water on the night stand next to the bed,	02310		

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02310	Continued From page 65 two dead plants on the windowsill, which had started to fuse to the window, and a table cluttered with pills, old food, and melted ice cream. The investigator asked permission to open the kitchen fridge and observed several items of old or expired food, an open glass of milk and noted the temperature of the refrigerator felt warm. On September 22, 2023, at 1:50 p.m. the investigator requested the facility registered nurse (RN)-B to observe R1 and R1's room. The investigator asked RN-B when the last time R1 was provided incontinent care and RN-B replied, this morning. When questioned why it had been so long between cares, RN-B stated she would need to check documentation and explained staff check on R1 every few hours, but R1 refuses care. The investigator pointed out the urine soaked pad that R1 was lying on and RN-B acknowledged the pad was wet. The investigator questioned what staff were directed to do when R1 refused care, and RN-B replied, they redirect and reapproach R1 and staff were scheduled to check on R1 every 2-3 hours and that was care planned for staff to do. The investigator questioned RN-B on the urine smell in R1's room and RN-B stated the odor of urine was acceptable and confirmed R1's mattress was likely soaked with urine and went on to say the smell was usual and they were trying to manage it and seek other care options for R1. RN-B further stated R1 often refused offers for assistance with the bathroom and refused for staff to clean her window and room. RN-B also confirmed R1's lunch in the Styrofoam box was still on the table, untouched, and unopened.	02310		

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02310	Continued From page 66 On September 22, 2023, at 3:30 p.m. the investigator again went to R1's room. R1 remained in bed. R1 had not been provided incontinent care and remained lying in a wet incontinent product and on top of the pad saturated with urine. R1 stated she was hungry and R1's Styrofoam box from lunch remained on the table, untouched, and unopened. On September 22, 2023, at 4:20 p.m., RN-B returned to R1's room with the investigator. RN-B attempted to change R1's brief. R1 refused and told RN-B she was "doing this for Trump." The resident later stated, "I don't trust anybody in this dump. This is a hell hole." RN-B was asked about the medications in R1's room, including one that had expired in 2011, as well as toilet cleaner on the counter next to a drinking cup and several various liquid medication bottles. RN-B stated the resident could have access to cleaner since it's her apartment and they had trouble removing things from her room due to her behaviors. The MDH investigator requested R1's medical record for review. R1's diagnoses included dementia, weakness, and type two diabetes. R1's service plan dated October 28, 2022, indicated the resident received assistance with dressing, grooming, bathing, toileting, and transfers. R1's Self-Med Assessment dated October 18, 2021, indicated the resident did not take any prescribed medications and only takes milk of magnesia over the counter. The resident was determined to be able to self administer her own milk of magnesia. No additional medications were	02310		

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02310	Continued From page 67 included. The assessment did not include information on R1's storage of medications. R1's progress notes contained the following entries: -September 21, 2023, a ULP documented the resident refused toileting all day. "She told me she just wants to die and to leave her alone. I've tried multiple times. I asked her to change her in bed and she yelled no. She ate breakfast in bed but refused her lunch." -September 21, 2023, a night shift ULP documented the resident refused cares at the first attempt but accepted help at 3:15 a.m. -September 19, 2023, a ULP documented the resident refused scheduled cares on the night shift and "held onto her brief not allowing writer to change her." -September 17, 2023, a ULP documented the resident refused toileting or to have her brief changed on the night shift, telling the ULP, "No get away! I don't want it changed." -September 14, 2023, a ULP documented the resident came downstairs in her wheelchair with just a shirt and a brief on. The resident exhibited verbal behaviors including thinking the devil was coming to get her. The ULP documented the resident was hitting the front door button with her walker and setting off the wander alarm. Redirection attempts were not successful. -September 10, 2023, a ULP documented the resident had been in bed sleeping all day and "had not eaten anything or let me check on her. She refused to get up to the bathroom. She told	02310		

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02310	Continued From page 68 me to leave her alone and just cover her up with her blanket. I've tried a couple times and she keeps refusing." -September 7, 2023, a ULP documented the resident had been in bed sleeping all day. The resident refused attempts to change her brief. The ULP wrote, "I explained to her brief is soaking wet and she told me it will eventually dry out. I told her she is going to get sore if she doesn't let me change and she said she don't care and the world is ending." -On September 7, 2023, a night shift ULP documented the resident refused toileting but allowed her to change her brief. The ULP noted she removed an uneaten meal from the resident's room. -September 2, 2023, a ULP documented the resident was out by the elevator and noted she needed her brief changed. The ULP offered to help and the resident was "calling writer names and said she was going to get the police cause the facility was keeping her here like an animal." -September 1, 2023, RN-B documented she met with the resident for a 90 day review of services and noted the resident has "remained independent with supports of nail care, showers, cognitive support, pericare, housekeeping, laundry, meals, and emergency pendant...resident reports good appetite, sleeping well at night, and normal urination and bowel movements." -September 1, 2023, a ULP documented the resident refused to get up for toileting or allow for the staff member to change her brief.	02310		

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02310	Continued From page 69 -August 29, 2023, a ULP documented the resident refused to get up and use the bathroom. "She was soaked in urine through her brief and her chuck pads. I was able to get the soaked pads off of her and then she was kicking and hitting me. She screamed at me that I was wasting her briefs, I explained to her it was all wet." The resident refused to put the dry brief on and went to bed without one on. -August 28, 2023, RN-B documented she assessed the resident after a fall. -August 25, 2023, a ULP documented they checked on the resident and she was not wearing a brief. The resident refused to put one on. -August 24, 2023, a ULP documented the resident came to the dining room "with no bottoms on and seemed agitated." -August 22, 2023, a ULP documented the resident refused to use the bathroom or let her change the bed. -August 22, 2023, a night shift ULP documented the resident refused toileting on the overnight shift. The ULP removed the resident's uneaten supper from her room. -August 21, 2023, a ULP documented the resident refused toileting and refused her supper. -August 20, 2023, a ULP documented the resident refused her lunch as she thought it was poison. -August 19, 2023, a ULP documented the resident refused toileting and would not let staff change her brief.	02310		

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02310	Continued From page 70 -August 17, 2023, the resident refused to change her brief on the overnight shift. The resident had soaked her bedsheets with urine but refused to allow them to be changed. The ULP placed a dry absorbent pad on the bed. -August 2, 2023, a ULP documented the resident was yelling in her doorway at 4 a.m. -July 23, 2023, a ULP documented the resident was agitated and tired and did not get up all day long. The resident was noted to have not eaten. -July 23, 2023, a ULP documented she reapproached the resident after she refused cares all day. The resident was eventually cooperative and put on a dry brief, but "kneed the writer in the jaw." -July 23, 2023, a night shift ULP documented the resident was combative about changing her soaked brief. -July 21, 2023, a ULP documented the resident refused toileting or incontinence product changes "but reluctantly complied at 5:00 a.m. when very soaked." -July 12, 2023, a ULP documented they tried three times to get the resident to put a brief on or go to the bathroom but the resident refused. The ULP "removed two meals from the resident's room that had been sitting there since 10 p.m. Resident did not eat any of those meals." -July 11, 2023, a ULP documented the resident was uncooperative with evening cares and would not allow staff to put a brief on.	02310		

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02310	Continued From page 71 -July 5, 2023, a ULP documented the resident came down to the dining room and was upset someone stole a small plate. -July 4, 2023, a ULP documented the resident was unwilling to let staff change her brief and became combative. -July 3, 2023, a ULP documented the resident came downstairs in just a shirt and a brief and asked to use the bathroom. "She was agitated and stated there is nobody around here to help her that she had to come downstairs and look for help. I explained to her that I'm the only one working. I was busy at the time. She continued to be upset when I brought her back to her room." -June 29, 2023, a ULP documented the resident was yelling out at 7:00 a.m. needing to use the bathroom. The resident sat on the toilet for 1.5 hours. -June 27, 2023, a ULP documented the resident was sitting at her door, yelling out. -June 20, 2023, a ULP documented the resident refused overnight cares. -June 19, 2023, RN-B wrote she "instructed staff to put a roam alert pendant on resident wheelchair due to exiting the building without staff knowledge and resident unaware of own safety in doing this." -June 17, 2023, a ULP documented the resident had behaviors and redirection was not successful. The resident attempted to elope "multiple times over the course of the next four hours."	02310		

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02310	Continued From page 72 -June 17, 2023, a ULP documented the resident came to the dining room with a pair of pants in her lap. The ULP later "found the resident outside in the middle of the street. Writer went and got resident and asked what she was doing." The resident claimed she was saving some chickens from getting hurt. The resident became combative with the ULP. -June 13, 2023, a ULP documented the resident refused toileting all shift and was in bed sleeping. -June 8, 2023, a ULP documented the resident was in front of an elevator not allowing other residents to use it. The resident was redirected back to her room. -June 6, 2023, RN-B documented she completed a 90 day review. The resident remained independent with supports of nail care, bathing, cognitive support, scheduling of appointments and transportation, housekeeping, laundry, meals." -June 2, 2023, a ULP documented the resident refused 5:00 a.m. cares. -May 31, 2023, a ULP documented the resident refused cares overnight. -May 28, 2023, a ULP documented the resident "refused to let writer help change her incontinence products at 4:40 a.m. even though her briefs were saturated..." -May 25, 2023, a ULP documented the resident "sat in the commons area talking about how the water is going to kill everyone and we should not be washing clothing or showering." The resident refused to go back to her room and wanted to "sit	02310		

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02310	Continued From page 73 there and make sure everyone know that the water is going to kill them and that it is all Trump's doing." R1's care plan indicated the resident had mild/moderate/severe memory loss and required reminders for activities and meals and frequent hygiene checks. The resident needed assistance to use the toilet and maintain bladder continence. Behaviors noted were behaviors of disrobing, taking things belonging to others, wandering aimlessly, showing anger, provocation, verbal abuse, or other extreme or erratic behavior patters. It was noted the resident hits out at staff and thinks people are taking things from her. The care plan did not include any assessment of the resident's ongoing refusals to change her brief or use the bathroom. The care plan lacked specific interventions for staff to use when the resident exhibited behaviors or refusals. R1's careplan also included no interventions to address behaviors documented in R1's progress notes and provided no direction for staff on how to approach, redirect, or provide care to R1 during times R1 was disoriented or exhibiting behaviors or refusals. R1's careplan and service plan failed to address R1's refusals for toileting despite multiple incidents of saturating through incontinent products, clothing, and bedding, and provided no modifications, updates, or interventions to address incontinent care. No direction or reapproach techniques were identified on the careplan or service plan for staff in how to manage behaviors or refusals. R1's most recent assessment, dated September 1, 2023, indicated the resident was disoriented to time, place, and situation. The assessment did not include an assessment of the resident's	02310		

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02310	Continued From page 74 ongoing refusals to change incontinence products or use the bathroom. The assessment lacked specific interventions for staff to use when the resident exhibited behaviors or refusals. The resident was noted to have a history of elopements and was at risk for elopement. The resident was noted to refuse cares including dressing, grooming, bathing, getting out of bed, or allowing staff to change her incontinence products. No interventions were documented. On September 22, 2023, at 4:50, LALD-A stated she felt the facility was able to meet R1's needs and had appropriately assessed the resident's behaviors but R1 would still refuse and had the right to refuse care. LALD-A asked the investigator what they were missing from R1's assessments or what else they could do to ensure R1's needs were met. LALD-A questioned if they should just send the resident to the emergency room if she kept refusing to change her saturated brief. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days On September 28, 2023, the immediacy of correction order 2310 was removed, however non-compliance remained at a level three isolated scope (G).	02310		
02350 SS=G	144G.91 Subd. 7 Courteous treatment Residents have the right to be treated with courtesy and respect, and to have the resident's property treated with respect	02350		

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02350	Continued From page 75 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the licensee failed to ensure one of one resident (R1) was treated in a courteous, respectful, and dignified manner. This resulted in an immediate order on September 22, 2023. 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: On September 22, 2023, at 12:00 p.m. a Minnesota Department of Health (MDH) investigator entered the facility on a complaint investigation. An entrance conference was conducted with the licensed assisted living director (LALD)-A at 12:15 p.m. On September 22, 2023 between 12:15 - 12:50 p.m., the MDH investigator conducted observations of the facility's second floor and noted a strong urine smell. During the observation period of the second floor, the MDH investigator knocked on R1's door and asked permission to enter. Upon entering the room, the investigator observed R1 laying in the middle of the bed. R1 had white sneakers on, had no pants on but did have an incontinent product on, and was wrapped in a fleece blanket laying on top of a fitted sheet. R1's head was on top of rags	02350		

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02350	Continued From page 76 and there was no pillow, or additional sheets or blankets observed on or around the bed. R1 was laying on top of a disposable soaker pad in the middle of the bed. The pad was saturated with urine and several flies were observed around R1. A fly swatter was observed near R1's right side on top of the saturated soaker pad. R1 provided her name to the investigator. The investigator asked R1 is she was comfortable and R1 replied " I don't know." The investigator asked R1 if she needed to use the bathroom or if her pad or sheets were wet and R1 replied "I suppose, it always is I don't know, I don't care." Upon further observation of R1's room, the investigator observed several white Styrofoam cups of water on the night stand next to the bed, two dead plants on the windowsill, which had started to fuse to the window, and a table cluttered with pills, old food, and melted ice cream. The investigator asked permission to open the kitchen fridge and observed several items of old or expired food, an open glass of milk and noted the temperature of the refrigerator felt warm. On September 22, 2023, at 1:50 p.m. the investigator requested the facility registered nurse (RN)-B to observe R1 and R1's room. The investigator asked RN-B when the last time R1 was provided incontinent care and RN-B replied, this morning. When questioned why it had been so long between cares, RN-B stated she would need to check documentation and explained staff check on R1 every few hours, but R1 refuses care. The investigator pointed out the urine soaked pad that R1 was lying on and RN-B acknowledged the pad was wet. The investigator questioned what staff were directed to do when R1 refused care, and RN-B replied, they redirect	02350		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02350	Continued From page 77 and reapproach R1 and staff were scheduled to check on R1 every 2-3 hours and that is what was care planned for staff to do. The investigator questioned RN-B on the urine smell in R1's room and RN-B stated the odor of urine was acceptable and confirmed R1's mattress was likely soaked with urine and went on to say the smell was usual and they were trying to manage it and seek other care options for R1. RN-B further stated R1 often refused offers for assistance with the bathroom and refused for staff to clean her window and room. RN-B also confirmed R1's lunch in the Styrofoam box was still on the table, untouched, and unopened. On September 22, 2023, at 3:30 p.m. the investigator again went to R1's room. R1 remained in bed. R1 had not been provided incontinent care and remained lying in a wet incontinent product and on top of the pad saturated with urine. R1 stated she was hungry and R1's Styrofoam box from lunch remained on the table, including ice cream, untouched, and unopened. On September 22, 2023, at 4:20 p.m., RN-B returned to R1's room with the investigator. RN-B attempted to change R1's brief. R1 continued to refuse and told RN-B she was "doing this for Trump." The resident later stated, "I don't trust anybody in this dump. This is a hell hole." RN-B was asked about the medications in R1's room, including one that had expired in 2011, as well as toilet cleaner on the counter next to a drinking cup and several various liquid medication bottles. RN-B stated the resident could have access to cleaner since it's her apartment and they had trouble removing things from her room due to her	02350		

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	20201	A. BUILDING: _____ B. WING _____	C 09/28/2023

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02350	Continued From page 78 behaviors. The MDH investigator requested R1's medical record for review. R1's diagnoses included dementia, weakness, and type two diabetes. R1's service plan dated October 28, 2022, indicated the resident received assistance with dressing, grooming, bathing, toileting, and transfers. R1's care plan indicated the resident had mild/moderate/severe memory loss and required reminders for activities and meals and frequent hygiene checks. The resident needed assistance to use the toilet and maintain bladder continence. Behaviors noted were inappropriate behaviors of disrobing, taking things belonging to others, wandering aimlessly, showing anger, provocation, verbal abuse, or other extreme or erratic behavior patters. It was noted the resident hits out at staff and thinks people are taking things from her. The care plan did not include any assessment of the resident's ongoing refusals to change her brief or use the bathroom. The care plan lacked specific interventions for staff to use when the resident exhibits behaviors or refusals. R1's most recent assessment, dated September 1, 2023, indicated the resident was disoriented to time, place, and situation. The assessment did not include any assessment of the resident's ongoing refusals to change incontinence products or use the bathroom. The assessment lacked specific interventions for staff to use when the resident exhibited behaviors or refusals. The resident was noted to have a history of elopements and was at risk for elopement. The	02350		

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02350	Continued From page 79 resident was noted to refuse cares including dressing, grooming, bathing, getting out of bed, or allowing staff to change her incontinence products. No interventions were documented. R1's progress notes contained the following entries: -September 21, 2023, a ULP documented the resident refused toileting all day. "She told me she just wants to die and to leave her alone. I've tried multiple times. I asked her to change her in bed and she yelled no. She ate breakfast in bed but refused her lunch." -September 21, 2023, a night shift ULP documented the resident refused cares at the first attempt but accepted help at 3:15 a.m. -September 19, 2023, a ULP documented the resident refused scheduled cares on the night shift and "held onto her brief not allowing writer to change her." -September 17, 2023, a ULP documented the resident refused toileting or to have her brief changed on the night shift, telling the ULP, "No get away! I don't want it changed." -September 14, 2023, a ULP documented the resident came downstairs in her wheelchair with just a shirt and a brief on. The resident exhibited verbal behaviors including thinking the devil was coming to get her. The ULP documented the resident was hitting the front door button with her walker and setting off the wander alarm. Redirection attempts were not successful. -September 10, 2023, a ULP documented the resident had been in bed sleeping all day and	02350		

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02350	Continued From page 80 "had not eaten anything or let me check on her. She refused to get up to the bathroom. She told me to leave her alone and just cover her up with her blanket. I've tried a couple times and she keeps refusing." -September 7, 2023, a ULP documented the resident had been in bed sleeping all day. The resident refused attempts to change her brief. The ULP wrote, "I explained to her brief is soaking wet and she told me it will eventually dry out. I told her she is going to get sore if she doesn't let me change and she said she don't care and the world is ending." -On September 7, 2023, a night shift ULP documented the resident refused toileting but allowed her to change her brief. The ULP noted she removed an uneaten meal from the resident's room. -September 2, 2023, a ULP documented the resident was out by the elevator and noted she needed her brief changed. The ULP offered to help and the resident was "calling writer names and said she was going to get the police cause the facility was keeping her here like an animal." -September 1, 2023, RN-B documented she met with the resident for a 90 day review of services and noted the resident has "remained independent with supports of nail care, showers, cognitive support, pericare, housekeeping, laundry, meals, and emergency pendant...resident reports good appetite, sleeping well at night, and normal urination and bowel movements." -September 1, 2023, a ULP documented the resident refused to get up for toileting or allow for	02350		

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02350	Continued From page 81 the staff member to change her brief. -August 29, 2023, a ULP documented the resident refused to get up and use the bathroom. "She was soaked in urine through her brief and her chuck pads. I was able to get the soaked pads off of her and then she was kicking and hitting me. She screamed at me that I was wasting her briefs, I explained to her it was all wet." The resident refused to put the dry brief on and went to bed without one on. -August 28, 2023, RN-B documented she assessed the resident after a fall. -August 25, 2023, a ULP documented they checked on the resident and she was not wearing a brief. The resident refused to put one on. -August 24, 2023, a ULP documented the resident came to the dining room "with no bottoms on and seemed agitated." -August 22, 2023, a ULP documented the resident refused to use the bathroom or let her change the bed. -August 22, 2023, a night shift ULP documented the resident refused toileting on the overnight shift. The ULP removed the resident's uneaten supper from her room. -August 21, 2023, a ULP documented the resident refused toileting and refused her supper. -August 20, 2023, a ULP documented the resident refused her lunch as she thought it was poison. -August 19, 2023, a ULP documented the	02350		

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02350	Continued From page 82 resident refused toileting and would not let staff change her brief. -August 17, 2023, the resident refused to change her brief on the overnight shift. The resident had soaked her bedsheets with urine but refused to allow them to be changed. The ULP placed a dry absorbent pad on the bed. -August 2, 2023, a ULP documented the resident was yelling in her doorway at 4 a.m. -July 23, 2023, a ULP documented the resident was agitated and tired and did not get up all day long. The resident was noted to have not eaten. -July 23, 2023, a ULP documented she reproached the resident after she refused cares all day. The resident was eventually cooperative and put on a dry brief, but "kneed the writer in the jaw." -July 23, 2023, a night shift ULP documented the resident was combative about changing her soaked brief. -July 21, 2023, a ULP documented the resident refused toileting or incontinence product changes "but reluctantly complied at 5:00 a.m. when very soaked." -July 12, 2023, a ULP documented they tried three times to get the resident to put a brief on or go to the bathroom but the resident refused. The ULP "removed two meals from the resident's room that had been sitting there since 10 p.m. Resident did not eat any of those meals." -July 11, 2023, a ULP documented the resident was uncooperative with evening cares and would	02350		

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02350	Continued From page 83 not allow staff to put a brief on. -July 5, 2023, a ULP documented the resident came down to the dining room and was upset someone stole a small plate. -July 4, 2023, a ULP documented the resident was unwilling to let staff change her brief and became combative. -July 3, 2023, a ULP documented the resident came downstairs in just a shirt and a brief and asked to use the bathroom. "She was agitated and stated there is nobody around here to help her that she had to come downstairs and look for help. I explained to her that I'm the only one working. I was busy at the time. She continued to be upset when I brought her back to her room." -June 29, 2023, a ULP documented the resident was yelling out at 7:00 a.m. needing to use the bathroom. The resident sat on the toilet for 1.5 hours. -June 27, 2023, a ULP documented the resident was sitting at her door, yelling out. -June 20, 2023, a ULP documented the resident refused overnight cares. -June 19, 2023, RN-B wrote she "instructed staff to put a roam alert pendant on resident wheelchair due to exiting the building without staff knowledge and resident unaware of own safety in doing this." -June 17, 2023, a ULP documented the resident had behaviors and redirection was not successful. The resident attempted to elope "multiple times over the course of the next four	02350		

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02350	Continued From page 84 hours." -June 17, 2023, a ULP documented the resident came to the dining room with a pair of pants in her lap. The ULP later "found the resident outside in the middle of the street. Writer went and got resident and asked what she was doing." The resident claimed she was saving some chickens from getting hurt. The resident became combative with the ULP. -June 13, 2023, a ULP documented the resident refused toileting all shift and was in bed sleeping. -June 8, 2023, a ULP documented the resident was in front of an elevator not allowing other residents to use it. The resident was redirected back to her room. -June 6, 2023, RN-B documented she completed a 90 day review. The resident remained independent with supports of nail care, bathing, cognitive support, scheduling of appointments and transportation, housekeeping, laundry, meals." -June 2, 2023, a ULP documented the resident refused 5:00 a.m. cares. -May 31, 2023, a ULP documented the resident refused cares overnight. -May 28, 2023, a ULP documented the resident "refused to let writer help change her incontinence products at 4:40 a.m. even though her briefs were saturated..." -May 25, 2023, a ULP documented the resident "sat in the commons area talking about how the water is going to kill everyone and we should not	02350		

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02350	Continued From page 85 be washing clothing or showering." The resident refused to go back to her room and wanted to "sit there and make sure everyone know that the water is going to kill them and that it is all Trump's doing." R1's careplan included no interventions to address behaviors documented in R1's progress notes and provided no direction for staff on how to approach, redirect, or provide care to R1 during times R1 was disoriented or exhibiting behaviors or refusals. R1's careplan and service plan failed to address R1's refusals for toileting despite multiple incidents of saturating through incontinent products, clothing, and bedding, and provided no modifications, updates, or interventions to address incontinent care. No direction or reapproach techniques were identified on the careplan or service plan for staff in how to manage behaviors or refusals. On September 22, 2023, at 4:50, LALD-A stated she felt the facility was able to meet R1's needs and had appropriately assessed the resident's behaviors but R1 would still refuse and had the right to refuse care. LALD-A asked the investigator what they were missing from R1's assessments or what else they could do to ensure R1's needs were met. LALD-A questioned if they should just send the resident to the emergency room if she kept refusing to change her saturated brief. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02350		

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02350	Continued From page 86 On September 28, 2023, the immediacy of correction order 2350 was removed, however non-compliance remained at a level three isolated scope (G).	02350		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure two of two residents reviewed (R1, R2) were free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No plan of correction is required for this tag.	