Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL30638003M
Compliance #: HL30638004C

Date Concluded: May 9, 2022

Name, Address, and County of Licensee Investigated:
Ecumen North Branch
383rd St. 19
North Branch, Mn 55056
Chisago County

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

Evaluator's Name:
Jana Wegener, 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.

Allegation(s):
It is alleged neglect occurred when the alleged perpetrator (AP), a staff member, failed to follow the residents plan of care which directed two staff to assist with transfers. The AP transferred the resident independently using the standing mechanical lift and the resident fell from the lift causing a skin tear, bruising, swelling, and pain to the residents' lower legs.

Investigative Findings and Conclusion:
Neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to ensure the AP was competent and properly trained prior to providing care for residents. The AP was not trained and independently transferred the resident using a mechanical standing lift. The safety straps of the sling were not attached correctly and the resident fell out of the sling.

The investigation included interviews with facility staff including administrative staff, nursing staff, and unlicensed staff. The investigator reviewed the residents medical records, employee files, employee training, facility policy and procedures, and incident reports. Observations were

completed of the facility environment, staff and resident interactions, and mechanical lift transfers.

The residents medical record indicated the resident was admitted to the memory care unit with diagnoses including dementia, osteo arthritis, displaced femur fracture with delayed healing, and history of falls. The resident was severely cognitively impaired, required a secure memory care unit, and was receiving hospice services for end-of-life care.

The residents plan of care directed staff the resident required a physical assist of two staff and the EZ mechanical standing lift for all transfers. The plan of care indicated the second staff would physically assist the resident through the transfer to ensure safety.

A review of the residents' service delivery of care record indicated the AP was assigned to the resident's group (a list of resident's staff is responsible for on their shift) and documented providing the resident with physical assist of two staff and a mechanical standing lift to transfer the resident on the morning of the incident.

The facility investigation indicated the AP as a new employee who had only been working on her own a few days when she used a EZ stand mechanical lift to transfer the resident independently instead of using two staff assist. The resident fell in the EZ stand mechanical lift and the AP yelled for another unlicensed personnel (ULP) staff for assistance. The investigation indicated staff reported observing the resident kneeling on the standing lift platform with her right leg to one side, and the resident's wheelchair on top of her right foot, with the mechanical lift arms raised all the way up to the highest point, and only one side of the lift sling attached to the lift arms. The investigation indicated the resident was screaming and crying, and the two staff were unable to assist the resident up so they called for maintenance staff to help get the resident out of the lift.

The facility investigation indicated the EZ stand was inspected for operation and found to be in good working order. The sling used was the correct size for the resident. The investigation indicated staff failed to transfer the resident with two staff, failed to notify nursing, and did not report the incident to management or nursing until the following day during the morning meeting. The investigation indicated the AP was educated on reporting timely to prevent a delay in treatment.

The resident's progress notes indicated the evening after the incident occurred facility staff had reported to the on-call hospice nurse the resident had complaints of right ankle pain and documented the resident's right ankle appeared swollen. Staff was advised to give the resident pain medication and apply ice to the resident's ankle. The resident record had no documentation of the incident, assessment of the residents' injuries, monitoring, or actions taken by facility staff after the incident occurred.

The next morning, two days after the resident had fallen in the EZ stand mechanical lift, a hospice visit assessment note indicated the resident's left shin was bruised, her right ankle was painful and bruised, and she had swelling of her right lower leg. The note indicated the facility reported the resident had a fall due to incorrect use of the EZ stand, and an x-ray was ordered with no acute fracture or dislocation noted.

The resident's hospice notes indicated the resident continued to have pain in her right foot and ankle for 12 days following the incident.

The AP's personnel records included a blank document titled "On Site Mechanical Stand Transfer Form." The form included demonstration of competency for staff using the EZ way stand mechanical lift with a check list of competency skills including checking the residents care plan and ensuring the loops on the sling are properly attached to the lift arms. The document included a handwritten note that indicated "This is what is covered when skills are assessed". There was no indication the information was reviewed with the AP.

Email communication with RNCM indicated skills competency was documented on the "Assisted Living New Hire Competency Skills Check List", and the "On Site Mechanical Standing Lift Form" was used only as a reference for the nurses when completing staff competencies.

A review of the AP's "Assisted Living New Hire Competencies Skills Check List" indicated it was used to track competency of skills completed after the initial training. The document indicated the AP initial review date occurred nine days prior to the incident. However, the document indicated the AP had not completed the skills competency to use of mechanical lift for transfers at the time of the incident. The document indicated RNCM had verified the AP had completed competency two months after the incident occurred. The AP's personnel records had no other documentation of mechanical lift competency completed prior to the incident.

When interviewed facility nursing staff stated the AP had been working independently at the time of the incident and was assigned to her own group. The nurse stated staff did not report the incident until the following day.

The AP stated she was working independently assigned to a group on the memory care unit alone when the incident occurred. The AP stated she was getting the resident up and ready for the day and did not know the resident required two staff assist with the EZ stand mechanical standing lift.

Another unlicensed staff stated she was working with the AP the morning of the incident and they were each assigned a group (their own assignments and set of residents) on the memory care unit. The staff stated the resident fell in the EZ stand mechanical lift when the AP transferred the resident alone and did not connect the sling loops to the lift arms correctly. The staff stated the resident was yelling "OUCH, OUCH, OW, oh my God" and was crying in pain.

The staff stated they were not able to get the resident back onto the bed, so they called out to the maintenance staff for help.

When interviewed the maintenance staff stated he was doing his morning rounds when a staff called him to assist with lifting a resident who had fallen. The maintenance staff stated when he entered the residents' room she was yelling "Help me, help me", and was kneeling on the standing lift platform, hanging by one arm, with only one loop connected to the lift.

When interviewed the registered nurse (RN) stated one Monday morning during huddle at the start of the shift staff reported the resident had fallen out of the EZ stand mechanical lift the previous morning. The RN stated staff did not report the incident prior to that. The RN stated she had assessed the resident's injuries after being notified of the incident, however, a review of the resident record had no documentation an assessment was completed. The RN stated the AP had not been confirmed to be safe to work on her own yet.

An incident report completed by the RN two months after the incident occurred, and after the investigator was onsite indicated the AP accidentally dropped the resident while using the EZ stand mechanical lift. The incident report indicated a loop slipped off the lift arm and the resident was hanging in the lift by one arm and kneeling on the platform. The report indicated the resident received a skin tear on her right calf and had right foot pain following the incident.

In conclusion, neglect was substantiated. The facility was responsible for the neglect when they failed to ensure the AP was competent to follow the resident plan of care and operate a EZ stand mechanical standing lift prior to providing care for the resident.

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

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means:
(a) 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.
(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility: The facility provided education to the AP on EZ stand mechanical lift transfers and inspected the mechanical standing lift.

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.

cc: The Office of Ombudsman for Long-Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Chisago County Attorney
North Branch City Attorney
North Branch Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30638	A. BUILDING: _____ B. WING _____	C 04/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECUMEN NORTH BRANCH	5379 383RD STREET NORTH BRANCH, MN 55056

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0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, 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: On April 5, 2022, the Minnesota Department of Health conducted a complaint investigation for #HL30638003M, and HL30638004C at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 65 residents receiving services under the provider's Assisted Living Dementia Care license. The following correction orders were issued for #HL30638003M, and HL30638004C, tag identification 0620, 0730, 1300, 1370, 1380, 2320, 2360, 3000, and 3030.	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.	
0 620 SS=D	144G.42 Subd. 6 (a) 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 record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment for one of one residents (R1) reviewed. R1 was neglected when the facility failed to ensure a untrained unlicensed personnel, (ULP)-A, was competent to provide care to residents. ULP-A failed to ensure the safety leg strap and sling loops were properly attached to a EZ stand mechanical lift prior to transferring R1, and failed to follow R1's plan of care which indicated R1 required two staff assist and the EZ stand mechanical lift for transfers. As a result R1 fell out of the lift and was injured. 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 was admitted to the facility on May 18, 2021,	0 620		

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0 620	Continued From page 2 with diagnoses including coronary artery disease, hypertension, right femur fracture, dementia without behavioral disturbances, and osteoarthritis. R1's service agreement effective November 29, 2021, indicated the resident was severely cognitively impaired and required a secure memory care. The service agreement indicated R1 was receiving hospice services and instructed staff to call the hospice nurse for questions, concerns, and updates. R1's service plan effective December 15, 2022, indicated R1 required physical assistance from two staff and a EZ stand mechanical lift for all transfers. The service plan indicated R1 required the second staff to physically assist the resident through the transfer. The undated facility investigation completed by the Registered Nurse Clinical Manager (RNCM)-E identified ULP-A was a new employee who had been working on her own for a few days at the time of the incident. The investigation indicated the incident occurred on Sunday January 30, 2022, but was not reported internally until the following morning January 31, 2022, during a nursing huddle. The investigation indicated ULP-A was getting R1 ready for the day and forgot she required two staff physical assistance with the EZ stand mechanical lift and ULP-A transferred the resident alone. The investigation indicated ULP-A had not properly connected R1 to the lift and R1 fell. The investigation indicated R1 was observed hanging from the lift by one arm, with her knees on the platform, and her right foot sideways under her wheelchair. The investigation indicated the resident did not have injuries noted until the	0 620		

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0 620	Continued From page 3 evening of January 31, 2022, when a skin tear, pain, and swelling of her right foot was noted. The investigation indicated then Hospice was notified of the incident on February 1, 2022, and an X-ray was completed with no fracture or dislocation noted. A incident report completed by RNCM-E on April 5, 2022, at 5:22 p.m. after the investigator entered the facility indicated the fall occurred on January 30, 2022, and incorrectly documented the time of occurrence at 7:00 p.m. The incident report indicated ULP-A had transferred R1 independently with the EZ stand mechanical lift when a strap slipped off and the resident dropped. The report indicated the resident had a skin tear on her right calf, and had right foot pain. ULP-A's personnel training records indicated she had not completed training and competency for using a mechanical standing lift to transfer residents at the time of the incident. Facility documentation titled "Assisted Living New Hire RA Competency Skill Checklist" indicated ULP-A's skills were reviewed on January 21, 2022. However, the document indicated ULP-A had not been verified as competent to perform tasks including operation of the EZ stand mechanical lift until March 30, 2022, two months after the incident occurred. Documentation of ULP-A's lift training and competency completed prior to the incident was requested, none was provided. The facility reported the incident to the Minnesota Adult Abuse Reporting Center (MAARC) dated February 2, 2022, at 4:20 p.m. which indicated the incident occurred on Sunday, January 30, 2022, at 8:00 a.m. The MAARC report indicated staff had not reported the incident internally until	0 620		

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0 620	Continued From page 4 the following morning on Monday January 31, 2022. The incident was reported to MAARC on February 2, 2022, at 4:20 p.m., three days and eight hours after the incident occurred and over 24 hours after staff were made aware of the incident. On April 15, 2022, at 1:38 p.m. ULP-G stated she wrote down what happened on a piece of paper and slid it under one of the RN's doors the day of the incident. ULP-G stated ULP-A was assigned to work on her own, and had asked ULP-A to start getting R1 ready while she finished something at the medication cart. ULP-G stated ULP-A came out of R1's room screaming for help, and when she entered the room R1 had no safety strap on the lower part of her legs and the lift arms were raised up to the highest level with only one strap connected. ULP-G stated R1 was hanging in the lift by the strap around her belly and one loop, kneeling on the platform with her right leg cocked to one side and her foot caught under her wheelchair. ULP-G stated R1 was yelling in pain crying "ouch ouch ouch, ow, oh my God". ULP-G stated R1 was in pain and they needed help, she went to the door and asked Maintenance Technician (MT)-F to help lift the resident. ULP-G indicated it was an emergency and she needed help to get R1 up or she would have to call 911 for assistance. ULP-G stated with MT-F's assistance they were able to get R1 on the bed and indicated R1 was still in pain after the incident. ULP-G stated she reported the incident till the next day during morning stand up, but indicated she thought it was within 24 hours. ULP-G stated she should have reported the incident to the RN on call but did not, and indicated since ULP-A was working independently she was responsible to report the incident. ULP-G indicated it was not her reasonability to report the	0 620		

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0 620	Continued From page 5 incident. On April 5, 2022, at 11:01 AM Maintenance Technician (MT)-F stated he was doing my morning rounds when one of the ULP's asked for help with a resident who fallen in the EZ stand mechanical lift. MT-F stated when he entered R1's room the lift sling was around R1, and only one loop was hooked to the lift arm. MT-F stated R1 was hanging the one hooked side, her knees were on the platform, and feet were on the ground curled under and right next to the bed. MT-F stated R1 was yelling "Help me, help me" and crying. MT-F stated he did not report the incident to anyone. On April 5, 2022, at 10:05 a.m. Licensed Practical Nurse (LPN)-C stated R1 was assigned to ULP-A who was working independently on January 30, 2022. LPN-C stated on January 31, 2022, ULP-G initially reported to her R1 had a fallen from the EZ stand mechanical lift the previous morning. LPN-C stated ULP-A failed to follow R1's plan of care and transferred R1 independently, then failed to use the EZ stand mechanical lift properly. LPN-C stated staff did not immediately report the incident to the on call nurse as they should have. On April 5, 2022, at 10:33 a.m. RNCM-E stated the incident happened over the weekend and was not reported by staff involved until Monday, January 31, 2022, during morning huddle. RNCM-E stated ULP-A was working independently when the incident occurred, but her orientation process was not completed, and she had not been confirmed to be safe on her own. RNCM-E stated ULP-A failed to check R1's care plan indicating R1 required two staff assistance and the EZ stand mechanical lift, but transferred	0 620		

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0 620	Continued From page 6 R1 alone. RNCM-E stated ULP-A did not hook the sling strap into the lift all the way which caused the sling strap to slip off when the lift arms were raised. RNCM-E stated as a result R1 fell and was hanging from the lift by one arm, with her knees on the platform, and feet on the ground. RNCM-E stated if any sort of incident occurred staff were expected to report the incident immediately, and verified the incident was not reported internally until the next day. RNCM-E stated a investigation should be done and a report made to the Minnesota Adult Abuse Reporting Center (MAARC) with in 24 hours of becoming aware of the incident. RNCM-E stated she waited to report to MAARC until after cooperate office reviewed the information from the incident to determine if the incident was reportable. The facility policy and procedure titled "Vulnerable Adult Maltreatment Policy" dated July 17, 2021, indicated the purpose was to establish guidelines for internal and external reporting of potential maltreatment of vulnerable adults. Section 3. titled "Immediate Steps - Witnessed Incident or Allegation of Maltreatment" indicated staff would intervene and ensure safety of the vulnerable adult and immediately notify the RN or Licensed Assisted Living Director (LALD). The policy indicated if neither were onsite staff were to notify the on call RN. If the alleged perpetrator was a staff person, they would be directed to leave the building immediately and not return to work until further notice. Section 4. titled "Reporting Maltreatment" indicated any staff person who witnesses or suspects maltreatment of a vulnerable adult will report the incident immediately. If the incident appears to be suspected abuse, neglect, or financial exploitation the RN or LALD would immediately make a report	0 620		

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0 620	Continued From page 7 to the common entry point. The policy defined immediately as no later than 24 hours after receiving initial knowledge the incident occurred. The procedure indicated if it was unclear weather maltreatment occurred an investigation will begin immediately, and indicated if with in 24 hours it was still unclear weather maltreatment occurred a report would be made to MAARC. Section 5. titled "Internal Investigation" indicated staff would complete an incident report and make appropriate notifications under section 3. The procedure indicated the RN, LALD, or designee would complete an internal investigation pertaining to the report of potential or suspected maltreatment. Section 6. titled "Education" indicated all staff were educated on reporting potential or suspected maltreatment of a vulnerable adult and their obligation to report as mandated reporters. The education included internal reporting process and the choice to report directly to MAARC. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 620		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history,	0 730		

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0 730	Continued From page 8 allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure resident records had the required content including documentation of	0 730		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECUMEN NORTH BRANCH	5379 383RD STREET NORTH BRANCH, MN 55056

(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
0 730	Continued From page 9 incidents involving the resident, assessment of injuries, changes in the resident condition, actions taken in response to the needs of the resident, and documentation of reporting to the appropriate supervisor or health care professional for one of one resident (R1) reviewed. 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 was admitted to the facility on May 18, 2021, with diagnoses including coronary artery disease, hypertension, right femur fracture, dementia without behavioral disturbances, and osteoarthritis. R1's service agreement dated November 29, 2021, indicated she was severely cognitively impaired and required a secure memory care. The service agreement indicated R1 was receiving hospice services and instructed staff to call the hospice nurse for questions concerns and updates. R1's service plan effective December 15, 2022, indicated R1 required physical assistance from two staff and a EZ stand mechanical lift for all transfers. The service plan indicated R1 required the second staff to physically assist the resident through the transfer. The undated facility investigation completed by	0 730		

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0 730	Continued From page 10 the Registered Nurse Clinical Manager (RNCM)-E indicated ULP-A was a new employee who had been working on her own for a few days at the time of the incident. The incident occurred on Sunday January 30, 2022, but was not reported internally until the following morning, January 31, 2022, during a nursing huddle. The investigation indicated ULP-A was getting R1 ready for the day and forgot R1 required two staff physical assistance with the EZ stand mechanical lift and ULP-A transferred the resident without a second staff member. The investigation indicated ULP-A had not properly connected R1 to the lift and R1 fell. R1 was observed hanging from the lift by one arm, with her knees on the platform, and her right foot sideways under her wheelchair. The investigation indicated the resident did not have injuries noted until the following evening January 31, 2022, when a skin tear, pain, and swelling of her right foot was noted. The investigation indicated then Hospice was notified of the incident on February 1, 2022, and X-ray was completed with no fracture or dislocation noted. A incident report completed by RNCM-E on April 5, 2022, at 5:22 p.m. after the investigator entered the facility indicated the fall occurred on January 30, 2022, and incorrectly documented the time of occurrence at 7:00 p.m. The incident report indicated ULP-A had transferred R1 independently with the EZ stand mechanical lift when a strap slipped off and the resident dropped. The report indicated the resident had a skin tear on her right calf, and had right foot pain. The incident report indicated R1's provider, family, and the manager on duty were notified of the incident on January 31, 2022. The resident's record lacked documentation of notification of the incident being done.	0 730		

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0 730	Continued From page 11 A review of R1's facility nursing progress notes from January 3, 2022, to March 31, 2022, was completed and included the following: - On January 31, 2022, at 11:17 p.m. a ULP staff reported to on call hospice RN that R1's ankle appeared to be swollen, and indicated R1 was able to move her ankle but it is painful. The ULP was advised to give lorazepam and morphine to to R1 to help her sleep and manage pain and apply ice to ankle, and indicated the clinical manager would follow up tomorrow. - On February 1, 2022, at 2:19 p.m. Licensed Practical Nurse (LPN)-C documented a message was sent to hospice regarding R1's right foot pain, and questioned the need for an X-ray. LPN-C indicated a X-ray order was obtained and R1 experienced pain with repositioning during X-ray. LPN-C received orders from hospice to change R1 to a hoyer lift for all transfers. R1's facility progress notes failed to include any information regarding the incident that occurred on January 30, 2022, when R1 had a fall from the EZ stand mechanical lift. R1's facility record had no documentation of notification of the incident to the on call nurse, hospice nurse, provider, or family. R1's record lacked documentation of assessment of injuries, and monitoring of the residents pain and injuries following the incident until resolved. A review of R1's hospice records included a hospice progress note dated February 1, 2022, at 9:48 a.m. two days after the incident occurred, indicated a hospice RN had assessed R1 after the facility reported the resident had a fall involving the incorrect use of the EZ stand	0 730		

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0 730	Continued From page 12 mechanical lift that resulted in injury to R1's right foot. The progress note indicated the RN assessed R1 for injuries and indicated her left shin was bruised, right foot was tender to the touch. The RN documented R1's right foot and ankle were bruised and swollen with moderate pain. The RN indicated R1 was unable to bear weight, and R1's provider was notified, with orders received for a portable X-ray to right foot. No acute fractures were identified, and the family was updated. The hospice record documentation indicated R1 continued to have right foot and ankle swelling and pain related the the fall for 12 days following the incident until February 11, 2022. On April 5, 2022, at 10:33 a.m. RNCM-E stated she had completed an assessment of R1's injuries on Monday January 31, 2022, after being notified of the incident. However, the facility documentation had no record of a assessment being completed, and R1's facility record had no documentation the incident occurred. RNCM-E stated unlicensed staff involved indicated R1's ankle hurt a bit at the time of the incident but R1 "seemed fine". RNCM-E stated staff had completed an incident report at the time of the incident, however no incident report completed by the staff involved at the time of the incident was provided. On April 27, 2022, at 3:16 p.m. RNCM-E verified no incident report was completed until after the investigator was onsite. RNCM-E stated staff should have notified the on call nurse immediately after the incident occurred and verified they had not. RNCM-E indicated the incident report, resident assessment, investigation, and reporting of the incident was not done timely or thoroughly. .	0 730		

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0 730	Continued From page 13 Policy and procedure titled "Resident Records" dated July 25, 2022, indicated all staff were accountable to ensure the resident record would include information if applicable to services received including documentation of services provided, documentation of a significant change in resident status and actions taken including reporting to the appropriate supervisor or healthcare personnel documentation of incidents involving the resident and actions taken in response to the needs of the resident including pertinent details about the incident and reporting to the appropriate supervisor, and other documentation relevant to the resident services. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
01300 SS=F	144G.60 Subd. 2 Qualifications, training, and competency All staff persons providing assisted living services must be trained and competent in the provision of services consistent with current practice standards appropriate to the resident's needs, and promote and be trained to support the assisted living bill of rights. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to ensure a unlicensed personnel (ULP) was trained and competent in the provision of services with current practice standards appropriate to the residents' needs for one of one employees (ULP-A) reviewed. This had the potential to affect all 65 residents residing at the facility.	01300		

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01300	Continued From page 14 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 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 clients). Findings include: R1 was admitted to the facility on May 18, 2021, with diagnoses including coronary artery disease, hypertension, right femur fracture, dementia without behavioral disturbances, and osteoarthritis. R1's service agreement effective November 29, 2021, indicated she was severely cognitively impaired and required a secure memory care. The service agreement indicated R1 was receiving hospice services. R1's service plan effective December 15, 2022, indicated the resident required physical assistance from two staff and a EZ stand mechanical lift for all transfers. The service plan indicated R1 required the second staff to physically assist the resident through the transfer. The undated facility investigation completed by the Registered Nurse Clinical Manager (RNCM)-E identified ULP-A as a new employee who had been working on her own for a few days at the time of the incident. The investigation indicated ULP-A was getting R1 ready for the day and forgot R1 required two staff physical assistance with the EZ stand mechanical lift and transferred the resident alone. The investigation	01300		

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01300	Continued From page 15 indicated the resident was not properly connected to the lift and fell. The resident was hanging from the lift by one arm and kneeling on the platform with her right foot sideways under the wheelchair. A incident report completed by RNCM-E on April 5, 2022, at 5:22 p.m. after the investigator entered the facility, indicated the fall occurred on January 30, 2022, and incorrectly documented the time at 7:00 p.m. The incident report indicated ULP-A had transferred R1 independently with the EZ stand mechanical lift when a strap slipped off and the resident dropped. R1 was hanging onto the lift by one arm and her knees were on the platform with her legs to the side. The report indicated the resident received a skin tear on her right calf, and had right foot pain. The document titled "Assisted Living New Hire RA Competency Skill Checklist" indicated ULP-A's skills were reviewed on January 21, 2022. However, the section for evaluator attestation indicated RNCM-E documented she ranked and attested ULP-A was competent to perform tasks including operation of the EZ stand mechanical lift on March 30, 2022, two months after the incident occurred. Documentation of ULP-A's lift training and competency completed prior to the incident was requested, none was provided. On April 27, 2022, at 3:16 p.m. RNCM-E stated ULP-A's skill checklist was reviewed on January 21, 2022, but ULP-A had not completed her onsite training, and was not verified as competent to work on her own at the time of the incident. RNCM-E indicated she did not know the exact date ULP-A completed her training and was verified as competent to operate a EZ stand mechanical lift but indicated it was prior to March 30, 2022. RNCM-E stated she was new to her	01300		

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01300	Continued From page 16 role, and did not document when ULP-A's competency was completed. The facility provided schedule for January 30, 2022 indicated ULP-A was scheduled to train with ULP-G on the Prairie group in the memory care unit from 6:00 a.m. to 2:00 p.m. However, when reviewing the facility provided resident group lists for Ashton and Prairie with the services received record indicated ULP-A had documented providing care to resident's on the Prairie group from 6:00 a.m. till 2:00 p.m., and ULP-G documented providing care to resident's on the Ashton group from 6:00 a.m. till 2:00 p.m. ULP-D who was scheduled to work from 6:00 a.m. to 10:00 a.m. documented providing care to residents on both resident groups as a float. The January 30, 2022 schedule status log in record for devices used by all staff at the start of the shift to download the resident task list and care plans for the group they are assigned and document services delivered to residents during their shift indicated ULP-A logged in at 6:10 a.m., and the services received record indicated ULP-A documented providing cares to resident's on the Prairie group until 2:00 p.m. ULP-G logged in at 6:02 a.m. and the services received record indicated ULP-G documented providing cares to residents on the Ashton group until 2:00 p.m. The services received record and schedule status log in the record indicated ULP-A was not training with ULP-G at the time of the incident but was working independently on her own group the day of the incident and was assigned to R1 who resided on the Prairie group. On April 5, 2022, at 9:17 a.m. ULP-A stated the incident happened around 6:00 a.m. or 7:00 a.m. and she was scheduled to work on the memory	01300		

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01300	Continued From page 17 care unit independently with ULP-G. ULP-A stated she got R1 ready for the day, had her sit at the edge of the bed, placed the green sling around her back, put the sling straps under her arms, then clicked the safety waist strap around R1. ULP-A stated she thought R1 was attached correctly but when she raised the lift arms up the strap unhooked and R1 fell and was dangling in the EZ stand lift tangled in the sling. ULP-A stated she had never transferred a resident alone before and she thought the loop was clicked in. On April 15, 2022, at 1:38 p.m. ULP-G stated ULP-A was assigned to work on her own group the day of the incident. ULP-G asked ULP-A to start getting R1 ready while she was at the medication cart and ULP-A came out of R1's room screaming for help. ULP-G stated when she entered the room R1 was dangling from the mechanical lift, had no safety strap on the lower part of her legs, and the lift arms were raised up to the highest level with only one strap connected. ULP-G stated she trained ULP-A on the floor, and recalled a scheduling staff had texted her and asked how ULP-A was doing. ULP-G stated she had reported to the scheduling staff that ULP-A was not ready to be on her own, but indicated the next day ULP-A was scheduled to work by herself, then the incident occurred with R1. ULP-G stated she saw the scheduler the following Monday or Tuesday after the incident and they acknowledged ULP-G had voiced concerns about ULP-A working independently, however, the told her the facility decided to put her on her own. On April 15, 2022, at 2:21 p.m. ULP-D stated she was involved in ULP-A's on the floor training and had expressed concerns about her competency prior to ULP-A working independently and	01300		

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01300	Continued From page 18 operating mechanical lifts. ULP-D stated she was told to "push ULP-A to do more on her own". ULP-D stated two staff were always scheduled to work 6:00 a.m. to 2:00 p.m. with one staff in charge of Ashton group and one staff in charge of the Prairie group on each side, and a if they had a float shift they worked 6:00 a.m. to 10:00 a.m. and/or 10:00 a.m. to 2:00 p.m. On April 5, 2022, at 10:05 a.m. LPN-C stated ULP-G reported on January 31, 2022, during morning huddle that ULP-A had transferred R1 alone and the lift sling was not hooked up properly with only one loop attached on one side. LPN-C stated R1 required two staff assist. LPN-C stated when new staff are trained a skills check list of competencies needed to be completed before they could work on their own. LPN-C stated when staff come on shift they use a Ipod and log into a group to download the task list and resident care plans for the group they are assigned. LPN-C explained that the only staff who can document on a resident group is the staff who was assigned and had downloaded that group for the shift. LPN-C stated R1 was assigned to ULP-A on January 30, 2022, and indicated if ULP-A was training she would have been working and documenting on the same group as ULP-G that day. On April 5, 2022, at 10:33 a.m. RNCM-E stated the incident happened over the weekend and was reported Monday, January 31, 2022, during morning huddle. RNCM-E stated ULP-A was working independently, but her orientation process was not completed and she had not been determined to be competent to be safe on her own. A email communication on April 29. 2022, at	01300		

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01300	Continued From page 19 12:07 p.m. from RNCM-E included an email string which indicated ULP-G had expressed safety concerns regarding ULP-A's competency with scheduling staff the weekend the incident occurred. Additional documentation was requested for concerns reported by ULP-G that was referred to in the email string and text regarding ULP-A's competency and safety, none was provided. The facility policy and procedure titled "Training Documentation" dated August 1, 2021, indicated training would be documented completely and correctly. The policy indicated a record of staff training and competency would be maintained and would include the date of the training and/or competency evaluation, and the evaluator statement attesting the employee successfully completed the training and competency evaluation. The policy and procedure titled "Assisted Living Orientation - Unlicensed Personnel Staff" dated July 17, 2022, indicated in section 5. ULPs who are not a registered nursing assistant would receive training with a written or oral competency test AND a skill demonstration on required topics including safe transfer techniques, injuries and other observed changes that must be reported, and procedures in handling various emergency situations. The policy indicated an evaluation of competency for accepted documentation of training must be completed before the staff provided assistance to residents. TIME PERIOD TO CORRECTION: Twenty-one (21) Days	01300		

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01370	Continued From page 20	01370		
01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various	01370		

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01370	Continued From page 21 emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) trained and competency-evaluated an unlicensed personnel (ULP) in all required topics for one of one employees (ULP)-A with employee records reviewed. This had the potential to affect all residents residing at the facility. 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). The findings include: ULP-A was hired on January 11, 2022, and began providing assisted living cares to licensee's residents prior to completing skills competency evaluation. A undated facility investigation completed by the Registered Nurse Clinical Manager (RNCM)-E indicated ULP-A was a new employee who had been working on her own for a few days at the time of the incident. The investigation indicated ULP-A was getting R1 ready for the day and did not know R1 required two staff physical assistance with the EZ stand mechanical lift for transfers. ULP-A transferred R1 independently in the mechanical lift. The sling was not connected	01370		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01370	Continued From page 22 properly to the mechanical lift and the resident fell from the lift. The document titled "Assisted Living New Hire RA Competency Skill Checklist" indicated ULP-A's skills were reviewed on January 21, 2022. However, the document indicated ULP-A skills were not verified competent until March 30, 2022, by RNCM-E, two months after the incident occurred. ULP-A's employee training records lacked evidence she successfully completed practical skills evaluations as required for training in accordance with assisted living 144G statutes in the following areas: Training and competency evaluations for all unlicensed personnel must include the following: - Documentation requirements for all services provided; - reports of changes in the resident's condition to the supervisor designated by the facility; - basic infection control, including blood-borne pathogens; - maintenance of a clean and safe environment; - appropriate and safe techniques in personal hygiene and grooming, including: - hair care and bathing; - care of teeth, gums, and oral prosthetic devices; - care and use of hearing aids; and - dressing and assisting with toileting; - training on the prevention of falls; - standby assistance techniques and how to perform them; - medication, exercise, and treatment reminders; - basic nutrition, meal preparation, food safety, and assistance with eating; - preparation of modified diets as ordered by a licensed health professional; - communication skills that include preserving the	01370		

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	30638	A. BUILDING: _____ B. WING _____	C 04/05/2022

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01370	Continued From page 23 dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; - awareness of confidentiality and privacy; - understanding appropriate boundaries between staff and residents and the resident's family; - procedures to use in handling various emergency situations; and - awareness of commonly used health technology equipment and assistive devices. On April 5, 2022, at 10:33 a.m. RNCM-E stated ULP-A was working independently, but her orientation process was not completed and she had not been confirmed to be safe on her own. RNCM-E stated ULP-A failed to check the resident's care plan, and did not hook the sling strap into the lift all the way which caused the sling strap to slip off when the lift arms and the resident fell. On April 27, 2022, at 3:16 p.m. RNCM-E stated ULP-A's skill checklist was reviewed on January 21, 2022, but ULP-A had not completed her onsite training, and was not verified as competent to work on her own at the time of the incident. RNCM-E indicated she did not know the exact date ULP-A completed her training and was verified as competent to operate a EZ stand mechanical lift but indicated it was prior to March 30, 2022. RNCM-E stated she was new and did not document when ULP-A's competency was completed. The facility policy and procedure titled "Training Documentation" effective August 1, 2021, indicated training would be documented completely and correctly. The policy indicated a record of staff training and competency would be maintained and would include the date of the	01370		

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01370	Continued From page 24 training and/or competency evaluation, total amount of time for the training and competency evaluation, name and title of the instructor, instructor ' s signature, name and title and signature of the competency evaluator if different from the instructor, evaluator statement attesting the employee successfully completed the training and competency evaluation, name and title of the staff person completing the training, staff person ' s signature, staff person statement attesting they had successfully completed the training as described, a copy of the competency training, evaluation, retraining or orientation will be provided to the employee at the time of the evaluation or training completion. The policy and procedure titled "Assisted Living Orientation - Unlicensed Personnel Staff" dated July 17, 2022, indicated in section 5. ULPs who are not a registered nursing assistant would receive training with a written or oral competency test AND a skill demonstration on required topics including safe transfer techniques, injuries and other observed changes that must be reported, and procedures in handling various emergency situations. The policy indicated an evaluation of competency for accepted documentation of training must be completed before the staff provided assistance to residents. TIME PERIOD TO CORRECTION: Twenty-one (21) Days	01370		
01380 SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include:	01380		

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01380	Continued From page 25 (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) trained and had competency-evaluated for unlicensed personnel (ULP) in all required topics for one of one employees (ULP)-A with employee records reviewed. This had the potential to affect all residents residing in the facility. 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). The findings include: ULP-A was hired on January 11, 2022, and began providing assisted living cares to licensee's residents prior to completing skills competency evaluation.	01380		

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01380	Continued From page 26 An undated facility investigation completed by the Registered Nurse Clinical Manager (RNCM)-E identified ULP-A was a new employee who had been working on her own for a few days at the time of the incident. The investigation indicated ULP-A was getting R1 ready for the day and did not know R1 required two staff physical assistance with the EZ stand mechanical lift for transfers. ULP-A transferred the resident without a second staff member and R1 fell from the lift. The document titled "Assisted Living New Hire RA Competency Skill Checklist" indicated ULP-A's skills were reviewed on January 21, 2022. However, the document indicated ULP-A skills were not verified competent until March 30, 2022, by RNCM-E, two months after the incident occurred. ULP-A's employee training records lacked evidence she successfully completed practical skills evaluations as required for training in accordance with assisted living 144G statutes in the following areas: Training and competency evaluations for all unlicensed personnel must include the following: - Observing, reporting, and documenting resident status; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; - reading and recording temperature, pulse, and respirations of the resident; - recognizing physical, emotional, cognitive, and developmental needs of the resident; - safe transfer techniques and ambulation; - range of motioning and positioning; and - administering medications or treatments as	01380		

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01380	Continued From page 27 required. On April 27, 2022, at 3:16 p.m. RNCM-E stated ULP-A's skill checklist was reviewed on January 21, 2022, but ULP-A had not completed her onsite training, and was not verified as competent to work on her own at the time of the incident. RNCM-E indicated she did not know the exact date ULP-A completed her training and was verified as competent to operate a EZ stand mechanical lift but indicated it was prior to March 30, 2022. RNCM-E stated she was new and did not document when ULP-A's competency was completed. The facility policy and procedure titled "Training Documentation" effective August 1, 2021, indicated training would be documented completely and correctly. The policy indicated a record of staff training and competency would be maintained and would include the date of the training and/or competency evaluation, total amount of time for the training and competency evaluation, name and title of the instructor, instructor ' s signature, name and title and signature of the competency evaluator if different from the instructor, evaluator statement attesting the employee successfully completed the training and competency evaluation, name and title of the staff person completing the training, staff person ' s signature, staff person statement attesting they had successfully completed the training as described, a copy of the competency training, evaluation, retraining or orientation will be provided to the employee at the time of the evaluation or training completion. The policy and procedure titled "Assisted Living Orientation - Unlicensed Personnel Staff" dated July 17, 2022, indicated in section 5. ULPs who	01380		

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01380	Continued From page 28 are not a registered nursing assistant would receive training with a written or oral competency test AND a skill demonstration on required topics including safe transfer techniques, injuries and other observed changes that must be reported, and procedures in handling various emergency situations. The policy indicated an evaluation of competency for accepted documentation of training must be completed before the staff provided assistance to residents. TIME PERIOD TO CORRECTION: Twenty-one (21) Days.	01380		
02320 SS=G	144G.91 Subd. 4 Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure services were provided by individuals who were properly trained and competent for one of one residents, R1, reviewed for a fall from a mechanical lift. ULP-A was assisting R1 without a second staff member according to the residents individualized plan of care. Although R1 required assistance of two staff when transferring using the mechanical standing lift; ULP-A transferred R1 without a second staff using the mechanical lift and R1 fell out of the lift and was injured.	02320		

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02320	Continued From page 29 This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings Include: R1 was admitted to the facility on May 18, 2021, with diagnoses including coronary artery disease, hypertension, right femur fracture, dementia without behavioral disturbances, and osteoarthritis. R1's service agreement effective November 29, 2021, indicated she was severely cognitively impaired and required a secure memory care. The service agreement indicated R1 was receiving hospice services and instructed staff to call the hospice nurse for questions concerns and updates. R1's service plan effective December 15, 2022, indicated the resident required physical assistance from two staff and a EZ stand mechanical lift for all transfers. The service plan indicated R1 required the second staff to physically assist the resident through the transfer. The undated facility investigation completed by the Registered Nurse Clinical Manager (RNCM) - E identified ULP-A was a new employee who had been working on her own for a few days at the time of the incident. The investigation indicated ULP-A was getting R1 ready for the day and forgot she required two staff physical assistance	02320		

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02320	Continued From page 30 with the EZ stand mechanical lift and transferred the resident alone. The investigation indicated the resident was not properly connected to the lift and fell. The resident was hanging from the lift by one arm and kneeling on the platform with her right foot sideways under the wheelchair. The investigation indicated the incident occurred on January 30, 2022, was not reported to the facility until the following morning January 31, 2022, during a nursing huddle. The resident did not have pain or concerns until the evening of January 31, 2022, when a skin tear pain and swelling was reported to the hospice RN. The investigation indicated hospice was not notified of the incident the until the following day on February 1, 2022, then a X-ray was completed with no acute fracture or dislocation noted. Facility documentation titled "Assisted Living New Hire RA Competency Skill Checklist" indicated ULP-A's skills were reviewed on January 21, 2022. However, the document indicated ULP-A had not been verified as competent to perform tasks including operation of the EZ stand mechanical lift until March 30, 2022, two months after the incident occurred. Document titled Mechanical Stand, identified by the facility as lift re-education dated February 2, 2022, indicated RNCM-E provided coaching education on use of the EZ stand mechanical lift. Lift training and competency completed prior to the incident was requested, none was provided. ULP-A's personnel training records indicated she had not completed training and competency for using a mechanical standing lift to transfer residents at the time of the incident. A review of R1's facility nursing progress notes from January 3, 2022, to March 31, 2022, was	02320		

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02320	Continued From page 31 completed and included the following: - On January 31, 2022, at 11:17 p.m. a ULP staff reported to on call hospice RN that R1's ankle appeared to be swollen, and indicated R1 was able to move her ankle but it is painful. The ULP was advised to give lorazepam and morphine to to R1 to help her sleep and manage pain and apply ice to ankle, and indicated the clinical manager would follow up tomorrow. - On February 1, 2022, at 2:19 p.m. Licensed Practical Nurse (LPN)-C documented a message was sent to hospice regarding R1's right foot pain, and questioned the need for an X-ray. LPN-C indicated a X-ray order was obtained and R1 experienced pain with repositioning during X-ray. LPN-C received orders from hospice to change R1 to a hoyer lift for all transfers. R1's facility progress notes failed to include any information regarding the incident that occurred on January 30, 2022, when R1 had a fall from the EZ stand mechanical lift. R1's facility record had no documentation of notification of the incident to the on call nurse, hospice nurse, provider, or family. R1's record lacked documentation of assessment of injuries, and monitoring of the residents pain and injuries following the incident until resolved. A review of R1's hospice records included a hospice progress note dated February 1, 2022, at 9:48 a.m. two days after the incident occurred, indicated a hospice RN had assessed R1 after the facility reported the resident had a fall involving the incorrect use of the EZ stand mechanical lift that resulted in injury to R1's right foot. The progress note indicated the RN assessed R1 for injuries and indicated her left	02320		

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02320	Continued From page 32 shin was bruised, right foot was tender to the touch. The RN documented R1's right foot and ankle were bruised and swollen with moderate pain. The RN indicated R1 was unable to bear weight, and R1's provider was notified, with orders received for a portable X-ray to right foot. No acute fractures were identified, and the family was updated. The hospice record documentation indicated R1 continued to have right foot and ankle swelling and pain related the the fall for 12 days following the incident until February 11, 2022. A incident report completed by RNCM-E on April 5, 2022, at 5:22 p.m. after the investigator entered the facility indicated the fall occurred on January 30, 2022, and incorrectly documented the time of occurrence at 7:00 p.m. The incident report indicated ULP-A had transferred R1 independently with the EZ stand mechanical lift when a strap slipped off and the resident dropped. The report indicated the resident had a skin tear on her right calf, and had right foot pain. The incident report indicated R1's provider, family, and the manager on duty were notified of the incident on January 31, 2022. On April 5, 2022, at 10:33 a.m. RNCM-E stated she completed an assessment of R1's injuries on Monday January 31, 2022, after being notified of the incident. However, the facility documentation had no record of a assessment being completed, and R1's facility record had no documentation the incident occurred. RNCM-E stated unlicensed staff involved indicated R1's ankle hurt a bit at the time of the incident but R1 "seemed fine". RNCM-E stated staff had completed an incident report at the time of the incident, however no incident report completed by the staff involved at the time of the incident was provided.	02320		

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02320	Continued From page 33 On April 5, 2022, at 9:17 a.m. ULP-A stated she was working independently, attached R1 to the EZ stand lift, and as she raised the lift arms of the EZ stand mechanical lift a strap came unhooked. ULP-A stated R1 fell and was dangling in the EZ stand lift. ULP-A stated R1 was crying and stated her ankle hurt. ULP-A stated R1's ankle was under the platform and bent backwards. ULP-A stated she had never transferred a resident alone before that, and thought the loop was clicked in. ULP-A stated she had forgotten R1 required a two assist with transfers and did not check R1's plan of care before providing care and transfer the resident. On April 5, 2022, at 10:05 a.m. LPN-C stated staff reported on January 31, 2022, during morning huddle R1 had a fall from the EZ stand mechanical lift the previous morning. LPN-C stated ULP-G reported ULP-A had transferred R1 alone, and the lift sling was not hooked up properly with only one side attached. LPN-C stated staff did not report the incident to the on call nurse. LPN-C stated during a night shift on January 31, 2021 R1 had complaints of pain and staff noted her ankle was swollen and painful. LPN-C stated stated the hospice nurse was not notified of the incident until February 1, 2022, then a X-ray was done with no acute fracture. On April 5, 2022, at 11:01 AM Maintenance Technician (MT)-F stated he was doing my morning rounds when one of the ULP's asked for help with a resident who fell in the lift. MT-F stated when he entered R1's room the lift sling was around R1 and only one loop was hooked to the lift arm. R1 was hanging the one hooked side, her knees were on the platform, and feet were on the ground curled under and right next to the bed.	02320		

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02320	Continued From page 34 MT-F stated R1 was yelling "Help me, help me" and crying. MT-F stated he did not report the incident to anyone. On April 5, 2022, at 10:33 a.m. RNCM-E stated the incident happened over the weekend and was reported Monday, January 31, 2022, during morning huddle. RNCM-E stated ULP-A was working independently, but her orientation process was not completed and she had not been confirmed to be safe on her own. RNCM-E stated ULP-A failed to check R1's care plan indicating R1 required two staff assist. RNCM-E stated ULP-A did not hook the sling strap into the lift all the way which caused the sling strap to slip off when the lift arms were raised up causing R1 to fall, then hang from the lift by one arm with her knees on the platform, and feet on the ground. RNCM-E stated she had completed an assessment of R1's injuries on Monday January 31, 2022, after being notified of the incident. However, the facility documentation had no record of a assessment being completed, and had no documentation the incident occurred. RNCM-E stated unlicensed staff involved indicated R1's ankle hurt a bit but she "seemed fine". RNCM-E stated staff completed and incident report at the time of the incident, however no incident report completed by the staff involved at the time of the incident was in R1's record. RNCM-E stated if any sort of incident occurred it was expected staff would report the incident to nursing staff immediately. RNCM-E verified staff did not report the incident until the next day. On April 15, 2022, at 1:38 p.m. ULP-G stated R1 was hanging in the lift by the strap around her belly and one loop, kneeling on the platform with her right leg cocked to one side and her foot	02320		

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02320	Continued From page 35 caught under her wheelchair. ULP-G stated R1 was yelling in pain crying "ouch ouch ouch, ow oh my God". ULP-G stated R1 was in pain and they needed help, she went to the door and Maintenance Technician (MT)-F and asked him to help lift the resident. ULP-G indicated it was an emergency and she needed to get R1 up or call 911 for assistance. ULP-G stated with MT-F's assistance they were able to get R1 on the bed and indicated she was still in pain after the incident. ULP-G stated she did not immediately report the incident, and stated she should have called the on call nurse, but did not report the incident till the next day during morning stand up but within 24 hours after the incident. On April 27, 2022, at 3:16 p.m. RNCM-E verified no incident report was completed until after the investigator was onsite. RNCM-E stated staff should have notified the on call nurse immediately after the incident occurred and verified they had not. RNCM-E indicated the incident report, resident assessment, investigation, and reporting of the incident was not done timely. RNCM-E stated ULP-A's skill checklist was reviewed on January 21, 2022, but ULP-A had not completed her onsite training, and was not verified as competent to work on her own at the time of the incident. RNCM-E indicated she did not know the exact date ULP-A had completed her training and was verified as competent but indicated it was prior to March 30, 2022. RNCM-E stated she was new and had not document when ULP-A's competency was completed. The facility policy and procedure titled "Reporting Documenting Reviewing Incidents Involving Residents", dated July 17, 2021, instructed staff to 1. Ensure the resident is safe 2. Immediately	02320		

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02320	Continued From page 36 notify the nurse onsite 3. If no nurse is available staff will update the on call RN, and get direction from the nurse. 4. Staff discovering the incident were to complete an incident report and provide the same to the quality management team via the Licensed Assisted Living Director, or Clinical Nurse Manager 5. The nurse would complete an assessment of the resident in a time frame that is reasonable following the incident. The nurse will document in the resident chart the details of any incident involving the resident and their assessment including follow up actions taken. 7. The physician, and resident representative would be notified of the incident and documented. R1's record lacked any documentation of the incident, completion of a incident report at the time the incident occurred, and appropriate notifications. In addition, facility documentation lacked any assessment of injuries completed after the incident occurred, and had no evidence of monitoring injuries until resolved, or plan of action taken after the incident occurred. Policy and procedure titled "Initial and Ongoing Assessment of the Resident" dated July 25, 2022, indicated the RN would conduct ongoing re-assessment and monitoring as needed based on changes in the residents condition or needs. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act.	02360		

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02360	Continued From page 37 This MN Requirement is not met as evidenced by: Based on observations, interviews, and document review, the licensee failed to ensure one of one residents (R1) reviewed were free from maltreatment. R1 was neglected. Findings include: On April 5, 2022, the Minnesota Department of Health (MDH) issued a determination that neglect occurred for R1, and the facility was responsible for the maltreatment in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	
03000 SS=D	626.557 Subd. 3 Timing of report (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).	03000		

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03000	Continued From page 38 (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee staff failed to immediately report potential suspected maltreatment to the common entry point for one of one resident's (R1), after an untrained, unlicensed staff neglected to follow R1's plan of care and incorrectly transferred R1 alone using a EZ stand mechanical lift. As a result, R1 fell from the lift and was injured. The incident was not reported until three days after it	03000		

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03000	Continued From page 39 occurred. 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 was admitted to the facility on May 18, 2021, with diagnoses including coronary artery disease, hypertension, right femur fracture, dementia without behavioral disturbances, and osteoarthritis. R1's service agreement effective November 29, 2021, indicated the resident was severely cognitively impaired and required a secure memory care. The service agreement indicated R1 was receiving hospice services and instructed staff to call the hospice nurse for questions, concerns, and updates. R1's service plan effective December 15, 2022, indicated R1 required physical assistance from two staff and a EZ stand mechanical lift for all transfers. The service plan indicated R1 required the second staff to physically assist the resident through the transfer. The undated facility investigation completed by the Registered Nurse Clinical Manager (RNCM)-E identified ULP-A was a new employee who had been working on her own for a few days at the time of the incident. The investigation	03000		

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03000	Continued From page 40 indicated the incident occurred on Sunday January 30, 2022, but was not reported internally to management or nursing until the following morning January 31, 2022. The investigation indicated ULP-A was getting R1 ready for the day and did not know R1 required two staff physical assistance with the EZ stand mechanical lift. ULP-A transferred the resident independently with the mechanical standing lift. ULP-A had not properly connected R1 to the lift and R1 fell. The investigation indicated R1 was observed hanging from the lift by one arm, with her knees on the platform, and her right foot sideways under her wheelchair. The resident did not have injuries noted until the evening of January 31, 2022, when a skin tear, pain, and swelling of her right foot was noted. The investigation indicated Hospice was notified of the incident on February 1, 2022, and an X-ray was completed with no fracture or dislocation noted. A incident report completed by RNCM-E on April 5, 2022, at 5:22 p.m. after the investigator entered the facility indicated the fall occurred on January 30, 2022, and incorrectly documented the time of occurrence at 7:00 p.m. The incident report indicated ULP-A had transferred R1 independently with the EZ stand mechanical lift when a strap slipped off and the resident dropped. The report indicated the resident had a skin tear on her right calf, and had right foot pain. The facility reported Minnesota Adult Abuse Reporting Center (MAARC) dated February 2, 2022, at 4:20 p.m. indicated the incident occurred on Sunday, January 30, 2022, at 8:00 a.m. The MAARC report indicated staff had not reported the incident until the following morning on Monday January 31, 2022. The incident was reported to MAARC on February 2, 2022, at 4:20	03000		

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03000	Continued From page 41 p.m. three days and eight hours after the incident occurred and over 24 hours after staff were made aware of the incident. On April 15, 2022, at 1:38 p.m. ULP-G stated she wrote down what happened on a piece of paper and slid it under one of the RN's doors the day of the incident. ULP-G stated ULP-A was assigned to work on her own, and had asked ULP-A to start getting R1 ready while she finished something at the medication cart. ULP-G stated ULP-A came out of R1's room screaming for help, and when she entered the room R1 had no safety strap on the lower part of her legs and the lift arms were raised up to the highest level with only one strap connected. ULP-G stated R1 was hanging in the lift by the strap around her belly and one loop, kneeling on the platform with her right leg cocked to one side and her foot caught under her wheelchair. ULP-G stated R1 was yelling in pain and they needed help so they stepped into the hallway and asked Maintenance Technician (MT)-F to help lift the resident. ULP-G stated she reported the incident the next morning. ULP-G stated she should have reported the incident to the RN on call but did not, and indicated since ULP-A was working independently she was responsible to report the incident. On April 5, 2022, at 10:05 a.m. Licensed Practical Nurse (LPN)-C stated R1 was assigned to ULP-A who was working independently on January 30, 2022. LPN-C stated on January 31, 2022, ULP-G initially reported to her R1 had a fallen from the EZ stand mechanical lift the previous morning. LPN-C stated staff did not immediately report the incident to the on call nurse as they should have. On April 5, 2022, at 10:33 a.m. RNCM-E stated the incident happened over the weekend and was	03000		

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03000	Continued From page 42 not reported by staff involved until Monday, January 31, 2022. RNCM-E stated ULP-A failed to check R1's care plan which directed R1 required two staff assistance and the EZ stand mechanical lift and ULP-A transferred R1 alone. . RNCM-E stated if any sort of incident occurred staff were expected to report the incident immediately, and verified the incident was not reported internally until the next day. RNCM-E stated a investigation should be done and a report made to the Minnesota Adult Abuse Reporting Center (MAARC) with in 24 hours of becoming aware of the incident. RNCM-E stated she waited to report to MAARC until after cooperate office reviewed the information from the incident to determine if the incident was reportable. The facility policy and procedure titled "Vulnerable Adult Maltreatment Policy" dated July 17, 2021, indicated the purpose was to establish guidelines for internal and external reporting of potential maltreatment of vulnerable adults. Section 3. titled "Immediate Steps - Witnessed Incident or Allegation of Maltreatment" indicated staff would intervene and ensure safety of the vulnerable adult and immediately notify the RN or Licensed Assisted Living Director (LALD). The policy indicated if neither were onsite staff were to notify the on call RN. If the alleged perpetrator was a staff person, they would be directed to leave the building immediately and not return to work until further notice. Section 4. titled "Reporting Maltreatment" indicated any staff person who witnesses or suspects maltreatment of a vulnerable adult will report the incident immediately. If the incident appears to be suspected abuse, neglect, or financial exploitation the RN or LALD would immediately make a report to the common entry point. The policy defined	03000		

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03000	Continued From page 43 immediately as no later than 24 hours after receiving initial knowledge the incident occurred. The procedure indicated if it was unclear weather maltreatment occurred an investigation will begin immediately, and indicated if with in 24 hours it was still unclear weather maltreatment occurred a report would be made to MAARC. Section 5. titled "Internal Investigation" indicated staff would complete an incident report and make appropriate notifications under section 3. The procedure indicated the RN, LALD, or designee would complete an internal investigation pertaining to the report of potential or suspected maltreatment. Section 6. titled "Education" indicated all staff were educated on reporting potential or suspected maltreatment of a vulnerable adult and their obligation to report as mandated reporters. The education included internal reporting process and the choice to report directly to MAARC. TIME PERIOD FOR CORRECTION: Seven (7) days	03000		
03030 SS=D	626.557 Subd. (4,a) Internal reporting of maltreatment (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section. (b) A facility with an internal reporting procedure that receives an internal report by a mandated	03030		

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03030	Continued From page 44 reporter shall give the mandated reporter a written notice stating whether the facility has reported the incident to the common entry point. The written notice must be provided within two working days and in a manner that protects the confidentiality of the reporter. (c) The written response to the mandated reporter shall note that if the mandated reporter is not satisfied with the action taken by the facility on whether to report the incident to the common entry point, then the mandated reporter may report externally. (d) A facility may not prohibit a mandated reporter from reporting externally, and a facility is prohibited from retaliating against a mandated reporter who reports an incident to the common entry point in good faith. The written notice by the facility must inform the mandated reporter of this protection from retaliatory measures by the facility against the mandated reporter for reporting externally. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to immediately report potential maltreatment and do a thorough investigation for one of one resident, R1, who fell from a EZ stand mechanical lift when a untrained unlicensed staff neglected to follow R1's plan of care and incorrectly transferred R1 alone. As a result, R1 fell from the lift and was injured. The incident was not internally reported until the following day, and was not reported to the common entry point until three days after the incident occurred. 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	03030		

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03030	Continued From page 45 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 was admitted to the facility on May 18, 2021, with diagnoses including coronary artery disease, hypertension, right femur fracture, dementia without behavioral disturbances, and osteoarthritis. R1's service agreement effective November 29, 2021, indicated she was severely cognitively impaired and required a secure memory care. The service agreement indicated R1 was receiving hospice services and instructed staff to call the hospice nurse for questions concerns and updates. R1's service plan effective December 15, 2022, indicated the resident required physical assistance from two staff and a EZ stand mechanical lift for all transfers. The service plan indicated R1 required the second staff to physically assist the resident through the transfer. The undated facility investigation completed by the Registered Nurse Clinical Manager (RNCM)-E identified ULP-A was a new employee who had been working on her own for a few days at the time of the incident. The investigation indicated ULP-A was getting R1 ready for the day and forgot she required two staff physical assistance with the EZ stand mechanical lift and transferred the resident alone. The investigation indicated the resident was not properly connected to the lift and fell. The resident was hanging from the lift by one arm and kneeling on the platform	03030		

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03030	Continued From page 46 with her right foot sideways under the wheelchair. The investigation indicated the incident occurred on January 30, 2022, was not reported to the facility until the following morning January 31, 2022, during a nursing huddle. The investigation indicated the resident did not have pain or concerns until the evening of January 31, 2022, when a skin tear pain and swelling was reported by an unlicensed staff. The investigation indicated hospice was not notified of the incident the following day on February 1, 2022, and X-ray was completed with no fracture or dislocation noted. A incident report completed by RNCM-E on April 5, 2022, at 5:22 p.m. after the investigator entered the facility indicated the fall occurred on January 30, 2022, and incorrectly documented the time at 7:00 p.m. The incident report indicated ULP-A had transferred R1 independently with the EZ stand mechanical lift when a strap slipped off and the resident dropped. R1 was hanging onto the lift by one arm and her knees were on the platform with her legs to the side. The report indicated the resident received a skin tear on her right calf, and had right foot pain. Facility documentation titled "Assisted Living New Hire RA Competency Skill Checklist" indicated ULP-A's skills were reviewed on January 21, 2022. However, the document indicated ULP-A had not been verified as competent to perform tasks including operation of the EZ stand mechanical lift until March 30, 2022, two months after the incident occurred. Document titled Mechanical Stand, identified by the facility as lift re-education dated February 2, 2022, indicated RNCM-E provided coaching education on use of the EZ stand mechanical lift. Lift training and competency completed prior to	03030		

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03030	Continued From page 47 the incident was requested, none was provided. ULP-A's personnel training records indicated she had not completed training and competency for using a mechanical standing lift to transfer residents at the time of the incident. On April 27, 2022, at 3:16 p.m. RNCM-E stated ULP-A's skill checklist was reviewed on January 21, 2022, but ULP-A had not completed her onsite training, and was not verified as competent to work on her own. RNCM-E indicated she did not know the exact date ULP-A had completed her training and was verified as competent but indicated it was prior to March 30, 2022. RNCM-E stated she was new and had not document when ULP-A's competency was completed. On April 15, 2022, at 1:38 p.m. ULP-G stated she should have called the on call nurse, but did not, and indicated she did not report the incident till the next day during morning stand up but within 24 hours after the incident. On April 5, 2022, at 10:05 a.m. licensed practical nurse (LPN)-C stated the incident was reported to her on January 31, 2022, during morning huddle. LPN-C stated ULP-G reported ULP-A transferred R1 alone and the lift sling was not hooked up properly. LPN-C stated no call was made to report the incident to the on call nurse. LPN-C stated during a night shift on January 31, 2021 R1 had complaints of pain and staff noted her ankle was swollen and painful. LPN-C stated stated the hospice nurse was not notified of the incident until February 1, 2022, then a X-ray was done with no acute fracture identified. On April 5, 2022, at 11:01 AM Maintenance Technician (MT)-F stated he was doing my	03030		

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03030	Continued From page 48 morning rounds when one of the ULP's asked for help with a resident who fell in the lift. MT-F stated when he entered R1's room the lift sling was around R1 and only one loop was hooked to the lift arm. R1 was hanging the one hooked side, her knees were on the platform, and feet were on the ground curled under and right next to the bed. MT-F stated R1 was yelling "Help me, help me" and crying. MT-F stated he did not report the incident to anyone. On April 5, 2022, at 10:33 a.m. RNCM-E stated staff completed and incident report at the time of the incident, however no incident report completed by the staff involved at the time of the incident was provided. RNCM-E stated staff were expected to report the incident to nursing staff immediately. RNCM-E verified staff did not report the incident until the next day. The facility policy and procedure titled "Vulnerable Adult Maltreatment Policy" dated July 17, 2021, indicated the purpose was to establish guidelines for internal and external reporting of potential maltreatment of vulnerable adults. Section 3. titled "Immediate Steps - Witnessed Incident or Allegation of Maltreatment" indicated staff would intervene and ensure safety of the vulnerable adult and immediately notify the RN or Licensed Assisted Living Director (LALD). The policy indicated if neither were onsite staff were to notify the on call RN. If the alleged perpetrator was a staff person, they would be directed to leave the building immediately and not return to work until further notice. Section 4. titled "Reporting Maltreatment" indicated any staff person who witnesses or suspects maltreatment of a vulnerable adult will report the incident immediately. If the incident appears to be suspected abuse, neglect, or financial exploitation	03030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30638	A. BUILDING: _____ B. WING _____	C 04/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECUMEN NORTH BRANCH	5379 383RD STREET NORTH BRANCH, MN 55056

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03030	Continued From page 49 the RN or LALD would immediately make a report to the common entry point. The policy defined immediately as no later than 24 hours after receiving initial knowledge the incident occurred. The procedure indicated if it was unclear weather maltreatment occurred an investigation will begin immediately, and indicated if with in 24 hours it was still unclear weather maltreatment occurred a report would be made to MAARC. Section 5. titled "Internal Investigation" indicated staff would complete an incident report and make appropriate notifications under section 3. The procedure indicated the RN, LALD, or designee would complete an internal investigation pertaining to the report of potential or suspected maltreatment. Section 6. titled "Education" indicated all staff were educated on reporting potential or suspected maltreatment of a vulnerable adult and their obligation to report as mandated reporters. The education included internal reporting process and the choice to report directly to MAARC. TIME PERIOD FOR CORRECTION: Seven (7) days	03030		