Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL304061523M **Date Concluded:** October 31, 2022
Compliance #: HL304062963C

Name, Address, and County of Licensee Investigated:
Sunrise Village of Milaca
115 9th St NW #104
Milaca MN 56353
Mille Lacs County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:
Lissa Lin, RN, Special Investigator
Maggie Regnier, 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):
Allegation #1
The facility abused the resident when staff restrained her in a recliner chair and locked her in her room overnight.

Allegation #2
The facility neglected the resident when staff did not follow up on the resident's concern, she had a possible urinary tract infection (UTI). The resident admitted to the hospital and treated for a possible UTI.

Investigative Findings and Conclusion:
Allegation #1

The Minnesota Department of Health determined abuse was substantiated. The facility was responsible for the maltreatment. A facility staff member locked the resident in her room while she was restrained in her power recliner during the overnight shift due to “behaviors”, even though the resident was non-ambulatory and unable to reach her door and unlock it if she wanted or needed to leave her room. Although the facility was aware of these actions, the facility did not take action to prevent recurrence.

Allegation #2
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The resident verbally expressed concern about a UTI to unlicensed staff while the staff member performed catheter cares. Unlicensed staff said they verbally informed the nurse about the UTI; the nurse said she was unaware of R1’s condition. The resident’s record lacked documentation the facility assessed and monitored R1 for a UTI. R1 was hospitalized several days later for a UTI, low potassium, alcohol intoxication and suicidal ideation.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement for a police report. The investigator contacted the resident’s former case manager for an interview but did not get a response. The resident was hospitalized and unavailable for an interview. The investigation included review of the resident’s medical record, staff schedules, grievances, incident reports, policies, and procedures.

The resident lived in an assisted living facility. The resident’s diagnoses included stroke with right sided weakness, urinary retention, bi-polar disorder, and schizophrenia. The resident was her own decision-maker. The resident’s service plan included staff assistance with transfers to her wheelchair and her power recliner using a sit to stand device. The resident required staff assistance to evacuate in an emergency. She was assessed as physically and verbally abusive; her abuse prevention assessment instructed staff to redirect the resident during outbursts. Her speech was slurred and sometimes difficult to understand. The resident drank alcohol daily, sometimes to excess which exacerbated behaviors. Residents living at the facility were able to keep and drink alcohol in their rooms.

The resident had an unsigned, and undated drinking agreement with the facility she would stop consuming alcohol at a certain time of the afternoon, so she was sober enough to safely transfer at bedtime with a sit to stand device. If she was not sober by bedtime, staff left the resident seated where she was and waited additional hours for the resident to sober up.

One morning, the resident called police for assistance when she could not get staff assistance for her urinary catheter. Police arrived at the facility and found the resident locked in her room and unable to open the door for police because she could not independently get up from her chair and walk to the door to unlock it. Police located a manager who said she was aware the resident was locked in her room.

The resident told police she did not know how long she had been restrained in her chair and locked in her room. The resident had soiled herself with bowel movement while waiting for help. The manager told police that the resident was locked in her room by another staff member sometime during the night because she had been sneaking cigarettes into her room and sneaking into other resident rooms in the middle of the night and visiting with them. The manager told police that her behavior issues could also be from a UTI.

Police told the manager they could not lock the resident in her room for any reason because it could result in false imprisonment charges as well as a fire hazard. Police also told the staff the resident needed to be cleaned up and sent to urgent care for assessment.

During an interview, the manager said the resident had a drinking agreement with the facility in which facility staff members were supposed to monitor the resident for sobriety before transferring her with a sit-to-stand device. The manager said she was present when police arrived that morning and police asked her why the resident was locked in her room. She said the resident was not locked in her room, she could get out, but then said it was true, the resident could not get to the door to unlock it if she was seated and tipped back in her recliner. On the night in question, the resident was locked in her room because she had been smoking in her room and going to other resident rooms knocking on doors. The manager said the resident was never tied to her chair, so she was not restrained.

During an interview, the nurse said unlicensed staff were told to assess the resident's sobriety before they transferred her with the sit-to-stand device. The nurse stated there was no assessment tool on how to assess the resident for sobriety, but staff members knew to call her call if there were any concerns about the resident. The nurse said no staff members called her about the resident's catheter issues, UTI concern or behaviors even though she was available instead they called the manager who is not a nurse. The nurse said staff members should not have left the resident seated in her chair for hours just because they did not want to deal with her. If was a matter of the resident not being sober enough to safely transfer in the sit-to-stand device, then staff members needed to extend the four-hour wait time for her to sober up, document and contact her. The nurse said unlicensed staff members needed to do a better job documenting on residents.

During investigative interviews, multiple staff members stated the resident sometimes wanted to be locked in her room, but staff did not always document those requests.

During an interview, a staff member said the resident was always drunk. Her speech was normally slurred and hard to understand. He said staff had no special training on caring for the resident, who was "completely wasted". The staff member said the resident went on a "bender" one night and crashed her wheelchair into doors, yelled and screamed. He said the resident sometimes asked staff to lock her in her room, but he never locked her door unless she asked. He did not recall ever telling the resident he could not let her up and out of her recliner.

The staff member said scheduled safety checks were completed every two hours, but when the resident she had behaviors the safety checks were hourly and documented.

The facility's staff communication notes indicated during one shift the staff member told the resident she could not get up from her chair "because of what she had done last night" (referring to knocking on other resident doors late that night).

Another staff communication note indicated the resident wanted to get up from her chair and the staff member told her she could not get up. The same document indicated the staff member reset the resident's call buzzer and walked out of the room.

During an interview, a staff member said if the resident was unable to use the sit-to-stand device to transfer at bedtime, then they would have to leave her in her wheelchair, and she would have to recline it back to sleep.

During an interview, a staff member said staff members were supposed to document and call the nurse and let her know if the resident was unsafe to transfer with the sit-to-stand device if she had been in her chair sobering up for more than four hours. The staff member said she recalled the resident asking her to help put on her pants during one shift, but she could not safely transfer the resident because the resident had been awake 50 hours smoking and drinking which was unusual behavior for her. She stated she did not recall whether the nurse was contacted about the resident's behaviors or extending her sober up time.

The resident record lacked documentation on the resident's daily sober up start and end times, and if staff had to extend the four-hour window. There was no documentation for hourly safety checks on the resident.

Allegation #1:
In conclusion, abuse was substantiated.

UTI

One night, the resident needed her urinary catheter bag emptied. While a staff member emptied the catheter bag, the resident asked if her urine smelled like a UTI. The staff member told the resident her urine was dark and cloudy, and it could be from all the alcohol she drank. The resident told the staff member not to judge her and the staff member said she was not judging, she finished emptying the catheter bag and left the room.

During an interview, the staff member said she emptied the resident's urinary catheter bag, and the urine had a foul smell. The resident had concerns about UTIs, but the staff member did not know if she got many of them but knew the resident had been seen for UTIs in the past. The staff member said many residents with catheters get UTIs. The staff member said she let the nurse know about the UTI concern in a phone call and was told to just keep an eye on it and if it

got worse, they would send her in for evaluation. The staff member said any further steps would be documented although many of the updates on the resident were verbal.

Review of staff communication indicated after staff emptied the resident's catheter bag, she told the resident she did not want to continue the conversation and walked out of the room. There was no documentation the staff member contacted the nurse about the UTI concern.

During an interview, a staff member said that the resident had UTIs because she had a catheter. The staff member said they would usually contact the nurse the next day and send out a urine sample.

During an interview, the nurse said the unlicensed staff need to have clearer communication notes. She was aware the resident had pulled out her urinary catheter but was not called about other resident concerns.

The resident's record lacked documentation that staff reported a UTI concern to the nurse.

The resident's hospital records indicated the resident was admitted for evaluation and treatment for a UTI (positive urine culture for Klebsiella pneumoniae), low potassium, suicidal ideation and alcohol intoxication.

Allegation #2
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.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
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.

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, hospitalized.
Family/Responsible Party interviewed: No, resident is her own person.
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility sent the resident to the emergency room for evaluation.

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
Mille Lacs County Attorney
Milaca City Attorney
Milaca Police Department

Minnesota Board of Executives for Long Term Services and Supports
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30406	A. BUILDING: _____ B. WING _____	C 08/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE VILLAGE OF MILACA	115 9TH STREET NW #120 MILACA, MN 56353

(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: #HL304061523M/HL304062963C On August 15, 2022, the Minnesota Department of Health initiated a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 29 clients receiving services under the provider ' s Assisted Living license. Correction orders with a period to correct that are not immediate may be issued at a later date during the investigation. The following immediate correction order is issued for #HL304061523M/ HL304062963C: 460. ----------	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 License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	

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0 000	Continued From page 1 --- On August 22, 2022, the Minnesota Department of Health followed up regarding immediate correction orders for complaint #HL304061523M/ HL304062963C regarding 0460. The immediacy regarding 0460 remains in place. On August 15, 2022, and August 22, 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 29 residents receiving services under the provider's Assisted Living license. The following correction orders are issued for # HL304061523M/ HL304062963C/ tag identification 0450, 460, 1620, 2360, 2380, 2390 and 2400.	0 000		
0 450 SS=G	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall: (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required	0 450		

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0 450	Continued From page 2 by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to implement a system of delegation in a manner consistent with the Nurse Practice Act for one resident reviewed (R1) when the licensee directed unlicensed personnel (ULP) to base a transfer decision based on an assessment or determination of R1's state of intoxication. While the licensee did provide a 4-hour time-period for R1 stop drinking alcohol to "sober-up", the licensee did not document R1's agreement to this plan, ensure the ULPs documented this time-period, or provide the ULPs guidelines for determination R1's intoxication so a transfer decision could be made. As a result, the ULPs did not transfer the resident and R1 remained overnight and had a bowel movement in her chair. This practice resulted in a level three violation (a violation that harmed a client'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 clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings include: The Minnesota Nurse Practice Act defines delegation as: the transfer of authority to another nurse or competent, unlicensed assistive person to perform a specific nursing task or activity in a specific situation. (Subd. 7a.)	0 450		

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0 450	Continued From page 3 The National Guidelines for Nursing Delegation, dated April 1, 2019, reads: The licensed nurse cannot delegate nursing judgment or any activity that will involve nursing judgment or critical decision making. Nursing responsibilities are delegated by someone who has the authority to delegate. The delegated responsibility is within the delegator' s scope of practice. Clinical reasoning, nursing judgement and critical decision making cannot be delegated. *Each delegation situation should be specific to the patient, the licensed nurse and the delegatee. The licensed nurse is expected to communicate specific instructions for the delegated activity to the delegatee; the delegatee, as part of two-way communication, should ask any clarifying questions. *This communication includes any data that need to be collected, the method for collecting the data,the time frame for reporting the results to the licensed nurse, and additional information pertinent tothe situation. The delegatee must understand the terms of the delegation and must agree to accept the delegated activity. R1's diagnoses included a cerebral infarction (stroke), urinary retention, schizophrenia and bipolar disorder. R1's medical record indicated used an indwelling catheter for urination but required assistance of two staff members for transfer onto a commode and peri-care. The same document indicated R1 required staff assistance with dressing. R1's service plan, dated August 1, 2021, indicated R1 received toileting assistance, urinary catheter care daily, behavior services for	0 450		

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0 450	Continued From page 4 agitation, anxiety, physical aggression and verbal aggression daily. R1 required daily mobility assistance, transfer assistance with two staff and a lift, bed mobility and repositioning. R1 also received safety checks 4 times daily. The staff supervision section of R1's service plan read: unlicensed staff are trained by the nurse and directly supervised performing the delegated tasks within 30 days of employment and at the nurses' discretion thereafter. The restriction of residents rights section of R1's service plan read: these restrictions have been determined necessary for the resident's health and safety, such restrictions are documented below and in the resident's record". This document included no restrictions for R1. R1 was on a Coordinated Services and Supports Plan (CSSP) from October 1, 2021 to September 30, 2022. A CSSP allowed 24-hour customized living services for R1 at the licensee. The CSSP assessment, completed by R1's former case manager (CM)-F, identified R1 as at risk for behaviors and was responsible for her own health and safety. R1's individual abuse prevention plan (IAPP), dated May 4, 2022, was completed by registered nurse (RN)-D. R1's assessment indicated she was not able to walk and would need help in an emergency since she did not ambulate and could not rise from a chair at knee height. R1 consumed alcohol daily to the point of intoxication and agreed to stop drinking at 4:30 p.m. daily so she was "safe enough" to transfer to her power recliner to sleep. R1's assessment, dated May 4, 2022, indicated	0 450		

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0 450	Continued From page 5 R1 usually made herself understood but had some difficulty communicating some words and finishing thoughts but was able, if prompted and given time. R1's speech was sometimes difficult to understand due to fast or slow speech and tone. An untitled document, dated May 4, 2022, indicated R1 agreed to quit drinking several hours before bedtime. "When I quit drinking I will press my button to have a caregiver verify that I have finished consuming alcoholic beverages for the day and want to start the four hour waiting period so I can be put to bed". The document lacked signatures and dates from R1, the assisted living director in residence (AL)-A, or DON-C. A ULP note, dated June 11, 2022 at 4:2 p.m., read "(a staff member) was able to print of [sic] a calendar for 104's room and hoping that when she tells you she's done drinking we can do [sic] document it for the next shift." An incident summary report, dated June 1, 2022 to August 15, 2022, listed incidents that involved R1 and ULP-G on 6/12/22. ULP-G called 911 because of R1's aggressive behavior: 6/12/22 at 8:42 p.m. R1 tried to run down staff with her wheelchair. Police called and they talked with R1, nothing resolved. ULP-G reported other R1 incidents of "aggressive behavior" with no detailed information on 6/12/22: at 5:00 p.m., 6:00 p.m., and 10:30 p.m. A note by ULP-E dated June 13, 2022, at 9:06 p.m., read: "Asked her if she needed anything while we were there and she said 'I want some pants on, I want to get up! We spoke with assisted living diretor in residence (AL-A), on the phone to see what we should do about her and if	0 450		

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0 450	Continued From page 6 we were allowed to get her up." ULP-E wrote that R1 was loud and belligerent. Later, around 8:30 ULP-E, ULP-H went to R1's room to "assess the situation". They found a lit cigarette on the carpet that had burned a hole in the rug next to R1's recliner. ULP-H asked R1 what else they could do for her. R1 "demanded us to get her up again saying she wanted pants and ULP-H asked her 'Well if we get you up are you going to do the same thing you did to us last night?' and R1 said no. ULP-E threw cigarette butts away and R1 yelled that those were hers and they owed her cigarettes. The ULPs left the room, called AL-A, and said they were not getting R1 up out of her chair for their safety. There was no documentation that the ULPs assessed R1 for sobriety as the reason to leave her in the recliner. A note by ULP-B dated June 13, 2022, at 11:34 p.m. indicated R1 "wanted to get the f- up now and told her she can't get up right now so she screamed and cussed and at me so i [sic] reset her buzzer and walked out." The same document did not include documentation regarding the criteria used to determine R1's sobriety regarding the transfer. A police incident report dated June 14, 2022, at 0853 (8:53 a.m.) indicated R1 called police because she had issues with her urinary catheter and licensee staff were not responding to her. Police arrived and found R1 locked in her room. Police located AL-A and asked her to unlock R1's door. R1 told police she did not know how long she waited for help after contacting staff; it could have been 15 minutes to two hours. R1 was seated in her chair and told police she had soiled herself. A note by ULP-B dated June 14, 2022, (time	0 450		

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0 450	Continued From page 7 unreadable, a.m.) read: "around 12:20 a.m. the cops showed up for R1 do to her calling [sic] them so the end result of everything so the cop could leave is for me to make a PBJ sandwich and get her chips and dip and wanted Xanax to help her sleep. She also wanted to get up but I told her she needed to get some sleep...I said I also couldn't get her up because of what she did last nite [sic] to all the residents she woke up and the rooms she barged into in the am." The same document did not include documentation regarding whether R1's intoxication as part of the reason not to transfer R1 and leave her in her recliner. An incident report, dated June 14, 2022, indicated ULP-G called 911 when R1 was aggressive towards staff and tried to run them down in her power chair. The same document indicated R1 mocked police who arrived. Unnamed staff members called AL-A who came to building to meet with R1. During an interview on August 15, 2022, at 1:16 p.m., AL-A stated R1 is her own person and decision-maker. AL-A stated R1 consumes alcohol, can drink excessively, and get aggressive. R1 had an "agreement" with AL-A and DON-C to stop drinking around 4:30 p.m. and to let staff know this so she could be sober and safe enough to transfer at bedtime, around 10:30 p.m. AL-A said the ULPs monitor R1 for sobriety and need to call DON-C if there were questions on R1's condition. During an interview on August 25, 2022, at 3:27 p.m., ULP-E said she recalled the pants incident. If R1 sat in her recliner it was hard to put pants on her because she does not move side to side easily. R1 also wanted to get up from her recliner	0 450		

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0 450	Continued From page 8 but she had been awake 50 hours, drinking and smoking in her room. I told her I cannot stand her up. ULP-E said it was unusual for R1 to be awake 50 hours and her behaviors was from a lack of sleep and alcohol. During an interview on August 22, 2022, at 10:57 a.m., director of nursing (DON)-C said staff should not just leave R1 in her chair because they do not want to deal with her. DON-C stated if R1 was not sober then that is a different issue, they should go through the same process of her not drinking alcohol for four hours before transferring her and document. There was no assessment tool for ULPs to use to assess R1's sobriety. DON-C said the night in question she was available to take calls from staff with concerns about R1's condition, but staff called AL-A instead although AL-A is not a nurse. DON-C said when she read ULP notes about R1 "doing the same things you did last night" DON-C said she did not know what that meant. DON-C said she thinks the ULP notes need improvement and be clearer. DON-C stated not giving R1 her pants was somewhat of a dignity issue, but she was covered with a blanket and not exposed. Because of R1's mobility issues and size, staff would need to put R1's pants on using the sit to stand device and R1 is very particular about her pants. A policy titled Delegation of Assisted Living Services, dated August 1, 2021, indicated a registered nurse (RN) or licensed health professional may delegate tasks only to staff who are competent and possess knowledge and skills consistent with the complexity of the tasks and according to the appropriate Minnesota Practice Act. The licensee will establish and implement a system to communicate up-to-date information to the RN or licensed health professional regarding	0 450		

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0 450	Continued From page 9 the current available staff and their competency so the RN has sufficient information to determine the appropriateness of delegating tasks to meet individual resident needs and preferences. The registered nurse or licensed health professional will document instructions for the delegated tasks in the resident record. MDH surveyors requested a signed copy of R1's drinking agreement but it was not provided. MDH surveyors requested a copy of the calendar pages ULP staff used to track the times R1 stopped drinking but it was not provided. The licensee did not have a policy on restraints. TIME PERIOD TO CORRECT: Seven (7) Days	0 450		
0 460 SS=I	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living	0 460		

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0 460	Continued From page 10 facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure staff did not use restraints and lock doors to limit resident behaviors for one of one resident (R1) reviewed. This practice resulted in a level three violation (a violation that harmed a client'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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the clients). This resulted in an immediate correction order identified at 3:03 p.m., August 15, 2022. Findings include: R1's medical diagnoses included cerebral infarction, right side hemiplegia, morbid obesity, and schizophrenia. R1's service plan addendum, dated August 1, 2021, indicated R1 received assistance with toileting, mobility, bed mobility, catheter care, bathing, and grooming. R1's Individual abuse prevention plan (IAPP), dated May 4, 2022, indicated R1 drank alcohol to the point of intoxication and agreed to stop drinking at 4:30 p.m. daily so she is safe enough to transfer to her reclining chair to sleep at 10:30 p.m.	0 460	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.	

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0 460	Continued From page 11 On June 14, 2022, law enforcement was dispatched to the facility. The police incident report dated June 14, 2022, at 0853 (8:53 a.m.), indicated R1 called police because she had issues with her urinary catheter and staff was not responding. The police officer arrived and was not able to enter R1's room because the door was locked from the outside and R1 could not get out of her recliner. R1 did not know how much time she had spent in the recliner, but she had had a BM in the recliner prior to the officer's arrival. The police report indicated Assisted Living Director (AL)-A was at the facility and aware R1 had been locked in her room by ULP-B sometime last night. AL-A told police R1 was placed in her recliner chair so she could not get out of it because she "sneaks" into other resident rooms in the middle of the night. The police officer told AL-A R1 could not be locked in her room for any reason. During an interview on August 15, 2022, at 1:16 p.m., AL-A said R1 would not be safe to transfer from her wheelchair with the sit-to-stand device when she has been drinking alcohol. AL-A said staff will leave R1 in her recliner chair until she is sober enough to transfer and that could take several hours. AL-A said it could be a dignity issue if R1 sat in her recliner and had a bowel movement (BM) in her recliner and no staff came to assist her. AL-A said placing R1 in her recliner so she could not get out of it was not a restraint; she said a restraint would be tying someone down. AL-A stated if R1 was discharged back to their care after hospitalization they would continue to place her in the recliner so she could not get out without staff help if she has behaviors.AL-A said locking R1 in her room from the outside was also done to keep her from	0 460		

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0 460	Continued From page 12 wandering into other resident rooms. Time Period for Correction: IMMEDIATE ---------- On August 22, 2022, at 9:33 a.m., Minnesota Department of Health (MDH) surveyors followed up regarding correction order 0460 issued on August 15, 2022. Findings include: At 10:00 a.m. the Assisted Living Director gave the MDH surveyors an undated document titled, Survey Corrective Action Plan. The corrective action plan indicated the facility would: "-provide education to the ALD, CNS, and staff regarding the use of restraints in assisted living -review facility policy re: restraints and revise as necessary -when R1 returns, service plan and care plan will be reviewed and correctly align so as not to utilize restraints in behavior management." The plan also indicated the restraint policy would be reviewed annually and updated through the Quality Committee, and resident rights education would be completed annually per statute. During an interview on August 22, 2022, at 1:21 p.m., AL-A stated they had talked with their consultant to create a training plan. The AL-A stated the licensees online training did not have anything on restraints and the consultant was	0 460		

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0 460	Continued From page 13 going to put something together on restraints within the next 24-48 hours for staff. AL-A said there might be on-line training and a staff emergency meeting but no communication from management to staff about restraints and future reeducation had occurred yet. AL-A said it was still a plan amongst management. Time Period for Correction Remains Immediate	0 460		
01620 SS=G	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced	01620		

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01620	Continued From page 14 by: Based on interview and record review, the licensee failed to ensure staff members conducted and documented on-going assessments for one of one resident (R1) reviewed, when R1 displayed increased aggressive verbal and physical behaviors and told staff she thought she had a urinary tract infection (UTI). R1 was hospitalized and treated for a UTI, low potassium, alcohol intoxication and suicidal ideation. This practice resulted in a level three violation (a violation that harmed a client'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 clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings include: R1's diagnoses included a cerebral infarction (stroke), chronic urinary retention, schizophrenia, and bipolar disorder. R1's signed service plan dated August 1, 2021. R1 received bathing and toileting assistance, urinary catheter care, behavior services for agitation, anxiety, physical aggression, and verbal aggression. R1 required mobility assistance, transfer assistance with two staff and a sit to stand lift, bed mobility and repositioning. R1 also received safety checks 4 times daily. R1's Individual Treatment and Therapy Management Plan, dated August 1, 2021, indicated R1 received catheter cares 1 day a	01620		

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01620	Continued From page 15 week or 5 days a week from the licensed practical nurse (LPN); catheter cares 4 times daily from ULPs. R1's nursing assessment, dated May 4, 2022, indicated R1 had bladder and bowel incontinence. R1's individual abuse prevention plan (IAPP), dated May 4, 2022, completed by licensee registered nurse (RN)- D, R1's assessment indicated R1 consumed alcohol daily to the point of intoxication and agreed to stop drinking at 4:30 p.m. daily so she was "safe enough" to use the sit to stand lift to transfer to her recliner chair to sleep at 10:30 p.m. The licensee instructed staff members to redirect R1 when she was verbally abusive to others; nurse and staff to monitor resident during any behavioral outbreaks until she has calmed down. An untitled document, dated May 4, 2022, indicated R1 agreed to a plan to quit drinking several hours before bedtime. "When I quit drinking, I will press my button to have a caregiver verify that I have finished consuming alcoholic beverages for the day and want to start the four-hour waiting period so I can be put to bed". The document lacked signatures and dates from R1 and licensed staff members. A note dated June 13, 2022, at 2:37 a.m., indicated that R1 asked ULP-H if her urine smelled like a UTI when ULP-H emptied R1's catheter bag. ULP-H's note read: I said probably not, it is probably from all the alcohol she's been drinking, and she got belligerent and told me not to judge because I didn't know her and that I didn't want to get to know her. ULP-H told R1 she did not want to finish the conversation and left the room. There was no documentation that ULP-H	01620		

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01620	Continued From page 16 notified a nurse about R1's UTI concern or follow up by the nurse. A police incident report dated June 14, 2022, at 0853 (8:53 a.m.) indicated R1 called police because she had issues with her urinary catheter and licensee staff were not responding to her. Police arrived and found R1 locked in her room. Police located AL-A and asked her to unlock R1's door. R1 told police she did not know how long she waited for help after contacting staff; it could have been 15 minutes to two hours. R1 was seated in her chair and told police she had soiled herself. AL-A told police R1 had been locked in her room the night before by ULP-B because an unknown person gave her cigarettes to smoke in her room. AL-A told police R1 had yelled and threatened staff the night before, and her behavior was maybe due to a urinary tract infection (UTI). R1's progress note, dated June 14, 2022, at 10:25 a.m., indicated R1 coughed, and her catheter came out, was found on the floor. RN-D documented that R1's perineum cares were completed, new catheter placed, draining clear yellow urine, no concerns. A note by ULP-I, dated June 14, 2022, at 10:27 a.m., indicated R1 was "screaming in her room like she has been for a couple of days". The same document indicated staff members told R1 to calm down. Police and emergency medical technicians (EMT) arrived around 10:00 a.m. and tried to get R1 to go to a hospital, however R1 refused. ULP-I's note indicated R1 "pulled her catheter out and RN-D put a new one in [and] R1 was covered in bowel movement and even had it under her chair."	01620		

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01620	Continued From page 17 R1's after visit summary from the ER, June 15, 2022, indicated R1 was seen for alcohol intoxication and discharged. R1's hospital record, dated June 16, 2022, indicated her urinalysis result was positive for a UTI, but R1 had an indwelling Foley catheter so there could be a contaminant in the sample. The physician planned to treat to potential UTI with Cephalexin (an antibiotic) while urine culture results were pending. R1's hospital record, dated June 16, 2022, indicated R1 had a positive urine culture for Klebsiella pneumoniae possibly due to colonization of her previous indwelling urinary catheter and pyuria in the urinalysis from her catheter. R1's progress note, dated June 17, 2022, at 4:11 p.m., indicated the hospital treated R1 for a UTI and low potassium. During an interview on August 22, 2022, at 10:57 a.m., director of nursing (DON)-C said R1 had been more violent recently hitting, and pinching staff. DON-C said she advised staff members R1's demeanor was different when drunk, such as she slurred her words and leaned in her chair. DON-C said she verbally educated the overnight staff on assessing R1 for behaviors. DON-C said no one called her about R1's increased behaviors that night. She was the nurse on call and available, but staff called AL-A instead. During an interview on August 25, 2022, at 2:59 p.m., ULP-H said she documented emptying R1's catheter bag and R1 did ask about her urine and a UTI. ULP-H said she called DON-C, but a lot of the updates were "just verbal".	01620		

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01620	Continued From page 18 During an interview on August 25, 2022, at 3:27 p.m., ULP-E said R1 had UTIs because of her catheter. Staff were supposed to contact the nurse and then the next day send in a urine sample. ULP-E said R1 had been awake 50 hours, drinking and smoking in her room. ULP-E said it was unusual for R1 to be awake 50 hours and her behaviors were from a lack of sleep and alcohol and R1 needed mental health help. During an interview on August 31, 2022, at 11:30 a.m., ULP-B said R1 went on a "bender" for three or four days before she was hospitalized. R1 yelled, screamed, went into other resident rooms, and rammed doors with her wheelchair. ULP-B said he would document and call his nurse if he had concerns about R1. A policy titled Resident Change in Condition, dated August 1, 2021, read: When changes in condition or need are identified, a registered nurse will initiate a change in condition assessment. The assessment may be limited to only these issues where a change has been identified. The same document indicated a change of condition assessments will also be initiated after every resident readmission from the hospital, emergency department or other medical/treatment stay. A policy titled Assessments, Reviews and Monitoring, dated July 27, 2022, indicated resident monitoring and review must be conducted as needed based on changes in the needs of the resident. Time Period to Correct: Seven (7) Days	01620		

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02360	Continued From page 19	02360		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one residents reviewed (/R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	
02380 SS=D	144G.91 Subd. 10 Individual autonomy Residents have the right to individual autonomy, initiative, and independence in making life choices, including establishing a daily schedule and choosing with whom to interact. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a resident had individual autonomy to make life choices and decisions including drinking alcohol for one of one resident, (R1), reviewed. The licensee	02380		

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SUNRISE VILLAGE OF MILACA	115 9TH STREET NW #120 MILACA, MN 56353

(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
02380	Continued From page 20 confiscated R1's alcohol, required R1 must attend a detoxification program, and stop drinking alcohol to return to the licensee. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety) and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). Findings include: R1's diagnoses included a cerebral infarction (stroke), urinary retention, hypertension, schizophrenia, and bipolar disorder. R1's service plan, dated August 1, 2021, indicated R1 received bathing and toileting assistance, urinary catheter care, behavior services for agitation, anxiety, physical aggression, and verbal aggression. R1 required mobility assistance, transfer assistance with 2 staff and a lift, bed mobility and repositioning. R1 was on a Coordinated Services and Supports Plan (CSSP) from October 1, 2021, to September 30, 2022. A CSSP allowed 24-hour customized living services for R1 at the licensee (formerly called Heritage House of Milaca). The CSSP assessment, completed by CM-F, identified R1 as at risk for behaviors and R1 was responsible for her own health and safety. R1's progress note, dated June 13, 2022, at 1:00 p.m., indicated a pre-termination meeting was held about R1's escalating behaviors towards residents and staff due to increased alcohol use.	02380		

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02380	Continued From page 21 AL-A, director of nursing (DON)-C and former case manager (CM)-F were present. The progress note read: Agreements reached about interventions or alternatives that will be used to avoid termination of the residents' assisted living contract: In order to continue living in this residence, resident must agree to attend a detox program." During an interview on August 15, 2022, at 1:16 p.m., AL-A stated that R1 is her own person and can make decisions for herself. AL-A said the licensee is not a dry facility and residents can drink alcohol in their rooms. AL-A said R1 purchased and kept several bottles of alcohol in her room, but AL-A confiscated them and has stored them in her office for now. She is not sure what to do with R1's alcohol bottles. AL-A said several residents are recovering alcoholics and find it difficult to deal with R1 and her behaviors. AL-A said she has concerns about R1 and caring for her when she returns to the licensee. During an interview on August 22, 2022, at 10:57 a.m., director of nursing (DON)-C said she is not sure R1 will met the requirement of not drinking alcohol. "She'll come back, ask for her alcohol and start drinking. It's a long-standing pattern." During an interview on August 31, 2022, at 11:30 a.m., unlicensed personnel (ULP)-B said he could never see R1 give up alcohol permanently. The Minnesota Bill of Rights for Assisted Living Residents item 7 reads: "Residents have the right to individual autonomy, initiative and independence in making life choices". A policy titled Protecting Resident Rights, dated July 27, 2022, read: It is the policy of the licensee	02380		

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02380	Continued From page 22 to protect the rights of our residents. Sunrise Village of Milaca will not request or require that any resident waive any of the rights provided at any time for any reason, including as a condition of admission. TIME PERIOD TO CORRECT: Seven (7) Days	02380		
02390 SS=D	144G.91 Subd. 11 Right to control resources Residents have the right to control personal resources. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure one of one resident (R1) reviewed, had the right to control her resources when staff confiscated multiple bottles of alcohol she purchased with her own funds. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety) and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). Findings include: R1's diagnoses included a cerebral infarction (stroke), urinary retention, schizophrenia, and bipolar disorder. R1's service plan, dated August 1, 2021,	02390		

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02390	Continued From page 23 indicated R1 received bathing and toileting assistance, urinary catheter care, behavior services for agitation, anxiety, physical aggression, and verbal aggression. R1 required mobility assistance, transfer assistance with two staff and a lift, bed mobility and repositioning. The section of R1's service plan titled "Restriction of Resident Rights" read: These restrictions have been determined necessary for the resident's health and safety, such restrictions are documented below and in the resident's record", however, there were no documented restrictions for R1. R1 was on a Coordinated Services and Supports Plan (CSSP) from October 1, 2021, to September 30, 2022. A CSSP allowed 24-hour customized living services for R1 at the licensee (formerly called Heritage House of Milaca). The CSSP assessment, completed by R1's former case manager (CM)-F, identified R1 as at risk for behaviors and R1 was responsible for her own health and safety. R1 was also on a Community Access for Disability Inclusion (CADI) waiver that helped R1 live as independently as possible in a community setting. R1 met the criteria for CADI waiver because she had disabilities that required a level of care provided in a nursing facility. R1's individual abuse prevention plan (IAPP), dated May 4, 2022, was completed by licensee registered nurse (RN)- D. R1's assessment indicated she was not able to walk but could still be a fall risk if she leaned too far forward in her wheelchair to pick something up. R1 consumed alcohol daily to the point of intoxication and agreed to stop drinking at 4:30 p.m. daily so she was "safe enough" to use the sit to stand lift to	02390		

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02390	Continued From page 24 transfer to her recliner chair to sleep. An untitled document, dated May 4, 2022, indicated R1 agreed to an amended plan to wait four hours instead of six to put the resident to bed. "When I quit drinking, I will press my button to have a caregiver verify that I have finished consuming alcoholic beverages for the day and want to start to four-hour waiting period so I can be put to bed". The document lacked signatures and dates from R1 and licensee staff members. R1's record included an unsigned, undated 2022 Acknowledgement of Receipt of Minnesota Bill of Rights for Assisted Living Residents. A ULP note, dated June 13, 2022, at 2:37 a.m., read "earlier today per AL-A's permission, took 4 bottles of alcohol out of R1's room due to physical and verbal aggression towards staff, residents and even a police officer. The aggression continued all evening to the point where AL-A had to come in to help us....124 (another resident) told this staff that R1 had three more bottles of alcohol in her room, so we took those as well and locked them in the med room until AL-A can figure out what to do with the whole situation." R1's progress note, dated June 13, 2022, at 1:00 p.m., indicated a pre-termination meeting occurred with AL-A, DON-C and CM-F to discuss R1's escalating behaviors towards residents and staff due to increased alcohol use. The same document indicated the agreements reached about any accommodation or modifications as none. The same document indicated the agreements reached about interventions or alternatives to avoid termination of R1's AL contract was to continue living in this residence, resident must agree to attend a detox program.	02390		

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02390	Continued From page 25 A ULP note, dated June 15 , 11:03 a.m., indicated an unknown staff member "took 4 bottles of liquor away that she kept stored in her drawer and informed AL-A about what I did. Little did I know she had three brand new bottles hidden under some food tucked away under her table which later on other staff found and removed so now there is a total of 7 large liquor bottles locked up in med room 2." On June 15, 2022, R1's after visit summary from the emergency room indicated R1 was seen for alcohol intoxication and discharged. On August 22, 2022, at 1:30 p.m., Minnesota Department of Health (MDH) surveyors observed R1's confiscated bottles of alcohol stored in AL-A's office. Surveyors counted 12 large bottles of vodka, rum, tequila, and brandy stored in a plastic shopping bag and a cardboard box. The alcohol bottles were not marked as belonging to R1. During an interview on August 15, 2022, at 1:16 p.m., AL-A stated R1 is her own person and decision-maker. AL-A stated R1 consumes alcohol, can drink excessively, and get aggressive. R1 had an "agreement" with AL-A and DON-C to stop drinking around 4:30 p.m. and to let staff know this so she could be sober and safe enough to transfer at bedtime, around 10:30 p.m. AL-A said the ULPs monitor R1 for sobriety and need to call DON-C if there are questions on R1's condition. During an interview on August 22, 2022, at 10:57 a.m., DON-C said she had safety concerns with R1's drinking so AL-A and CM-F discussed trying a 4-hour window for R1 to sober up at night.	02390		

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02390	Continued From page 26 DON-C sad R1 suggested 4 hours although the time was not based on R1's height, weight, or calorie intake. DON-C said they asked R1's physician to participate and give guidance but "he did not want any part of that." A policy titled Handling Resident Finances and Property, dated August 1, 2021, read the licensee may help residents with simple financial tasks such as budgeting, paying bills or purchasing household goods, but will not otherwise manage a resident's property. A policy titled Protecting Resident Rights, dated July 27, 2022, read: It is the policy of the licensee to protect the rights of our residents. Sunrise Village of Milaca will not request or require that any resident waive any of the rights provided at any time for any reason, including as a condition of admission. R1 was hospitalized and not available for an interview. TIME PERIOD TO CORRECT: Seven (7) Days	02390		
02400 SS=D	144G.91 Subd. 12 Visitors and social participation (a) Residents have the right to meet with or receive visits at any time by the resident's family, guardian, conservator, health care agent, attorney, advocate, or religious or social work counselor, or any person of the resident's choosing. This right may be restricted in certain circumstances if necessary for the resident's health and safety and if documented in the	02400		

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02400	Continued From page 27 resident's service plan. (b) Residents have the right to engage in community life and in activities of their choice. This includes the right to participate in commercial, religious, social, community, and political activities without interference and at their discretion if the activities do not infringe on the rights of other residents. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one resident (R1) had individual autonomy when the licensee locked the resident in her room to prevent her leaving her room and visiting other residents. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety) and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). Findings include: R1's diagnoses included a cerebral infarction (stroke), hypertension, schizophrenia, and bipolar disorder. R1's service plan, dated August 1, 2021, indicated R1 received bathing and toileting assistance, urinary catheter care, behavior services for agitation, anxiety, physical aggression, and verbal aggression. R1 required mobility assistance, transfer assistance with 2 staff and a lift, bed mobility and repositioning. R1 also received safety checks every two hours.	02400		

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02400	Continued From page 28 R1 was on a Coordinated Services and Supports Plan (CSSP) from October 1, 2021, to September 30, 2022. A CSSP allowed 24-hour customized living services for R1 at the licensee (formerly called Heritage House of Milaca). The CSSP assessment, completed by CM-F, identified R1 as at risk for behaviors and R1 was responsible for her own health and safety. A police incident report dated June 14, 2022, at 0853 (8:53 a.m.), indicated R1 called police because she had issues with her urinary catheter and staff was not responding. The police officer arrived and was not able to enter R1's room because the door was locked from the outside and R1 could not get out of her recliner. R1 did not know how much time she had spent in the recliner, but she had had a BM in the recliner prior to the officer's arrival. The police report indicated Assisted Living Director (AL)-A was at the facility and aware R1 had been locked in her room by ULP-B sometime last night. AL-A told police R1 was placed in her recliner chair so she could not get out of it because she "sneaks" into other resident rooms in the middle of the night. The police officer told AL-A R1 could not be locked in her room for any reason. During an interview with AL-A on August 15, 2022, it was known to her and staff that R1 was placed in a recliner that she could not get out of and locked in her room because R1 was knocking on other residents' doors and wanted to visit with them. AL-A stated she communicated to "staff" that R1 should not be allowed to visit with other residents when intoxicated. During an interview with DON-C on August 22,	02400		

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02400	Continued From page 29 2022, stated staff should not leave R1 in a chair just because they do not want to deal with her. DON-C also stated she was not called by any staff member the night R1 placed in her recliner and locked in her room. During an interview on August 22, 2022, RN-D stated that would not think R1 would want to be locked in her room because R1 was not worried about anyone coming into her room. RN-D also stated that the resident room locks could be locked from inside the room by the resident if they could get to the door. RN-D also stated the facility had no restraint policy. During an interview on August 25, 2022, ULP-H stated all resident rooms are locked from the outside. ULP-H stated if a resident's door were locked, licensee staff members would do hourly safety checks which including looking at R1 through the blinds on window. A policy titled Retaliation Prohibited dated July 27, 2022, stated retaliation is prohibited at this facility. The policy states that retaliation against a resident includes but is not limited to restriction or prohibition of access of the resident to the facility or visitors. Retaliation also includes the imposition of involuntary seclusion or the withholding of food, care or services. Time period to correct: 7 (seven) days	02400		