Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL28989001M
Compliance #: HL28989002C

Date Concluded: December 27, 2021

Name, Address, and County of Licensee Investigated:
Lilac Homes Assisted Living
2615 Parkview Drive
Moorhead, MN 56560
Clay County

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

Evaluator's Name: Jill Hagen, RN, Special Investigator

Finding: Substantiated, facility and individual 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.

Allegation(s):
It is alleged: The alleged perpetrator (AP) abused the resident by placing bilateral ankle weights on the resident's ankles to prevent the resident's legs from moving.

Investigative Findings and Conclusion:
Abuse was substantiated. The facility and the AP were responsible for the maltreatment. The AP placed bilateral ankle weights on the resident's ankles, preventing the resident from freely moving her legs. Other facility unlicensed personnel (ULPs) observed the weights on the resident but failed to remove them from the resident's ankles for approximately 13 hours.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included an interview with the AP and the resident's family member. The investigation included observations of the facility, and a review of the resident's medical record, facility policies and procedures, and staff schedules.

The resident had diagnoses that included Parkinson's disease, Lewy body dementia, a progressive dementia, and degenerative joint disease. The resident inconsistently made her needs known and required assistance from others with decision-making. The resident required staff assistance to complete all activities of daily living, including assistance with eating due to hand tremors, toileting, repositioning and transfers. The resident used a wheelchair for mobility. The resident's care plan directed staff to use a weighted coffee cup and blanket to help with the resident's tremors.

Review of a facility event report indicated during an evening shift the AP placed weights on the resident's ankles because the resident had seizure-like symptoms. The event report indicated the AP did not notify the nurse of the resident's symptoms, and that the AP was aware ankle weights were a restraint.

During interview, ULP #1 stated she worked the morning shift following the AP placing the ankle weights. ULP #2 dressed the resident before ULP #1 arrived. The resident had breakfast and returned to her recliner. About one hour later, a family member visited the resident in her room. The family member requested ULP #1 assist the resident with toileting. Once the resident was on the toilet, ULP #1 stated she saw the weights on each of the resident's ankles. ULP #1 stated she was aware the ankle weights were a restraint but contacted the nurse before removing them.

During interview, ULP #2 stated she worked the night shift following the placement of the ankle weights. ULP #2 assisted the resident during the night shift with toileting and repositioning. ULP #2 stated she noticed the weights on the resident's ankles but thought they were a type of dressing placed there by the nurse or family member. ULP #2 stated she did not check the resident's care plan for any changes in the resident's care or contact the nurse.

During interview, the AP indicated she was responsible for the resident's care one evening. Around 9:00 p.m. while assisting the resident with her pajamas, the resident's whole body began to shake. Although other staff told her of these tremors, the AP said that was the first time the AP witnessed the resident's body tremors. To keep the resident from falling off the commode, the AP stated she found weights in the resident's room and placed them on the resident's lap. Because the resident's legs came off the ground, the weights fell off the resident's lap. To keep the resident's legs from moving, the AP stated she used the Velcro on the weights to secure the weights around the resident's ankles. The AP stated the resident's body tremors lasted about five minutes.

Once the resident was calm, the AP stated she transferred the resident to her bed, left the ankle weights on, covered the resident with blankets, and left the resident's room. The AP said she was so "freaked out" by the resident's tremors, she forgot to notify the nurse or inform the next shift of the tremors and ankle weights. The AP indicated she was aware the ankle weights were a restraint, but she wanted to keep the resident safe.

During interview, a licensed practical nurse (LPN) indicated she was the nurse on-call the evening of the incident. The LPN stated she first heard of the ankle weights used on the resident when a family member called her the next morning to inform the LPN about the weights. The LPN stated facility staff should notify the nurse of any changes in a residents' condition. Staff interventions to keep the resident safe during body tremors included removing any food from her mouth, finding a safe location, and staying with the resident until the episode ends. The LPN stated the resident usually slept following an episode. The LPN stated the resident's weight at the time was 120 pounds.

During interview, the registered nurse (RN) stated the facility did not obtain or store ankle weights. The RN stated the resident had a progression of her Parkinson's disease and, at times, the resident's entire body shook. The RN stated the AP knew ankle weights were a restraint.

During interview, a family member stated when she came to visit the resident around 10:00 a.m. one morning, the resident's ankles looked "puffy." The family member said she lifted the resident's pant legs and discovered two and one-half pound ankle weights on each of the resident's ankles. The family member stated she removed the weights (13 hours after placed on the resident's ankles by ULP-E) and contacted the nurse on-call.

Review of the resident's medical record did not include a physician's order or nursing instruction to apply ankle weights on the resident.

In conclusion, abuse was substantiated. The AP applied ankle weights, a restraint, to keep the resident's legs from moving. Other facility staff were aware the ankle weights on the resident were a restraint but failed to remove them.

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.

Abuse: Minnesota Statutes section 626.5572, subdivision 2
"Abuse" means:
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening;

(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult; and
(4) use of any aversive or deprivation procedures for persons with developmental disabilities or related conditions not authorized under section 245.825.

Vulnerable Adult interviewed: No, the resident passed away.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility: Facility management provided education to staff on the definition of restraints. The AP is no longer employed by the facility.

Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:
https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

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

cc: The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Clay County Attorney
Moorhead City Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28989	A. BUILDING: _____ B. WING _____	C 12/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LILAC HOMES ASSISTED LIVING	2615 PARKVIEW DRIVE MOORHEAD, MN 56560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments 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: #HL28989002C/#HL28989001M On December 14, 2021, 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 nine residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL28989002C/#HL28989001M, tag identification 0620, 0630, 1460, 1540, 1620, 2360, 3000.	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.	
0 620 SS=F	144G.42 Subd. 6 Compliance with requirements for reporting ma	0 620		

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0 620	Continued From page 1 144G.42 Subd. 6. Compliance with requirements for reporting maltreatment of vulnerable adults; abuse prevention plan. (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. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to comply with the requirements for investigating, reporting, and protecting residents during an investigation of suspected maltreatment of vulnerable adults for one of one resident (R1) with records reviewed. The licensee failed to file a Minnesota Adult Abuse Reporting Center (MAARC) report, investigate, and protect other residents after an unlicensed personnel (ULP)-E applied restraints (ankle weights) to R1's ankles. This practice had the potential to affect all nine residents that resided in the licensee's residence. 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's Facesheet with an intake date of August 23, 2021, indicated R1's diagnoses included	0 620		

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0 620	Continued From page 2 Parkinson's disease, Lewy body dementia (a progressive dementia), and degenerative joint disease. R1's Service Plan with an effective date of October 22, 2021, indicated R1 required staff to anticipate her needs and provide assistance to complete all activities of daily living, including incontinence care every three hours, assistance to eat due to hand tremors, transfers and repositioning. R1 used a wheelchair for mobility. R1's vulnerability assessment dated October 22, 2021, indicated R1 was at risk to be abused by others. R1's assessment directed staff to monitor R1 and remove R1 from unsafe situations. Review of the licensee's staff schedule for October 1, 2021, to October 31, 2021, indicated ULP-E worked her scheduled shifts on October 25 and 26, 2021, from 3:00 p.m. to 9:00 p.m., two days after ULP-E was reported to the registered nurse (RN) for abusing R1. A communication to all staff from the owner (OW)/registered nurse (RN)-D dated October 24, 2021, at 1:06 p.m. indicated there would be an investigation into the use of ankle weights used on R1. The communication to staff occurred more than 24 hours after the discovery of the ankle weights on R1. The licensee's Employee Event Record signed by the owner OW/RN-D and ULP-E on October 27, 2021, read that on October 22, 2021, on the p.m. shift, ULP-E applied ankle weights to R1. The ankle weights were noticed by family the following morning. ULP-E admitted to applying the weights because R1 had seizure like symptoms. ULP-E failed to notify the nurse of R1's symptoms. The	0 620		

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0 620	Continued From page 3 record indicated ULP-E was aware the bilateral ankle weights placed on R1 was a restraint. When interviewed on December 14 2021, at 12:56 p.m., ULP-A stated she discovered the weights on R1's ankles the morning of October 23, 2021, around 10:00 a.m. when toileting R1. R1's family member, (FM)-F, was in the room with ULP-A. ULP-A left the ankle weights on R1 until ULP-E contacted a nurse. When interviewed on December 14, 2021, at 2:07 p.m., OW/RN-D indicated on October 24, 2021, she requested licensed practical nurse (LPN)-C "handle" the investigation. OW/RN-D stated she failed to immediately report because she had to decide if the use of restraints was abuse by definition. OW/RN-D reported the allegation to MAARC on October 27, 2021, four days following the discovery of the ankle weights on R1. When interviewed on December 17, 2021, at 1:54 p.m. ULP-E stated on the evening of October 22, 2021, while assisting R1 with putting on her pajamas while on the commode, R1's entire body began to shake. ULP-E found weights in R1's room and first placed the weights on R1's lap. Because R1's legs went off the floor, the weights fell off R1's lap. ULP-E stated she wanted to keep R1 from falling so she strapped the weights around both of R1's ankles. ULP-E stated the episode lasted about five minutes. When R1 calmed, ULP-E transferred R1 to bed leaving the ankle weights on R1. ULP-E was aware the weights would be considered a restraint. ULP-E did not refer to R1's care plan, contact a nurse about R1's change in condition, or report the ankle weights on R1 to the nurse or staff on the next shift.	0 620		

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0 620	Continued From page 4 When interviewed on December 20, 2021, at 10:10 a.m., R1's family member (FM)-F indicated when she came into visit R1 the morning of October 23, 2021, and R1's ankles looked "puffy." FM-F stated she lifted R1's pant legs and discovered two and one-half pound ankle weights on each of R1's ankles. FM-F stated she removed the weights and contacted the nurse on-call. During interview, on December 22, 2021, at 1:03 p.m., LPN-C indicated she was nurse on-call the evening of the incident. LPN-C first heard of the ankle weights used on R1 when a FM called her the next morning. Facility staff should notify the nurse of any changes in a resident's condition. Staff interventions to keep R1 safe during body tremors included removing any food from her mouth, finding a safe location, and staying with R1 until the episode ends. Usually R1 slept following an episode. The licensee's policy and procedure titled, Vulnerable Adult Reporting and Investigation, with a revised date of August 17, 2021, indicated suspected abuse would be investigated by the RN in coordination with the home care director. If a staff person is an alleged perpetrator of maltreatment of a resident, the staff person would be directed to leave the building immediately and would be instructed not to return to work until further notice by the RN. If an incident appeared to be suspected abuse, the RN/LPN would immediately make a report to MAARC. Immediately means as soon as possible but no longer than 24 hours from the time the RN/LPN received the initial knowledge of the incident. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 620		

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0 630 SS=D	144G.42 Subd. 6 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 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 interview document review, the licensee failed to update an individual abuse prevention plan (IAPP) for one of one residents (R1) reviewed following an incident of abuse, a new vulnerability for R1, and risk of being abused by others. Unlicensed personal (ULP)-E placed ankle weights, a restraint, on R1's ankles for approximately 13 hours. 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 Facesheet with an intake date of August 23,	0 630		

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0 630	Continued From page 6 2021, indicated R1's diagnoses included Parkinson's disease, Lewy body dementia or a progressive dementia, and degenerative joint disease. R1's Service Plan with an effective date of October 22, 2021, indicated R1 required staff to anticipate her needs and staff assistance to complete all activities of daily living, including incontinence care every three hours, assistance with eating due to hand tremors, transfers and repositioning. R1 used a wheelchair for mobility. R1's vulnerability assessment dated October 22, 2021, indicated R1 required staff supervision every two hours around the clock. R1 was at risk to be abused by others. Staff were directed to monitor and remove R1 from any unsafe situations. The Licensee's Employee Event Record signed by the facility and ULP-E on October 27, 2021, read that on October 22, 2021, on the p.m. shift, ULP-E applied ankle weights to R1. The ankle weights were noticed by family the following morning. ULP-E admitted to applying the weights because R1 had seizure like symptoms. ULP-E failed to notify the nurse of R1's symptoms. The record indicated ULP-E was aware the bilateral ankle weights placed on R1 was a restraint. A communication to all staff from the owner (OW)/registered nurse (RN)-D dated October 24, 2021, at 1:06 p.m. indicated there would be an investigation into the use of ankle weights used on R1. RN-D failed to update R1's vulnerability assessment following the use of ankle weights by ULP-E. When interviewed on December 14 2021, at	0 630		

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0 630	Continued From page 7 12:56 p.m., ULP-A stated she discovered the weights on R1's ankles the morning of October 23, 2021, around 10:00 a.m. when toileting R1, or approximately 13 hours after ULP-E secured the weights on R1's ankles. ULP-A left the ankle weights on R1 until ULP-A contacted a nurse. When interviewed on December 17, 2021, at 1:54 p.m. ULP-E stated on the evening of October 22, 2021, while assisting R1 with putting on her pajamas while on the commode, R1's entire body began to shake. ULP-E found weights in R1's room and first placed the weights on R1's lap. Because R1's legs went off the floor, the weights fell off R1's lap. ULP-E stated she wanted to keep R1 from falling so she strapped the weights around both of R1's ankles. ULP-E stated the episode lasted about five minutes. When R1 calmed, ULP-E transferred R1 to bed leaving the ankle weights on R1. ULP-E was aware the weights would be considered a restraint. ULP-E did not refer to R1's care plan, contact a nurse about R1's change in condition, or report the ankle weights on R1 to the nurse or staff on the next shift. When interviewed on December 20, 2021, at 10:10 a.m., a family member (FM)-F indicated when she came into visit R1 the morning of October 23, 2021, R1's ankles looked "puffy." FM-F stated she lifted R1's pant legs and discovered two and one-half pound ankle weights on each of R1's ankles. FM-F stated she removed the weights and contacted the nurse on-call. During interview, on December 22, 2021, at 1:03 p.m., LPN-C indicated she was nurse on-call the evening of the incident. LPN-C first heard of the ankle weights used on R1 when a FM called her	0 630		

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0 630	Continued From page 8 the next morning to inform LPN-C of the weights. Facility staff should notify the nurse of any changes in a residents condition. Staff interventions to keep R1 safe during body tremors included removing any food from her mouth, finding a safe location, and staying with R1 until the episode ends. Usually R1 slept following an episode. The interventions provided by LPN-C to keep R1 safe during body tremors were not included on staff interventions on the service plan and IAPP. During an interview on December 29, 2021, at 8:31 a.m. owner OW/RN-D confirmed R1's vulnerability assessment was not updated following the incident with using restraints on R1's ankles. RN-D stated facility staff failed to update and include the interventions on R1's IAAP to keep R1 safe during her tremors. The licensee's policy and procedure titled Monitoring of Clients and Their Services with a review date of September 27, 2014, stated the RN would monitor the clients' [residents'] needs and services on an ongoing basis to determine if the services were appropriate to the clients' needs or if changes in the services plan were needed. The RN would identify any problems and any changes in condition or new symptoms. During the monitoring visit and reassessment the RN would identify any new vulnerability and identify interventions to address those issues. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 630		
01460 SS=F	144G.63 Subdivision 1 Orientation of staff and supervisors	01460		

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01460	Continued From page 9 All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide orientation to the assisted living licensing requirements and regulations for one of one employee, unlicensed personnel (ULP)-E, with employee records reviewed. This had the potential to affect all residents receiving care from the licensee. 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: ULP-E began providing assisted living services for the licensee on August 1, 2021. ULP-E's employee records did not have documentation to indicate ULP-E received training on the the assisted living requirements and regulations in accordance with 144G statutes. On December 29, 2021, at 8:32 a.m., the owner (OW)-registered nurse (RN)-D stated she was	01460		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28989	A. BUILDING: _____ B. WING _____	C 12/14/2021

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01460	Continued From page 10 not aware the training for staff included orientation to assisted living requirements and regulations in accordance with 144G statues. No additional information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01460		
01540 SS=F	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of one unlicensed personnel (ULP)-E received the required amount of dementia care training in the required time frame with employee records reviewed. This practice had the potential to affect all residents	01540		

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01540	Continued From page 11 receiving cares from the licensee. 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: The licensee had a current assisted living with dementia care license. ULP-E began providing assisted living services for the licensee under the assisted living with dementia care license on August 1, 2021. ULP-E's employee record did not have documentation to indicate ULP-E completed the required eight (8) hours of training on specific dementia care topics within the first 80 working hours of providing services for the licensee. On December 29, 2021, at 8:32 a.m., the owner (OW)-registered nurse (RN)-D stated she was not aware the training for staff for dementia care included eight hours of training within the eighty hours of providing care under the assisted living with dementia care requirements and regulations in accordance with 144G statues. No additional information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01540		

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01620	Continued From page 12	01620		
01620 SS=D	144G.70 Subd. 2 Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive re-assessment following a change in condition for one of one (R1) residents reviewed. Unlicensed personnel (ULP)-E applied ankle weights, a restraint, to R1's ankles for approximately 13 hours and reported to the RN R1's seizure like episode. This practice resulted in a level two violation (a	01620		

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01620	Continued From page 13 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 Facesheet with an intake date of August 23, 2021, indicated R1's diagnoses included Parkinson's disease, Lewy body dementia (a progressive dementia), and degenerative joint disease. R1's vulnerability assessment dated October 22, 2021, indicated R1 was at risk to be abused by others. R1's assessment directed staff to monitor R1 and remove R1 from unsafe situations. R1's Service Plan with an effective date of October 22, 2021, indicated R1 required staff to anticipate her needs and provide assistance to complete all activities of daily living, including incontinence care every three hours, assistance to eat due to hand tremors, transfers and repositioning. R1 used a wheelchair for mobility. Review of R1's progress notes dated October 22, 2021, through November 30, 2021, lacked an entry made by a RN of R1's episodes of body tremors reported by staff. A communication to all staff from the owner (OW)/registered nurse (RN)-D dated October 24, 2021, at 1:06 p.m. indicated there would be an investigation into the use of ankle weights used on R1. There was no additional documentation or	01620		

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01620	Continued From page 14 re-assessment of R1 following the application of ankle weights. The licensee's Employee Event Record signed by OW/RN-D and ULP-E on October 27, 2021, read that on October 22, 2021, on the p.m. shift, ULP-E applied ankle weights to R1. The ankle weights were noticed by family the following morning. ULP-E admitted to applying the weights because R1 had seizure like symptoms. ULP-E failed to notify the nurse of R1's symptoms. When interviewed on December 14, 2021, at 12:56 p.m., ULP-A stated she discovered the weights on R1's ankles the morning of October 23, 2021, around 10:00 a.m. when toileting R1. R1's family member (FM)-F was in the room with ULP-A. ULP-A left the ankle weights on R1 until ULP-A contacted a nurse. When interviewed on December 17, 2021, at 1:54 p.m. ULP-E stated on the evening of October 22, 2021, around 9:00 p.m. while assisting R1 with putting on her pajamas while on the commode, R1's entire body began to shake. ULP-E found weights in R1's room and first placed the weights on R1's lap. Because R1's legs went off the floor, the weights fell off R1's lap. ULP-E stated she wanted to keep R1 from falling so she strapped the weights around both of R1's ankles. ULP-E stated the episode lasted about five minutes. When R1 calmed, ULP-E transferred R1 to bed leaving the ankle weights on R1. ULP-E did not contact a nurse about R1's change in condition, or report the ankle weights on R1 to the nurse or staff on the next shift. When interviewed on December 20, 2021, at 10:10 a.m., FM-F indicated when she came into visit R1 the morning of October 23, 2021, around	01620		

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01620	Continued From page 15 10:00 a.m. (13 hours after placement of the ankle weights), R1's ankles looked "puffy." FM-F stated she lifted R1's pant legs and discovered two and one-half pound ankle weights on each of R1's ankles. FM-F stated she removed the weights and contacted the nurse on-call. During interview on December 22, 2021, at 1:03 p.m., LPN-C indicated she was the nurse on-call the evening of the incident. LPN-C first heard of the ankle weights used on R1 when R1's family member (FM) called her the next morning. Facility staff should notify the nurse of any changes in a residents condition. Staff interventions to keep R1 safe during body tremors included removing any food from her mouth, finding a safe location, and staying with R1 until the episode ends. Usually R1 slept following an episode. The interventions provided by LPN-C to keep R1 safe during the body tremor episodes were not included on staff interventions on R1's assessments and service plan. During an interview on December 29, 2021, at 8:31 a.m. OW/RN-D confirmed a comprehensive re-assessment for R1 was not completed following the incident with using restraints on R1's ankles. OW/RN-D failed to assess R1's ankles after the restraints were placed for over 13 hours. Although OW/RN-D was aware of R1's episodes of body tremors, she thought they were due to R1's advancing Parkinson's disease. R1's assessment and service plan did not provide any information of R1's body tremors or staff interventions. The licensee's policy and procedure titled Monitoring of Clients and Their Services with a review date of September 27, 2014,stated the RN would monitor the residents' needs and services	01620		

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01620	Continued From page 16 on an ongoing basis to determine if the services were appropriate to the residents' needs or if changes in the services plan were needed. The RN would identify any problems and any changes in condition or new symptoms. During the monitoring visit and reassessment the RN would identify any new vulnerability and identify interventions to address those issues. TIME PERIOD FOR CORRECTION: Seven (7) days.	01620		
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 observations, interviews, and document review, the facility failed to ensure one of one residents reviewed (R1) was free from maltreatment. R1 was abused. Findings include: On December 14, 2021 , the Minnesota Department of Health (MDH) issued a determination that abuse occurred, and that the facility and an individual staff person were 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.	
03000 SS=F	626.557 Subd. 3 Timing of report	03000		

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03000	Continued From page 17 (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 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,	03000		

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03000	Continued From page 18 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 document review, the licensee failed to comply with the requirements for investigating, reporting, and protecting residents during an investigation of suspected maltreatment of vulnerable adults for one of one resident (R1) with records reviewed. The licensee failed to file a Minnesota Adult Abuse Reporting Center (MAARC) report, investigate, and protect other residents after an unlicensed personnel (ULP)-E applied restraints (ankle weights) to R1's ankles. This practice had the potential to affect all nine residents that resided in the licensee's residence. 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's Facesheet with an intake date of August 23, 2021, indicated R1's diagnoses included Parkinson's disease, Lewy body dementia (a	03000		

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03000	Continued From page 19 progressive dementia), and degenerative joint disease. R1's Service Plan with an effective date of October 22, 2021, indicated R1 required staff to anticipate her needs and provide staff assistance to complete all activities of daily living, including incontinence care every three hours, assistance to eat due to hand tremors, transfers and repositioning. R1 used a wheelchair for mobility. R1's vulnerability assessment dated October 22, 2021, indicated R1 was at risk to be abused by others. R1's assessment directed staff to monitor R1 and remove R1 from unsafe situations. The licensee's staff schedule for October 1, 2021, to October 31, 2021, indicated ULP-E worked her scheduled shifts on October 25 and 26, 2021, from 3:00 p.m. to 9:00 p.m., two days after ULP-E was reported to the registered nurse (RN) for abusing R1. A communication to all staff from the owner (OW)/registered nurse (RN)-D dated October 24, 2021, at 1:06 p.m. indicated there would be an investigation into the use of ankle weights used on R1. The communication to staff occurred more than 24 hours after the discovery of the ankle weights on R1. The licensee's Employee Event Record signed by the OW)/RN-D and ULP-E on October 27, 2021, read that on October 22, 2021, on the p.m. shift, ULP-E applied ankle weights to R1. The ankle weights were noticed by family the following morning. ULP-E admitted to applying the weights because R1 had seizure like symptoms. ULP-E failed to notify the nurse of R1's symptoms. The record indicated ULP-E was aware the bilateral	03000		

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03000	Continued From page 20 ankle weights placed on R1 was a restraint. When interviewed on December 14, 2021, at 2:07 p.m., OW/RN-D indicated on October 24, 2021, she requested licensed practical nurse (LPN)-C "handle" the investigation. OW/RN-D stated she failed to immediately report because she had to decide if the use of restraints was abuse by definition. OW/RN-D reported the allegation to MAARC on October 27, 2021, four days following the discovery of the ankle weights on R1. When interviewed on December 14 2021, at 12:56 p.m., ULP-A stated she discovered the weights on R1's ankles the morning of October 23, 2021, around 10:00 a.m. when toileting R1. R1's family member (FM)-F was in the room with ULP-A. ULP-A left the ankle weights on R1 until ULP-A contacted a nurse. When interviewed on December 17, 2021, at 1:54 p.m. ULP-E stated on the evening of October 22, 2021, while assisting R1 with putting on her pajamas while on the commode, R1's entire body began to shake. ULP-E found weights in R1's room and first placed the weights on R1's lap. Because R1's legs went off the floor, the weights fell off R1's lap. ULP-E stated she wanted to keep R1 from falling so she strapped the weights around both of R1's ankles. ULP-E stated the episode lasted about five minutes. When R1 calmed, ULP-E transferred R1 to bed leaving the ankle weights on R1. ULP-E was aware the weights would be considered a restraint. ULP-E did not refer to R1's care plan, contact a nurse about R1's change in condition, or report the ankle weights on R1 to the nurse or staff on the next shift. When interviewed on December 20, 2021, at	03000		

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03000	Continued From page 21 10:10 a.m., family member (FM)-F indicated when she came into visit R1 the morning of October 23, 2021, and R1's ankles looked "puffy." FM-F stated she lifted R1's pant legs and discovered two and one-half pound ankle weights on each of R1's ankles. FM-F stated she removed the weights and contacted the nurse on-call. During interview, on December 22, 2021, at 1:03 p.m., LPN-C indicated she was nurse on-call the evening of the incident. LPN-C first heard of the ankle weights used on R1 when a FM called her the next morning. Facility staff should notify the nurse of any changes in a residents condition. Staff interventions to keep R1 safe during body tremors included removing any food from her mouth, finding a safe location, and staying with R1 until the episode ends. Usually R1 slept following an episode. The licensee's policy and procedure titled, Vulnerable Adult Reporting and Investigation, with a revised date of August 17, 2021, stated suspected abuse would be investigated by the RN in coordination with the home care director. If a staff person is an alleged perpetrator of maltreatment of a resident, the staff person would be directed to leave the building immediately and would be instructed not to return to work until further notice by the RN. If an incident appeared to be suspected abuse, the RN/LPN would immediately make a report to MAARC. Immediately means as soon as possible but no longer than 24 hours from the time the RN/LPN received the initial knowledge of the incident. TIME PERIOD FOR CORRECTION: Seven (7) days	03000		