Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL20517004M
Compliance #: HL20517005C

Date Concluded: August 16, 2022

Name, Address, and County of Licensee Investigated:
Epiphany Care Homes
3704 Cardinal Road
Minnetonka, MN 55345
Hennepin County

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

Evaluator's Name: Peggy Boeck, RN
Special Investigator

Finding: Substantiated, facility responsibility

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

Initial Investigation Allegation(s):
The facility neglected a resident when they failed to change the resident's incontinence brief which caused skin breakdown of the resident's genitals. It is also alleged the facility neglected to treat the resident's pressure sores on his foot, resulting in the resident's inability to stand.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to ensure staff provided appropriate skin care when the resident's foot showed signs of skin breakdown. The resident's service plan and interventions on the resident's treatment plan failed to directed staff to observe, treat, or monitor the residents skin breakdown on his feet. Staff did not observe or treat the skin on the resident's foot. The resident's skin breakdown developed into four pressure ulcers with full thickness tissue loss.

It was inconclusive whether the facility neglected to change the resident's brief, creating skin breakdown on the resident's penis. One part-time night staff stated she was not allowed to change the resident on nights because he needed two people for transfers, and the other full-time night staff who worked opposite shifts stated he changed/toileted the resident using a sit to stand lift by himself. The facility received orders months earlier, to apply barrier cream to the resident's penis and documentation indicated staff used the barrier cream.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the hospice nurse, hospice social worker, hospice home health aide, as well as family members. The investigation included review of resident records, hospice records, skilled nursing facility records, incident reports, policies, and procedures related to change in condition, communication, competency training, complaints, individual abuse prevention, treatment administration, nursing assessments, referrals, staffing, maltreatment, and vulnerable adults.

The resident lived in an assisted living dementia care facility for several years with diagnoses including dementia, hypertension, and glaucoma. The resident's service plan included assistance with bathing, grooming, dressing, toileting, and hygiene checks. The resident received services from hospice beginning a few days before an incident with the resident's ankle.

According to a facility progress note, the resident had a swollen ankle one day with no known origin and he could not walk on it. The facility nurse wrapped the ankle in an ace bandage, elevated the resident's foot, and notified the nurse practitioner. The nurse practitioner ordered an x-ray, which determined the resident did not have a fracture.

Two days later the resident's ankle remained painful and swollen so a CAM boot (controlled ankle motion walking boot used for stabilization and treatment of severe sprains in the ankle or foot) was ordered by the facility nurse practitioner in consultation with hospice and placed on the resident's foot/ankle, to be worn during ambulation.

The facility made no changes to the resident's service plan and added no treatments related to the CAM boot or an ace wrap. The facility had no documentation of cares provided to the resident's ankle and had no direction for unlicensed staff for application or removal of the CAM boot or ace wrap.

Eight days after the order for the CAM boot, a hospice licensed practical nurse (LPN) noted the resident's foot was wrapped in an ace wrap. The LPN notified the hospice registered nurse (RN).

Eleven days after the order for the CAM boot, a hospice home health aide provided the resident with a shower and noticed the resident had multiple large purple areas on the skin around the resident's ankle. The hospice aide notified the hospice RN who directed the aide to

leave the CAM boot off. The hospice aide also noticed open, bleeding skin on the resident's penis.

The hospice RN assessed the resident's foot and noted the resident had pressure ulcers on his foot and ankle. The hospice RN notified the facility RN and provided education on the importance of protecting the resident's skin and elevating the foot.

The resident transferred to a skilled nursing facility 19 days after wearing the CAM boot, where it was discovered on admission that the resident had four pressure ulcers on his foot and ankle with full thickness tissue loss. The skilled nursing facility began treatment on the pressure ulcers.

During interviews, multiple unlicensed staff stated they had not observed the resident's foot/ankle due to it either having an ace wrap or CAM boot on it. Some staff reported the CAM boot stayed on all day and night, while others stated the CAM boot was only on when they needed to transfer the resident. Staff who recalled seeing an ace wrap on the resident's foot stated they never took it off.

During an interview, the facility RN stated the resident injured his ankle because of a fall, and so the CAM boot was ordered. The facility RN stated hospice provided orders for care with the CAM boot, however, the facility records did not include such orders. The facility RN stated the CAM boot created a sore on the resident's ankle from rubbing and as soon as the ankle got red, she took off the CAM boot and it remained stable for a long time. The facility nurse stated she informed family if the resident got to the point that he required a full mechanical lift, the facility could no longer care for him, because they only had one staff on the night shift.

During an interview, family members stated the resident twisted his ankle and had difficulty walking. The family members stated after the injury, the facility stated they could no longer care for the resident and the family needed to find him a new place. The family members stated the facility RN insisted the resident have a brace (CAM boot), so they could transfer him with a sit to stand lift. The family members stated the resident wore the CAM boot for a couple weeks and hospice discovered the pressure ulcers. The family members stated the unlicensed staff did not have direction for caring for the resident's skin, or to take the CAM boot off. The family members stated when they asked about the sores, the facility nurse said it was ok and getting better. The family members stated if they had known how bad the wounds were, they would have monitored the resident's skin themselves. The family members stated they first saw the pressure ulcers during the resident's admission to the skilled nursing facility. The family members stated the resident was in a lot of pain and crying. The family members stated it was very distressing to see the resident in so much pain. The family members stated they took pictures of the pressure ulcers and they appeared to be open down to the bone.

In conclusion, neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
Neglect means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: No, deceased
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.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Hennepin County Attorney
Minnetonka City Attorney
Minnetonka Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20517	A. BUILDING: _____ B. WING _____	C 07/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EPIPHANY CARE HOMES LLC	**3704 CARDINAL ROAD MINNETONKA, MN 55345**

(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 Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL20517001C, #HL20517002M/#HL20517003C and #HL20517004M/#HL20517005C On July 27, 2022, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 7 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL20517001C, #HL20517003C, #HL20517005C, tag identification 1040; #HL20517004M, tag identification 2360; and #HL20517005C, tag identification 2310.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
01040 SS=F	144G.52 Subd. 7 Notice of contract termination required	01040		

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01040	Continued From page 1 (a) A facility terminating a contract must issue a written notice of termination according to this section. The facility must also send a copy of the termination notice to the Office of Ombudsman for Long-Term Care and, for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, to the resident's case manager, as soon as practicable after providing notice to the resident. A facility may terminate an assisted living contract only as permitted under subdivisions 3, 4, and 5. (b) A facility terminating a contract under subdivision 3 or 4 must provide a written termination notice at least 30 days before the effective date of the termination to the resident, legal representative, and designated representative. (c) A facility terminating a contract under subdivision 5 must provide a written termination notice at least 15 days before the effective date of the termination to the resident, legal representative, and designated representative. (d) If a resident moves out of a facility or cancels services received from the facility, nothing in this section prohibits a facility from enforcing against the resident any notice periods with which the resident must comply under the assisted living contract. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to issue written notice of termination of services for three of three residents (R1, R2, R3) reviewed for discharge when the licensee gave R1's guardian a 30-day notice for non-payment when R1's payment was up to date, told R2's family the licensee could no longer care	01040	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column	

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01040	Continued From page 2 for R2 and wanted him transferred out but did not provide a notice, and did not provide a notice to R3's guardian, but informed the guardian R3 would not be admitted back from the hospital until he was mentally stable. In addition, the licensee failed to send a copy of the termination notice to the Office of Ombudsman for Long-Term Care. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: R1 R1's record indicated diagnoses that included cognitive deficits following cerebrovascular disease, alcohol dependence, type 2 diabetes, and anxiety disorder. R1's Private Pay Service Agreement dated September 6, 2019, indicated monthly rent payments were due on the first day of each month, and if received after the fifth of the month may be assessed a daily late fee of $50.00 per day. The document indicated if the resident/agent failed to make required payment by the fifteenth day of the month, the [licensee] may require the resident to vacate as described in resident rights section. R1's service plan dated November 30, 2021 indicated R1 received the following services from the facility: encouragement to participate in	01040	entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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01040	Continued From page 3 activities, assistance with grooming needs, assistance with ordering/purchasing personal care items, preparation of meals and snacks, reminders to attend meals, encouragement to eat meals, cues for bathing, nail care, assistance with appropriateness of clothing choices, verbal reminders to put on clean clothes, assistance with peri-care, hygiene checks twice daily, reminders/cues to use toilet to void, linen changes weekly, housekeeping, laundry, medication administration, reminders to call for assistance, transportation assistance and/or appointment reminders. R1's nursing assessment dated January 14, 2022, indicated R1 was able to communicate verbally and make himself understood. The assessment indicated R1 required close supervision in a secure location to prevent unsafe wandering and exhibited behaviors disturbing to others. The assessment indicated R1 usually responded to redirection in a positive manner, easily calmed, accepted support and feedback, but had poor recall. During an interview on July 27, 2022, at 1:20 p.m., Licensed Assisted Living Director/Registered Nurse (LALD/RN)-A stated R1 fell behind on his bill, so R1's guardian searched and found a new place for R1 to live. LALD/RN-A stated she did not give R1 a termination notice. During an interview on August 2, 2022, at 1:30 p.m. R1's guardian-care manager (CM)-B stated her role was as R1's guardian and R1 also had a Veteran's Administration fiduciary who paid R1's bills at the facility. CM-B stated LALD/RN-A informed her R1 was behind on his bill and the proposed amount of payment from the Elderly	01040		

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01040	Continued From page 4 Waiver was too low, so R1 had to leave. CM-B stated the licensee sent R1 a 30-day termination notice for lack of payment. CM-B stated she received an email from the licensee's operations manager that indicated R1's bill was up to date, but they would not accept the EW proposed payment. An email dated January 10, 2022, from R1's elderly waiver (EW) assessor to the licensee indicated Hennepin County proposed rate and plan of care for R1 would pay the facility a maximum of $112.89 per day/ $3,436.00 per month. R1's resident termination notice dated January 25, 2022, sent to CM-B, indicated the licensee would "cancel housing and care services effective March 1, 2022, due to 56 days late payment of $2,550.00 and 26 days late payment of $6,480.70 and pending amount due of $8,550.00". An email dated January 27, 2022, from the licensee to CM-B indicated the licensee "received payments for the balance of the December and January so [R1] is current as of today". The email further indicated "it would be wise if FFC [First Fiduciary Corporation -the guardian] place [R1] on a wait list at the VA [Veteran's Administration] due to the low EW rate." An email dated January 28, 2022, from LALD-A to CM-B indicated the facility "would unlikely be able to accept the $112.00 daily rate" and encouraged the county and CM-B to "locate another provider for [R1]". R2 R2's record indicated diagnoses that included	01040		

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01040	Continued From page 5 dementia, hypertension, and glaucoma. R2's most recent nursing assessment dated December 16, 2021, indicated R1's weight 224.8 pounds, skin color normal/pink with no interventions, required assistance of one to use toilet, required one-person extensive assistance to transfer in/out of bed or chair, transferred with "EZ or Hoyer" (assumed to mean sit to stand lift or full mechanical lift), required assistance to turn and reposition in bed and/or chair. The assessment indicated R1 had intact skin integrity at that time. R2's most recent service plan dated January 10, 2022, indicated R2 received services from the licensee including assistance with dressing, grooming, bedtime cares, meal preparation, encouragement with eating, assistance with bathing, assistance with toileting/peri-care, hygiene checks, safety checks, linen changes, housekeeping, laundry, assistance with mobility, and medication administration. R2's progress note dated January 28, 2022, 14:07 (2:07 p.m.) indicated an x-ray of R2's right foot was negative for a fracture. The progress note indicated a CAM boot (a controlled ankle motion walking boot used for treatment and stabilization of severe sprains, fractures, or ligament tears in the ankle or foot) was applied due to bruising and for comfort. R2's progress note dated February 8, 2022, at 10:28 a.m. indicated R2 had three open areas of his right foot. The note described "area one on the back of [R2's] heal with an intact fluid filled blister. Area two is on the outside ankle currently intact, 1x1 dark red with ¼ yellow soft area, which may have tunneling" (formation of a narrow passageway in a wound often the result of	01040		

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01040	Continued From page 6 infection, abscess formation, or trauma to the wound). The progress note indicated the facility notified the family and hospice. (The progress note did not describe area three.) R2's progress note dated February 9, 2022, at indicated R2 had a new fluid filled area on top of his foot (not identified as right or left foot). The progress note indicated the area was intact. The note indicated "two areas on the outer aspect of ankle are (sic) have pin sized holes with a very small amount of red drainage. Yellow, granular areas ¼ within 1x1 inch area appears softer. Resident denies pain or discomfort". The progress note indicated "3+ pitting edema" and "keeping areas open to air at this time". During an interview on July 27, 2022, at 1:45 p.m. LALD/RN-A stated R2 was unstable on his feet upon admission due to having three toes amputated on that foot but used a walker. LALD/RN-A stated R2 got a sore on his ankle from a CAM boot that hospice placed after R2 "had a fall". LALD/RN-A stated the facility had a plan for two staff to walk R2 with a gait belt but informed the family that if R2 needed a Hoyer, the facility would no longer be able to provide cares for R2. LALD/RN-A stated the facility only had one staff on nights and if there was an emergency, they would not be able to move R2, because "he is a big guy". LALD/RN-A stated she did not give R2 a termination notice. During an interview on August 2, 2022, at 9:30 a.m. hospice social worker (SW)-C stated she, the hospice nurse, LALD/RN-A and family member (FM)-G met for a care conference to discuss the facility wanting R2 placed elsewhere due to their inability to provide care.	01040		

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01040	Continued From page 7 During an interview on August 3, 2022, at 1:17 p.m. FM-G stated R2 twisted his ankle, had difficulty walking, and LALD/RN-A stated the facility could no longer care for R2. FM-G stated LALD/RN-A stated R2 had to go somewhere else, because he was less ambulatory, and staff could not turn him in bed. FM-G stated she was in a panic because they had nowhere to send R2 (even though he was on the list at the Minneapolis Veteran's Home) and FM-G worried the licensee would put R2 out on the street. FM-G stated the family did not receive a termination notice. FM-G stated R2 did admit to the Minneapolis Veteran's Home. R3 R3's record indicated R3 moved into the memory care facility on January 3, 2022, due to diagnoses that included hypertension, panic disorder, generalized anxiety, chronic kidney disease, and schizophrenia. R3's nursing assessment dated January 5, 2022, indicated R3 was weak, ambulated with a wheelchair, and required one-person extensive assistance with transfers in and out of bed/wheelchair. R3's service plan updated February 8, 2022, indicated R3 received the following services from the licensee: dressing assistance, bedtime cares, activities encouragement, assistance with grooming, dressing, bathing, toileting, incontinence cares, laundry, medication administration, and reorientation/redirection of behaviors. R3's progress note dated January 3, 2022, at 11:37 a.m. indicated upon admission, R3 expressed worry about falling during transfers.	01040		

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01040	Continued From page 8 The progress note indicated R3 apologized and stated he was scared. R3's progress note dated January 5, 2022 at 11:58 a.m. indicated R3 had behaviors related to transferring, with R3 yelling, swearing, and crying. R3's progress note dated January 5, 2022, at 15:49 (3:49 p.m.) indicated R3 was aggressive with yelling and swearing at staff. The note indicated LALD/RN-A felt R3 "appeared to be decompensating and I think this started a while ago, while at" [previous placement]. The progress note indicated LALD/RN-A felt R3 may not be safe and may need to be admitted to the VA for evaluation and treatment. R3's progress note dated January 11, 2022, at 12:10 p.m. indicated R3 verbally aggressive toward staff, especially in evening. R3's progress note dated January 12, 2022, at 14:08 (2:08 p.m.) written by LALD/RN-A indicated R3 "has been unapologetically demanding, rude, and verbally aggressive toward staff." R3's progress note dated January 13, 2022, at 12:56 p.m. indicated R3 "continued to complain, swear at staff, be rude, demanding, threatening staff, impulsive, obsessive about times, phone calls and sports. [R3] continues to look for a fight and reason to say no." R3's progress note dated January 15, 2022, at 20:21 (8:21 p.m.) indicated R3 "yelling and screaming at staff, stating no one understands the pain he is in." The progress not indicated R3 received relief with Tylenol and a heating pad on the painful area.	01040		

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EPIPHANY CARE HOMES LLC	3704 CARDINAL ROAD MINNETONKA, MN 55345

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01040	Continued From page 9 R3's progress note dated January 18, 2022, at 11:52 indicated LALD/RN-A made a "rules sheet with 7 basic rules (No yelling, no swearing, no hitting, be kind to people, be patient, wake up at 7:00 a.m., bedtime is at 9:35 p.m.)" for R3. R3's progress note dated January 21, 2022, at 18:00 (6:00 p.m.) written by LALD/RN-A indicated R3 "obsesses's (sic) and fixates on sports and will not cooperate with routine due to anxiety around sporting games". R3 progress note dated January 24, 2022, at 15:11 (3:11 p.m.) indicated R3 rated his anxiety at 7 out of 10 and that he is having 7 panic attacks a day. R3 progress note dated February 1, 2022, at 11:58 a.m. indicated R3 has been demanding, forgetful, repeating questions, as if confused and frustrated. The note indicated the resident had daily anxiety and/or panic attacks triggered by losing papers, standing close to him, putting shirts over his head, transfers, sitting in a recliner, and sporting events. R3 progress note dated February 7, 2022, at 13:43 (1:43 p.m.) indicated LALD/RN-A contacted R3's guardian to advise her of R3's behavior and need for a psychiatric evaluation. R3's guardian agreed and met R3 at the emergency department. The progress note indicated "[R3] cannot return to facility unless his behaviors are controlled: outburst, mincing (sic) behavior, verbal aggression, and homicidal threats." The progress note also indicated R3 "has a tendency (pattern) of denying behaviors and/or symptoms once at ED, he has an ability to change his personality and becomes "more agreeable and likeable" for a short period of time".	01040		

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01040	Continued From page 10 An email dated February 7, 2022, at 3:53 p.m. from LALD/RN-A to R3's guardian - care manager (CM)-B indicated LALD/RN-A "cannot take him back since he has been threatening staff and residents. They will need to keep him until he is mentally stable". During an interview on July 27, 2022, at 2:15 p.m. LALD/RN-A stated R3 was pleasant and cooperative when she assessed him a month before his admission, and LALD/RN-A knew he had mental health issues. LALD/RN-A stated R3 went to the emergency department at the VA, but the emergency department did not want to keep him. LALD/RN-A stated it took a lot of talking to the Veteran's Administration psychiatric doctor and psychiatric nurse, but they finally agreed to keep him for a while. During an interview on July 28, 2022, at 1:00 p.m. CM-B stated the licensee was aware of R3 mental health issues and confirmed that R3's behaviors increased at the facility with verbal aggression. CM-B stated R3 would say things and later apologize. CM-B stated R3 was difficult to redirect but was not physically capable of doing harm as he had limited mobility and relied on a wheelchair for mobility. CM-B stated the licensee never discussed their intent to terminate R3's services and she learned about it in an email. CM-B stated LALD/RN-A emailed her that R3 would not be welcome back from the emergency department due to threatening behaviors. CM-B stated LALD/RN-A told her that R3 could not return to the facility until he was mentally stable but did not define what that meant. CM-B stated the doctor in the emergency department stated R3 was ready for discharge February 7, 2022, but since the licensee would not take him back, he	01040		

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01040	Continued From page 11 spent the night in the emergency department and transferred to the mental health unit. CM-B stated R3 remained in the mental health unit for one week and returned to the licensee's facility while waiting for acceptance to the Minneapolis Veteran's Home three weeks later. CM-B stated R3 never received a termination notice. The Contract Termination policy dated July 1, 2022, indicated the licensee may initiate a termination of housing because of nonpayment of rent or a termination of services because of nonpayment for services. The policy also indicated the licensee may initiate a termination of the assisted living contract if the resident violated a lawful provision of the contract and the resident did not cure the violation within a reasonable amount of time after the facility provided a written notice of the ability to cure to the resident. TIME PERIOD FOR CORRECTION: SEVEN (7) DAYS	01040		
02310 SS=G	144G.91 Subd. 4 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 interview and document review, the licensee failed to provide care in accordance with accepted healthcare standards for one of one resident (R2) reviewed for pressure ulcers when	02310	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to	

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02310	Continued From page 12 R2 developed pressure ulcers on his right lower leg and the licensee failed to create and implement new care interventions to address appropriate skin care. As a result, R2 experienced severe pain and a pressure ulcer with full thickness tissue loss. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings include: R2 lived in the assisted living with dementia care due to diagnoses that included dementia, hypertension, and glaucoma. R2's most recent nursing assessment dated December 16, 2021, completed by licensed assisted living director/registered nurse (LALD/RN)-A indicated R1 weighed 224.8 pounds, had normal/pink skin color with no interventions, required assistance of one to use the toilet, required one-person extensive assistance to transfer in/out of bed or chair, transferred with "EZ or Hoyer" (assumed to mean sit to stand lift or full mechanical lift), required assistance to turn and reposition in bed and/or chair. The assessment indicated R1 had intact skin integrity at that time. R2's most recent service plan dated January 10, 2022, completed by LALD/RN-A indicated R2 received services from the licensee that included	02310	Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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02310	Continued From page 13 assistance with dressing, grooming, bedtime cares, meal preparation, encouragement with eating, assistance with bathing, assistance with toileting/peri-care, hygiene checks, safety checks, linen changes, housekeeping, laundry, assistance with mobility, and medication administration. R2's documentation of tasks completed dated January 1, 2022, through February 16, 2022, indicated staff completed the following tasks: activities, socialization, bathing, clipping nails, continence care, toileting, assistance with glasses, laundry, monitoring of behaviors, shaving, and documentation of bladder/bowel function. R2's progress note dated January 24, 2022, at 14:26 (2:26 p.m.) indicated R2's ankle was swollen and R2 refused to bear weight. The progress note indicated the nurse applied an Ace wrap and elevated R2's ankle. R2's progress note dated January 25, 2022, at 13:10 (1:10 p.m.) indicated nurse practitioner (NP)-H ordered an x-ray for R2's right ankle. R2's progress note dated January 26, 2022, at 10:36 a.m. indicated R2's right foot was painful and swollen. The progress note indicated a CAM boot (a controlled ankle motion walking boot used for treatment and stabilization of severe sprains, fractures, or ligament tears in the ankle or foot) was coming the following week. R2's progress note dated January 28, 2022, 14:07 (2:07 p.m.) indicated R2's x-ray was negative for a fracture. The progress note indicated a CAM boot was applied due to bruising and for comfort.	02310		

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02310	Continued From page 14 R2's progress note dated February 8, 2022, at 10:28 a.m. indicated R2 had three open areas of his right foot. The note described "area one on the back of [R2's] heal with an intact fluid filled blister. Area two is on the outside ankle currently intact, 1x1 dark red with ¼ yellow soft area, which may have tunneling" (formation of a narrow passageway in a wound often the result of infection, abscess formation, or trauma to the wound). The progress note indicated the facility notified the family and hospice. (The progress note did not describe area three.) R2's progress note dated February 9, 2022, at indicated R2 had a new fluid filled area on top of his foot (not identified as right or left foot). The progress note indicated the area was intact. The note indicated "two areas on the outer aspect of ankle are (sic) have pin sized holes with a very small amount of red drainage. Yellow, granular areas ¼ within 1x1 inch area appears softer. Resident denies pain or discomfort". The progress note indicated "3+ pitting edema" and "keeping areas open to air at this time". R2's progress note dated February 11, 2022, at 12:27 p.m. indicated no changes to open areas, skin to LLE (left lower extremity) dry. The progress note indicated hospice nurse agreed with current treatment plan to leave open areas open to air and elevated. R2's progress note dated February 11, 2022, at 16:31 (4:31 p.m.) indicated no changes in R2's status. R2's progress note dated February 11, 2022, at 16:34 (4:34 p.m.) indicated R2's family was planning to discharge R2 to VA SNF (Veteran's Administration skilled nursing facility) on February	02310		

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02310	Continued From page 15 16, 2022. The note indicated the facility encouraged the hospice nurse to speak with R2's family to start packing R2's belongings and that the facility had packed up all R2's medications for transport to the nursing facility. R2's progress note dated February 16, 2022, at 12:23 p.m. indicated R2 discharged to the Minneapolis VA SNF with all belongings. R2's treatment administration records for December 2021, January 2022, and February 2022 indicated staff completed the following treatments for R2: weekly vital signs/weight, twice daily barrier cream topically for bleeding and excoriated penis, daily nystatin cream topically to abdominal folds, ted hose apply/remove every 12 hours as needed. R2's record lacked documentation of skin care, skin checks, application, or removal of ace wrap or CAM boot on R2's right foot/ankle. R2's admission form dated February 16, 2022, for the Minnesota Veterans Home-Minneapolis skilled nursing facility (SNF) indicated the SNF nurse assessed R2 and found pressure ulcers on four areas of his right leg and ankle that measured as follows: (Wound #1) dorsal right foot 4.94 cm by 4.4 cm, (Wound #2) dorsal right foot (outer ankle) 5.93 cm by 1.76 cm, (Wound #3) right heel 3.68 cm by 2.16 cm, (Wound #4) right calf- lower leg 1.21 centimeters(cm) by 0.98 cm, and. All four areas staged as 'unstageable" (full thickness tissue loss in which the base of the ulcer was covered by slough (a mass of dead tissue separating from an ulcer) and/or eschar (a piece of dead tissue shed from the surface of the	02310		

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02310	Continued From page 16 skin after an injury)). During an interview on July 27, 2022, at 1:45 p.m. LALD/RN-A stated R2 required total care with everything including grooming, dressing, and bathing. LALD/RN-A stated R2 had a skin issue on his heel and outside ankle due to a fall. LALD/RN-A stated she spoke with hospice, and they decided to use the CAM boot, which created a wound. LALD/RN-A stated she removed the CAM boot as soon as the area became red. LALD/RN-A stated R2 developed a wound but it did not open up. LALD/RN-A stated hospice provided the CAM boot and orders for care with the boot. During an interview on August 1, 2022, at 12:53 p.m. unlicensed personnel (ULP)-D stated she worked with R2 from admission through his discharge. ULP-D stated she completed normal skin cares for R2 when he had the CAM boot on. ULP-D stated she checked for pressure ulcers, made sure the CAM boot was not on too tight and that it fit right. ULP-D stated R2 did have skin breakdown on his ankle but did not know about any other skin breakdown. During an interview on August 1, 2022, at 2:15 p.m. hospice registered nurse (RN)- E stated LALD/RN-A notified her on January 24, 2022, that R2's ankle was swollen. RN-E stated she went to the facility and assessed R2. RN-E stated LALD/RN-A had placed an ace wrap on R2's right foot. RN-E stated R2's nurse practitioner assessed R2's ankle, ordered an x-ray, and ordered a CAM boot for ambulation. RN-E stated the hospice home health aide notified her of R2's skin breakdown on February 8, 2022, and sent her a picture. RN-E stated she spoke with LALD/RN-A who stated R2 had a blister from the	02310		

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02310	Continued From page 17 CAM boot rubbing, so LALD/RN-A removed the CAM boot and left it open to air. RN-E stated LALD/RN-A told her the area was healing fine. RN-E stated the hospice home health aide also reported R2 had skin breakdown in the peri-area, with bleeding on his penis, for which the facility staff used barrier cream. During an interview on August 2, 2022, at 3:52 p.m. ULP-F stated R2 had skin breakdown on his ankle, so the facility stopped using the CAM boot, and LALD/RN-A put a dressing on the open skin. During an interview on August 3, 2022, at 1:17 p.m. R2's family member (FM)-G stated LALD/RN-A insisted hospice order a brace (the CAM boot), R2 wore it for several weeks and hospice notified the family that R2 had pressure ulcers under the CAM boot. FM-G stated the staff had no orders to remove the CAM boot or how to provide cares under it. FM-G stated the pressure ulcers were down to the bone when she finally saw it during the admission to the Minneapolis Veteran's Home. FM-G state LALD/RN-A did not include any information about the pressure ulcers on the paperwork that she sent to the next placement (Minneapolis Veteran's Home). During an interview on August 5, 2022, at 1:49 p.m. ULP-I stated R2 had the CAM boot on" pretty much all the time". ULP-I stated there was a time that R2 had a sore on his ankle that LALD/RN-A wrapped in an ace bandage all the time, so ULP-I stated she never saw the skin underneath. During an interview on August 5, 2022, at 4:00 p.m. ULP-J stated he provided cares for R2 on the overnight shift, ULP-J stated he used the sit to stand lift with R2. ULP-J stated facility staff	02310		

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02310	Continued From page 18 placed R2's CAM boot on when they transferred him with the sit to stand lift and took it off when R2 laid in his recliner or bed. During an interview on August 9, 2022, at 11:03 a.m. ULP-K stated she worked the overnight shift for the licensee but did not provide cares for R2, except for putting a blanket on him if it fell off. ULP-K stated she was "not able to change him" if his incontinence brief was wet and "not allowed to transfer him" because R2 was "a two person because he was unstable and a fall risk". ULP-K stated R2 required a gait belt with two people to transfer, for toileting or incontinence brief changes. ULP-K stated R2 wore his CAM boot all night long. The Competency Training policy dated August 1, 2021, indicated the registered nurse would determine what nursing services may be delegated to properly trained and competency tested unlicensed personnel. The policy listed nursing tasks frequently delegated to unlicensed personnel that would require training and competency testing included ace bandage application, protective boots, AFO brace, and wound cares. The Skin Care Assistance competency (undated) indicated unlicensed personnel assessed skin integrity during showers and dressing/undressing and notified the nurse of skin breakdown or injury. The Resident Change in Condition or Need policy dated August 1, 202,1 indicated when changes in condition or need are identified, a registered nurse will initiate a change in condition assessment. If the licensee determines there should be recommended change to services identified in the service plan, the licensee will	02310		

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02310	Continued From page 19 communicate with the resident's representative to determine if the change will be added to the service plan. Changes, or refusal of changes will be documented. TIME PERIOD FOR CORRECTION: SEVEN (7) DAYS	02310		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: Based on interviews, and document review, the facility failed to ensure one of one residents reviewed (R2) was free from maltreatment. R2 was neglected. Findings include: On July 27, 2022, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	