STATE LICENSING COMPLIANCE REPORT

Report #: HL306666044C

Date Concluded: January 9, 2024

Name, Address, and County of Facility Investigated:
Maple Woods Assisted Living
40170 County Road 257
Cohasset, MN 55721
Itasca County

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

Evaluator's Name: Barbara Axness, RN
Special Investigator

The Minnesota Department of Health conducted a complaint investigation to determine compliance with state laws and rules governing the provision of care under Minnesota Statutes, Chapter 144G. The purpose of this complaint investigation was to review if facility policies and practices comply with applicable laws and rules. No maltreatment under Minnesota Statutes, Chapter 626 was alleged.

To view a copy of the correction orders, if any, please visit: https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html, or call 651-201-4201 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached state form.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30666	A. BUILDING: _____ B. WING _____	C 11/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE WOODS ASSISTED LIVING	40170 COUNTY ROAD 257 COHASSET, MN 55721

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL306669745M /#HL306667782C #HL306666044C On November 27, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider. At the time of the complaint investigation, there were 18 residents receiving services under the provider's Assisted Living with Dementia Care license. The following immediate correction order is issued. Correction orders with a period to correct that are not immediate may be issued at a later date during the investigation. The following immediate correction order is issued issued for #HL306666044C, tag identification 2070. The immediacy was removed on December 4, 2023, however noncompliance remained at a lowered scope and severity of F. The following orders are issued issued for	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	

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0 000	Continued From page 1 #HL306666044C, tag identification 0430, 0450, 0470, 0485, 0490, 0510, 0530, 0620, 0700, 1290, 1620, 2310, 2370, 2480. The following correction orders are issued for #HL306669745M/HL306667782C, tag identification 0620, 1640, 2360.	0 000		
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the uniform checklist disclosure of services (UDALSA) accurately reflected services provided by the licensee. This had the potential to affect all residents.	0 430		

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0 430	Continued From page 2 This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee's UDALSA, last updated May 1, 2023, indicated there was a licensed assisted living director on site full time. On November 29, 2023, at 4:35 p.m., licensed assisted living director (LALD)-D confirmed she was the director of record for two facilities and was not on site full time. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430		
0 450 SS=F	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall: (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and	0 450		

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0 450	Continued From page 3 evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide services in a person-centered manner for four of four residents (R2, R3, R4, R7). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: RESIDENTS LEFT AT TABLE AFTER MEALS R4 R4's diagnoses included dementia, memory loss, and late onset Alzheimer's disease without behavioral disturbance. R4's most recent assessment dated October 12, 2023, indicated the resident required an assist of two staff members and a mechanical lift to transfer. The resident was dependent on staff for wheelchair mobility. On November 27, 2023, at 10:10 a.m., R4 was observed sitting in her wheelchair at the dining room table of the memory care unit.	0 450		

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0 450	Continued From page 4 On November 27, 2023, at 10:40 a.m., R4 was observed sitting in her wheelchair at the dining room table of the memory care unit. The resident's breakfast dishes were in front of her and she had finished eating breakfast. The resident appeared to be sleeping. On November 27, 2023, at 11:40 a.m., R4 was observed sitting in her wheelchair at the dining room table of the memory care unit. The resident's breakfast dishes were in front of her and she had finished eating breakfast. The resident appeared to be sleeping. On November 27, 2023, at 12:15 p.m., R4 was observed sitting in her wheelchair at the dining room table of the memory care unit having lunch. R7 On November 27, 2023, at 7:55 a.m., R7 was observed sitting in her wheelchair at the dining room table of the assisted living unit. On November 27, 2023, at 8:40 a.m., R7 was observed sitting in her wheelchair at the dining room table of the assisted living unit. The resident's breakfast dishes were in front of her and she had finished eating breakfast. On November 27, 2023, at 9:15 a.m., R7 was observed sitting in her wheelchair at the dining room table of the assisted living unit. The resident's breakfast dishes were in front of her and she had finished eating breakfast. On November 27, 2023, at 11:50 a.m., clinical nurse supervisor (CNS)-A stated residents are scheduled to be toileted and/or repositioned every three hours and should not be left at the table for extended periods of time. CNS-A stated some	0 450		

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0 450	Continued From page 5 residents preferred to sit out at the table in the common areas. MEDICATIONS GIVEN DURING MEALS On November 27, 2023, at 9:10 a.m., unlicensed personnel (ULP)-B was observed preparing medications to administer to R3. ULP-B brought the resident's medications, including insulin, to the resident as she was eating breakfast at the table in the assisted living dining room. ULP-B was observed administering the resident's insulin in front of two other residents at the table. R3 took her medications and used her inhaler at the table. COURTEOUS TREATMENT R2's diagnoses included dementia, cognitive dysfunction, altered mental status, psychosis, and anxiety. R2's most recent assessment dated November 21, 2023, indicated the resident had a history of traumatic brain injury and had difficulty concentrating or paying attention, was easily disoriented, and had impaired judgment. The resident had a history of eloping and wandering. The assessment indicated the resident had "difficulty weighing advice, impaired judgment and can be impulsive." On November 27, 2023, at 10:05 a.m., R2 was sitting next to the investigator in a common area on the assisted living side. ULP-B approached R2 and told the resident it was time to go back to the memory care side. ULP-B stated, "I let you come down here, if you can't listen, I can't let you come down here anymore. R2 did not respond to	0 450		

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0 450	Continued From page 6 ULP-B. ULP-B walked away and left the resident sitting at the table with the investigator. On November 27, 2023, at 11:05 a.m., the investigator observed three residents sitting at a table in the dining room of the memory care unit. The three residents were calmly talking with each other. ULP-B walked by the residents and a resident asked if there was any coffee down here. ULP-B told the resident there was not any and kept walking. A resident was overheard saying, "oh well, I asked." At 11:12 a.m., ULP-B returned to the memory care unit with a carafe of coffee. Before serving the coffee to the residents, ULP-B stated, "you don't know what I had to do to get this for you. I had to fly all the way to Europe and hand pick it." ULP-B continued to elaborately describe the lengths she had to go to in order to get coffee. A resident raised her voice and said to ULP-B, "Stop it with your shit. I just said it God damn it." ULP-B laughed at the resident and left the unit. For several minutes after ULP-B left the unit, the agitated resident was swearing at the other two residents at the table and accusing them of "being a God damn bitch. It's enough to make anyone swear." On November 27, 2023, at 12:45 p.m., licensed assisted living director (LALD)-D stated staff should be using a person-centered approach when interacting with residents. The licensee's Person Centered Care policy, dated September 19, 2022, indicated facility staff would work with providers and resident teams to provide care that's guided and informed by patient goals, preferences, and values. No further information was provided.	0 450		

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0 450	Continued From page 7 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 450		
0 470 SS=I	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide sufficient staffing to adequately meet resident needs for	0 470		

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0 470	Continued From page 8 two of two residents (R1, R2) with records reviewed. In addition, the licensee failed to ensure sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis. 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: STAFFING TO MEET RESIDENT NEEDS The licensee held an Assisted Living with Dementia Care license with a capacity of 30 residents and had a current census of 18 residents (ten residents residing in the memory care secured unit, eight residents residing in the assisted living secured units.) The physical layout of the facility consisted of two secured units. The assisted living and memory care were connected by a link that was separated from the units by fire exit doors, which required a key code to open. The licensee failed to develop and implement a staffing plan for determining its staffing level that: - ensured sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and	0 470		

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0 470	Continued From page 9 - ensured that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility. The licensee's Direct-Care Staffing Plan, last revised November 20, 2023, indicated when residents required a two-person assist, there would be a minimum of two staff available at all times. The plan indicated, "because of the number of resident service hours required on NOC (overnight) shift, the secured doorways between units will be open and not locked in order to create one unit for a single staff person to manage. The entire building is secured thereby mitigating elopement risk for the traditional secured units B and C." The plan further indicated "If there are call ins from staff and the organization must utilize two staff, the doors between secured units B and C will be unlocked creating one unit and one staff person will manage these two units." The staffing plan did not address how unit A, the locked assisted living unit, would be staffed. During observations on November 27, 2023, the doors between units B and C were open and unlocked. The staffing plan indicated there were 18 resident service hours on the day shift, 15 resident service hours on the PM shift, and 6.5 resident service hours on the night shift, for a total of 39.5 resident service hours per day. A daily service minute summary dated December 4, 2023, indicated during the week there was an average of 87 scheduled resident service hours per day and 78 scheduled resident service hours per day on weekends. The report did not factor in unscheduled services or additional tasks completed by staff on weekends like activities	0 470		

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0 470	Continued From page 10 and meal preparation. The licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA), last updated May 1, 2023, indicated on page 2, the number of unlicensed direct care staff typically scheduled per shift were: 2 ULP on the day shift 2 ULP on the evening shift 2 ULP on the overnight shift On November 27, 2023, the investigator requested a copy of the schedule reflecting actual hours worked. Individual employee time cards were provided. Time cards for all employees, including nursing management, from November 6, 2023, through November 19, 2023 were reviewed and the schedule of actual hours worked were: -November 6, 2023, two ULP worked on the day, evening, and overnight shift. -November 7, 2023, two ULP worked on the day, evening, and overnight shift. -November 8, 2023, two ULP worked on the day and evening shift. Only one ULP worked the overnight shift. -November 9, 2023, two ULP worked on the day, evening, and overnight shift. -November 10, 2023, one ULP was working from 7:00 a.m. to 8:00 a.m., when a second ULP came in. Two ULP worked the evening and overnight shift. -November 11, 2023, two ULP worked on the day, evening, and overnight shift. -November 12, 2023, two ULP worked on the day and evening shift. Only one ULP worked after midnight. -November 13, 2023, one ULP worked on days, two ULP worked on the evening and overnight shift.	0 470		

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0 470	Continued From page 11 -November 14, 2023, two ULP worked on days, two ULP worked on the evening shift but one left early leaving only one ULP working from 9:30 p.m. to 10:45 p.m. One ULP worked the night shift. -November 15, 2023, two ULP worked on the day and evening shift, one ULP worked the overnight shift from 10:30 p.m. to midnight until a second ULP came in at midnight. -November 16, 2023, two ULP worked on days, two ULP worked on evenings until 9:00 p.m., leaving one ULP working from 9:00 p.m. to 10:00 p.m., and two ULP worked the overnight shift. -November 17, 2023, two ULP worked on days, two ULP worked on evenings until 9:00 p.m., leaving one ULP working from 9:00 p.m. to 10:50 p.m., and two ULP worked the overnight shift. -November 18, 2023, two ULP worked the day and evening shift. Only one ULP worked the overnight shift. -November 19, 2023, one ULP worked the day shift. Two ULP worked the evening shift until 3:00 p.m., where there was only one ULP on from 3:00 p.m. to 5:00 p.m., when a second person came in. Only one ULP worked the night shift. Over the two week period, 11 individual instances were identified where only one ULP was working in the facility. On November 29, 2023, at 5:10 p.m., LALD-D was asked how resident minutes were calculated and if unscheduled tasks and tasks like cooking and activities were considered with the numbers. LALD-D stated they had gone through RTasks (electronic medical record) "and it tallies it up, we use that formula then we review that based on what resident needs are." LALD-D stated they look at the auto populated minutes as RTasks can under estimate the actual time it takes to	0 470		

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0 470	Continued From page 12 complete a task like assigning five minutes to complete a hoyer transfer as it would take longer than five minutes to do that transfer. LALD-D stated there were about eight residents on both sides that are on toileting plans or need repositioning every three hours, as well as safety checks. LALD-D stated while they do not have activities or kitchen staff on weekends, they use the same staffing formula as they do not offer baths or showers on the weekends so the time comes out the same. LALD-D stated she felt two ULP for each shift was sufficient and "they've been able to complete those tasks in a timely manner...From my perspective, I've worked on the floor and if we're prioritizing what we need to do, there's no issues, that's where we're working with staff on how to manage their day." LALD-D stated the section of the staffing plan addressing opening doors to allow one staff member to cover the whole building was part of their emergency plan and should be used in emergencies when staff call in. On November 29, 2023, at 9:50 a.m., clinical nurse supervisor (CNS)-A stated, "Ideally we want three as the goal what we want and strive for but sadly it's not always an option for us so we have the two. It can be done, [with two staff working] it is done. Monday [November 27, 2023] was definitely an off day, I'm sure you hear that a lot it was really a rough day." CNS-A stated the facility does not have a mandating policy in place so the RN on call would be notified and they would cover the floor if they couldn't fill the shift. CNS-A stated she figured two or three times in a week they would be short staffed. CNS-A stated LALD-D does the schedule and she doesn't have much involvement in it. CNS-A stated they do not maintain a schedule of actual hours worked but they'll make notes on time cards if someone calls	0 470		

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	30666	A. BUILDING: _____ B. WING _____	C 11/27/2023

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0 470	Continued From page 13 in or leaves early. On November 27, 2023, at 8:45 a.m., R3 stated she often waits a long time for call lights to be answered and there are times there isn't a staff member on her side as there's only one person working. R3 stated "they tell us this is your home, but it doesn't feel like it." On November 27, 2023, at 11:30 a.m., family member (FM)-P stated it "seems like the facility is very short handed...there's times I come in and I get [resident] up and dressed, I'm not sure if she's even had breakfast." FM-P stated she had raised concerns to management that [resident] had not received a bath on occasions. On November 28, 2023, at 6:30 p.m., family member (FM)-O stated he came to visit his relative one day and there was poop all over his chair and when he returned a few days later, the poop was still dried to the chair so he had to clean it himself. FM-O stated "they were so understaffed" and meals could be served late or with modifications that weren't on the menu. On November 28, 2023, at 7:15 p.m., family member (FM)-N stated there was a significant lack of staff at the facility and "we'd wait 15 minutes just to have someone come let us in the building." FM-N stated many times there was only one person in the building and finding help could take a long time. FM-N stated his relative eventually discharged from the facility due to their concerns over adequate staffing. On November 29, 2023, at 11:40 a.m., family member (FM)-M stated the facility seems to do ok during the week and there are numerous people running around to help out but with cooking or	0 470		

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0 470	Continued From page 14 cleaning on weekends, "staff is cut pretty short." On November 30, 2023, at 9:15 a.m., family member (FM)-L stated the facility seems short staffed and it's not unusual for someone to not show up for their shift. On November 30, 2023, at 9:30 a.m., family member (FM)-F stated his relative will often voice concerns about having to wait for staff assistance or have her call light answered. On December 1, 2023, at 8:50 a.m., CNS-A was asked about the hours worked as reflected on the time cards and if there were days where only one ULP was working. CNS-A confirmed there were some days where only one staff person was on and that's when they'd use their emergency plan and open the connecting doors to make one unit. CNS-A was asked if routine call ins or holes in the schedule would justify activating the emergency response plan. CNS-A stated she was not sure. On December 4, 2023, at 1:30 p.m., a resident's case manager (CM)-K stated she has been told by one of the residents at the facility that she went from getting a shower two or three times per week to once a week due to staffing and she was upset they were no longer able to accommodate her preferences. On December 4, 2023, at 1:40 p.m., a resident's case manager (CM)-J stated she had concerns on sufficient staffing and if the resident's care needs could be met appropriately. CM-J stated one day when she came to visit a client of hers, she found the resident crying in bed with a soaked brief. The resident told her she had been pushing her call button but no one came. CM-J stated she went to go look for staff and found two	0 470		

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0 470	Continued From page 15 employees in the hallway talking. CM-J stated she asked the staff members if they had seen the resident's light was on and was told by a staff member that "she was just in there and had checked on her an hour ago and she doesn't have to go." CM-J stated she told the staff "that may be but can you hear her in there crying, she said no one has been in there and she needs to be toileted so you should go in there and check." CM-J stated sometimes it can be difficult to find staff and she has come in to visit her clients and couldn't find anyone on the assisted living side and had to go to the memory care side to find staff. R1 R1's diagnoses included type two diabetes, hemiplegia (weakness on one side of the body) and hemiparesis (weakness on one entire side of the body) following cerebral infarction (stroke) affecting left non dominant side, and dysarthria (difficulty in speech due to weakness of speech muscles). R1's service plan dated August 11, 2023, indicated the resident received assistance with meals. R1's most recent assessment dated November 2, 2023, indicated the resident had "orders for a minced and moist diet, and back on nectar thick liquids with the exception she may have thin water. She is non compliant with this diet. She will refuse to eat if what she is brought does not suit her desires. Staff offer alternatives, but this is not always successful." The resident was noted to be independent with feeding after set up. "Per OT [occupational therapy] she should utilize a divided plate and dycem for self feeding. Resident will often tell staff she is not able to self feed and will	0 470		

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0 470	Continued From page 16 refuse to eat if staff do not hand feed her. Staff to ensure resident has the needed adaptive equipment to ensure self feeding is manageable." The resident was noted to need supervision while eating "due to difficulty eating/swallowing." Staff were to remind the resident to slow down while eating and encourage the resident to follow diet orders. On November 27, 2023, at 7:58 a.m., R1's call light was observed to be on. At 8:15 a.m., R1's call light was still on and the display showing call lights indicated it was at "manager level." On November 27, 2023, at 8:45 a.m., R3 stated she often has to help R1 eat otherwise staff are too busy to feed her. R3 stated if the resident has been sitting at the table for a while and isn't able to feed herself, she will help feed the resident. On November 27, 2023, at 9:00 a.m., R1 was observed being fed breakfast by R3. R3 was assisting R1 eat a bowl of mixed fruit. Dycem and other adaptive eating supplies were not present. Staff were not present in the dining room while R1 was eating. On November 27, 2023, at 9:10 a.m., ULP-B was asked if R3 usually feeds R1 and if R1 needs assistance with eating. ULP-B stated R3 will help feed R1 at times. In regards to R1 being able to feed herself, ULP-B stated, "She can. Is it easy for her, no. But, she can." On November 27, 2023, at 12:15 p.m., R1 was observed being fed lunch by R3. After kitchen staff served food, R1 was left unsupervised in the dining room. On November 29, 2023, at 9:45 a.m., clinical	0 470		

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0 470	Continued From page 17 nurse supervisor (CNS)-A stated the resident does not follow her diet of thickened liquids "but we have a risks versus benefits signed, she does know." CNS-A stated she had never observed any other residents feeding R1 but that would be concerning. CNS-A stated R1 should not be left unsupervised while eating. On December 1, 2023, at 9:20 a.m., registered nurse (RN)-H stated R1 was supposed to have a minced and moist diet "as she's an aspiration risk, she eats too fast." RN-H stated the resident should have dycem under her plate and use a lipped plate to increase her independence. RN-H stated she was not aware of the resident ever being fed by another resident but agreed it was "absolutely not safe. She should have supervision by staff in case they need to be there if she's choking or can't feed herself." RN-H stated providing supervision with the current staffing structure was "probably not realistic." On November 29, 2023, at 4:10 p.m., licensed assisted living director (LALD)-D stated R1 can eat independently with supervision. LALD-D stated she felt R1 was ok to eat unsupervised because "she hasn't been assessed not to, she hasn't choked, and she has a call pendant to push." LALD-D stated their average call light response time was around five to ten minutes. LALD-D stated she was not aware of R1 being fed by another resident. R2 R2's diagnoses included dementia, cognitive dysfunction, altered mental status, psychosis, and anxiety. R2's service plan dated September 15, 2022, indicated the resident received behavior	0 470		

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0 470	Continued From page 18 management services. R2's most recent assessment dated November 21, 2023, indicated the resident had a pattern of wandering and staff were to "watch closely and be sure that the unit is secured at all times." On November 27, 2023, at 9:35 a.m., R2 was observed sitting alone on a soft in the assisted living common area. On November 27, 2023, at 9:57 a.m., R2 walked through the assisted living unit common areas. R2 was observed trying to open exterior doors. On November 27, 2023, at 10:04 a.m., R2 was observed trying to go back to the memory care unit. R2 was unable as the door was locked. R2 came and sat next to the investigator. On November 27, 2023, at 10:05 a.m., R2 was sitting next to the investigator in a common area on the assisted living side. ULP-B approached R2 and told the resident it was time to go back to the memory care side. ULP-B stated, "I let you come down here, if you can't listen, I can't let you come down here anymore. R2 did not respond to ULP-B. ULP-B walked away and left the resident sitting at the table with the investigator. On November 27, 2023, at 11:40 a.m., R2 was observed sitting at a table in the assisted living common area. On November 29, 2023, at 10:10 a.m., CNS-A stated R2 does not go from unit to unit and if he was over in the assisted living side, he should be with a staff member. CNS-A stated on the morning of November 27th, R2 was "having an off morning."	0 470		

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0 470	Continued From page 19 On November 29, 2023, at 4:35 p.m., LALD-D stated it would not be normal for R2 to roam freely between the two units and unless he was with a staff member, he should not be over on the assisted living side. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 485 SS=C	144G.41 Subdivision 1. (13)(i)(A)and(C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post a menu a week	0 485		

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0 485	Continued From page 20 in advance that was made available to all residents. In addition, the licensee failed to ensure residents were informed in advance of menu changes. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The initial complaint document indicated residents were not being fed properly and one weekend, the owner showed up for lunch with loaves of bread and made peanut butter sandwiches for everyone. On November 27, 2023, the investigator was not able to locate a menu posted in the memory care unit. A menu was posted to the refrigerator of the assisted living unit. Menus provided to the investigator included the following: Monday Breakfast: Hot/cold cereal, toast, muffins, tropical fruit Lunch: leftovers or sandwich, pasta salad, cheese and crackers with summer sausage, fruit, veggies, and chips Dinner: Goulash, green beans, buttered bread, pineapple tidbits	0 485		

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0 485	Continued From page 21 Saturday: Breakfast: Fruit filled pancake wraps, cheese omelet, bacon, cereal, toast, peaches Lunch: scalloped potatoes and ham, carrots, dinner roll, brownies Dinner: BBQ ribs, potato wedges, bread, corn, mandarin orange cookie salad Sunday: Breakfast: eggs scrambled with potatoes, peppers, onions, and sausage, raisin toast, pears Lunch: country fried steak, mashed potatoes and gravy, broccoli, fresh fruit Dinner: Swedish meatballs over egg noodles, California blend veggies, oatmeal cream pies On November 27, 2023, breakfast on the assisted living unit was observed to be cold cereal, tropical fruit, and toast. Breakfast on the memory care unit was observed to be pancakes. The investigator did not observe any muffins served for breakfast at the facility. On November 27, 2023, lunch on the assisted living unit was observed to be a sausage, vegetables, fruit from breakfast, and pudding. Lunch on the memory care unit was observed to be chili. On November 27, 2023, at 8:50 a.m., R3 stated she and other residents had voiced concerns about food, especially on weekends when there is no cook. R3 stated there have been times everyone was served sandwiches for the meal and they aren't made aware of changes to the menu. On November 27, 2023, at 11:15 a.m., dietary aide (DA)-Q stated she works Monday through Friday 9:00 a.m. to 5:00 p.m. and she prepares	0 485		

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0 485	Continued From page 22 things for the unlicensed personnel to cook on weekends. DA-Q stated for today's meal, she only had enough leftovers for one side to have chili so the other side would have ham, green beans, and potatoes. DA-Q stated they try to stick to the menu but sometimes it will change. DA-Q was not sure how residents were notified of changes with the menu. On November 27, 2023, at 11:30 a.m., activities coordinator (AC)-G stated she is responsible for snacks during the week and she leaves snacks for staff to put out on weekends. AC-G stated there wasn't a snack calendar posted anywhere but she tries to offer granola bars, cookies, cheese and crackers, grapes, oranges, bananas. AC-G stated she wasn't sure if staff served the snacks over the weekends and confirmed a bag of popcorn intended for a weekend snack was still sitting unopened on the table. On November 27, 2023, at 11:45 a.m., clinical nurse supervisor (CNS)-A stated "There are occasions where they had to change whatever was on for that day if they didn't have enough supplies to feed everyone so have had to switch before. I'm assuming the delivery order was screwed up, I don't deal a whole lot with that." CNS-A was not sure how residents were notified of changes with the menu. On November 29, 2023, licensed assisted living director (LALD)-D stated she was not aware of any incidents where there were issues with serving or preparing meals on weekends. LALD-D stated, "We have not run into any issues, everything is prepped and everything is step by step, I've come in on weekends it's very easy to do. There's always going to be issues like any household but we always make a very good meal	0 485		

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0 485	Continued From page 23 on weekends, no issues everything's always prepped we have all week to make sure we have what we need at facility." LALD-D stated she felt the staffing on weekends was sufficient to ensure meals were prepared and made as planned. Attempts to contact the facility owner to discuss the initial allegations were unsuccessful. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 490 SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced	0 490		

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0 490	Continued From page 24 by: Based on observation, interview and record review, the licensee failed to have daily programs of social and recreational activities based on individual and group interests, physical, mental, and psychosocial needs. This had the potential to affect all residents of 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: On November 27, 2023, the investigator was unable to locate an activities calendar posted in a common area of the facility. On November 28, 2023, the investigator was provided copies of the October and November 2023 activities calendar. The calendar was used for both the assisted living and memory care residents. The provided calendars listed one activity per day, but no times or locations were listed. The activity for November 27, 2023, was card making. During observations from 7:45 a.m. to 12:30 p.m., the investigator did not observe any card making activities. Activities coordinator (AC)-G was observed making crafts with one resident in the assisted living common area. The activities calendar indicated the following activities were scheduled: November 24th: Coffee, tea or cocoa with a movie	0 490		

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0 490	Continued From page 25 November 25th: Social hour November 26th: music therapy On November 27, 2023, at 8:45 a.m., R3 stated over the weekend no activities were offered because staff didn't have time to do them. R3 stated they were supposed to have a movie and popcorn, but no one put one on. R3 stated the popcorn left out for staff to serve was still in the activities room. On November 27, 2023, at 9:00 a.m., the investigator observed an unopened bag of popcorn in the activities area. On November 27, 2023, at 11:00 a.m., AC-G stated she had just started in her position in July and was working on establishing the activities programming. AC-G stated she works from 9:00 a.m. to 5:00 p.m. and wasn't sure what staff did when she was not on site. AC-G stated she would leave activities for staff to do and assumed they would do them but stated some staff were better than others at ensuring activities were completed. On November 27, 2023, at 11:45 a.m., R3 was observed talking to AC-G. R3 reported to AC-G that activities did not occur over the weekend due to staffing. On November 30, 2023, at 9:50 a.m., clinical nurse supervisor (CNS)-A stated the activities calendar should have times on it but wasn't sure what was posted. CNS-A stated, "[AC-G] is kinda newer to this and I know [licensed assisted living director] has been working with her but I'm not sure if it got that far or not." On November 30, 2023, at 4:30 p.m., licensed assisted living director (LALD)-D stated they have	0 490		

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	30666	A. BUILDING: _____ B. WING _____	C 11/27/2023

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0 490	Continued From page 26 an activities coordinator on site 8 hours a day during the week and she does many activities and one on ones. CNS-A stated she wasn't aware they needed to put details like time and location on the calendar. On December 1, 2023, at 9:40 a.m., registered nurse (RN)-H stated there should be a calendar with dates, times, locations and should be individualized to each specific resident so would reflect things the assisted living residents could do and memory care residents could do. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 490		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program that	0 510		

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0 510	Continued From page 27 complies with accepted health care, medical, and nursing standards for infection control related to soiled linens. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On November 27, 2023, at 8:40 a.m., a pile of visibly soiled linens were observed at the end of the hallway. A pile of visibly soiled linens and a soiled soaker pad were observed on the floor of a resident's room. On November 27, 2023, at 10:30 a.m., a pile of visibly soiled linens were observed at the end of the hallway. A pile of visibly soiled linens and a soiled soaker pad were observed on the floor of a resident's room. On November 29, 2023, at 9:45 a.m., clinical nurse supervisor (CNS)-A confirmed dirty linens should be put in a laundry basket and be brought down to the laundry room instead of left in the hallway or on the floor. On November 29, 2023, at 4:30 p.m., licensed assisted living director (LALD)-D confirmed staff should not be putting soiled linens on the floor and they should be using a laundry basket if they can't get to the laundry room right away.	0 510		

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0 510	Continued From page 28 The licensee's Infection Prevention and Control Program policy, last updated February 19, 2023, indicated the licensee had a policy for disposal of contaminated materials, personal protective equipment, hand hygiene, standard precautions, TB [tuberculosis] program, disinfecting equipment and surfaces, quality program, and staff illness policy. The policy did not give guidance on how soiled linens should be handled. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 530 SS=C	144G.41 Subd. 5 Resident councils The facility must provide a resident council with space and privacy for meetings, where doing so is reasonably achievable. Staff, visitors, and other guests may attend a resident council meeting only at the council's invitation. The facility must designate a staff person who is approved by the resident council to be responsible for providing assistance and responding to written requests that result from meetings. The facility must consider the views of the resident council and must respond promptly to the grievances and recommendations of the council, but a facility is not required to implement as recommended every request of the council. The facility shall, with the approval of the resident council, take reasonably achievable steps to make residents aware of upcoming meetings in a timely manner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to designate a staff person who is	0 530		

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0 530	Continued From page 29 approved by the resident council to be responsible for providing assistance and responding to written requests that result from resident council meetings. This has the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On November 27, 2023, at 8:45 a.m., R3 stated residents had made requests to have a resident council meeting over the last few months. R3 stated the facility has yet to designate someone to help them with their meetings and get things started. R3 stated facility management will tell them it's something they're working on but nothing has been implemented over several months of asking to have resident council. On November 27, 2023, at 11:00 a.m., activities coordinator (AC)-G stated she was aware residents have made requests to do a resident council but one has not been set up yet. On November 30, 2023, at 4:30 p.m., licensed assisted living director (LALD)-D stated they were still working on getting resident council set up and she was aware some residents had requested it. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 530		

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0 530	Continued From page 30 (21) days	0 530		
0 620 SS=E	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter	0 620		

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0 620	Continued From page 31 knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment for two of two residents (R2, R3) reviewed for maltreatment. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the	0 620		

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0 620	Continued From page 32 situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2 The licensee failed to immediately report suspected neglect after the resident eloped from the building. Facility staff were aware the resident had eloped but a report was not made until ten days later. R2's diagnoses included dementia, cognitive dysfunction, altered mental status, psychosis, and anxiety. R2's most recent assessment dated November 21, 2023, indicated the resident had a history of traumatic brain injury and had difficulty concentrating or paying attention, was easily disoriented, and had impaired judgment. The resident had a history of eloping and wandering. The assessment indicated the resident had "difficulty weighing advice, impaired judgment and can be impulsive." R2's record contained a VA [vulnerable adult] Maltreatment Report & Investigation Summary dated September 20, 2023. The investigation indicated the "family of another resident had multiple family members/friends come to the facility on 9/10/23. Family let resident out of door and re-set alarm." The incident was noted to have happened on September 10, 2023, at 12:30 p.m. A description of the incident indicated the door did not alarm as a family member had entered the code. The resident was "escorted back to the building by a different family member unharmed. Family did not report this to the facility until the following week when they came to visit again."	0 620		

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0 620	Continued From page 33 On November 28, 2023, at 7:15 p.m., family member (FM)-N stated he had been at the facility on September 10, 2023, to watch a Vikings game with his relative who resided at the facility. FM-N stated he was in the dining room when he heard someone yell, "there goes one!" FM-N stated he tried to find staff but wasn't able to locate anyone and no one was going after the resident so he quickly ran after him. FM-N stated he did not have his cell phone on him so just started walking with the resident and tried to convince him to go back inside. FM-N stated R2 "took off towards the river going through the woods, by the time I caught up with him he was already in the woods." FM-N stated he walked about a quarter mile along side the resident trying to get him to turn around. At one point, R2 got tired so they sat down to take a rest and eventually turned back towards the facility. FM-N stated "it must have taken about 45 minutes" and they finally came across an employee outside mowing the lawn and flagged him down. FM-N stated the employee helped get the resident back into the facility and he went back to visiting with his relative at the facility. On November 29, 2023, at 10:00 a.m., clinical nurse supervisor (CNS)-A stated they did not know about the elopement until ten days after it happened because the family who brought the resident back in the building did not tell staff about the incident. CNS-A was asked if she had interviewed the family member who brought R2 back to the building and she stated she wasn't able to find a phone number for him. On November 29, 2023, at 4:30 p.m., licensed assisted living director (LALD)-D stated from her understanding, a family member came in to visit	0 620		

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0 620	Continued From page 34 someone and the resident got out when she opened the door. LALD-D stated another family member helped bring R2 back in the facility but he did not alert staff about the resident's elopement and just brought the resident back inside and left. LALD-D stated they were not aware of the incident until a week later when a family member reported it to them. LALD-D stated CNS-A had interviewed the family member who brought the resident back to the building. On December 1, 2023, at 9:45 a.m., registered nurse (RN)-H stated from what she knew, R2 had left the building after another resident's family member left the door open and a different family member helped get him back inside. RN-H stated she was told the family didn't report the incident until a week later and that's when the MAARC report was completed. RN-H stated she wasn't aware a ULP working that day was aware the resident had left the building. On December 1, 2023, at 10:45 a.m., ULP-E stated he was out mowing the lawn on September 10, 2023, and saw R2 leave the building. ULP-E stated it wasn't uncommon for people to take him out for a walk on nice days and since someone was with R2, he wasn't too concerned. ULP-E stated a little while later, he saw R2 and a family member again but this time the person with him was frantically waiving his arms trying to get his attention. ULP-E stated he approached them and the family member asked him "did you lose someone?" ULP-E stated he told the family member he'd take the resident from there and brought R2 back to the building and notified ULP-C that the resident had gotten out and a family member brought him back. ULP-E stated he assumed since he reported the incident to someone working in nursing, they	0 620		

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0 620	Continued From page 35 would handle the situation from there. On December 4, 2023, at 11:10 a.m., LALD-D stated she was aware ULP-C was aware the resident had left the building on September 10, 2023, but was not sure why ULP-C did not immediately report it to the nurse. LALD-D confirmed education or additional follow up was not done with ULP-C after it was identified she failed to immediately report the elopement. R3 The licensee failed to report suspected verbal abuse after the resident submitted two grievance forms alleging verbal abuse from another resident. A grievance form dated October 30, 2023, indicated R3 made a complaint in person regarding an incident on October 29, 2023. The complaint alleged another resident "started an argument with me, she has been saying this to me ever since I became a resident here." The complaint further indicated the other resident told a staff member she would get them fired if they took R3 out to smoke. The resident wrote "My anxiety was high I was getting angry with what was going on...I'm tired of her verbal abuse and singling me out on a daily basis..." Sections for signature of person receiving complaint, description of investigation, date investigation completed, resolution, date/method of resolution communicated to client were left blank. A grievance form dated November 1, 2023, indicated R3 made a complaint in person regarding an incident on October 31, 2023. The resident wrote, "I am sick and tired of being harassed by [resident]. I'd like a copy of this and the other one I wrote up. I'd also appreciate it if I	0 620		

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0 620	Continued From page 36 could speak with someone about this." Sections for signature of person receiving complaint, description of investigation, date investigation completed, resolution, date/method of resolution communicated to client were left blank. R3's record lacked any documentation of follow up related to the two grievances. On November 27, 2023, at 8:45 a.m., R3 stated she had submitted two grievances but the issue had not been resolved yet and due to the ongoing issues with the other resident, "I'm ready to stay in my room and that's not fair. I've told them that." R3 stated she didn't get any forms back or any update on the situation or what the resolution would be. On November 27, 2023, at 9:40 a.m., clinical nurse supervisor (CNS)-A stated she had received the initial grievances and gave the forms to the licensed assisted living director (LALD). CNS-A stated she had not taken any action on the forms as that was the LALD's responsibility. CNS-A stated they had not considered filing a MAARC report over the allegations of verbal abuse. On November 29, 2023, at 4:00 p.m., LALD-D confirmed she had not documented anything about R3's grievances because "it's not completed yet, it's taking longer than usual, I'm looking at someone triggered by anxiety, trying to weigh it out." LALD-D was asked if they had considered filing a MAARC report and stated they had not and that she didn't think it would fall under neglect or abuse since it wasn't physical abuse. The investigator read the definition of abuse and emotional abuse to LALD-D and asked if that would align with the resident's	0 620		

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0 620	Continued From page 37 allegations. LALD-D stated she "needed to do a bit more research on that one because I guess we're looking at things differently in how we're interpreting things." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure residents records were protected against unauthorized disclosure for electronic records. This had the potential to affect all residents. 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).	0 700		

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0 700	Continued From page 38 The findings include: On November 27, 2023, at 11:00 a.m. through 11:15 a.m., a computer with residents' private health information and access to the licensee's electronic health record (EHR) for its residents was observed to be unlocked and visible in the community dining room in the memory care unit. During the time the computer was observed to be unlocked, two facility staff members walked by the computer and failed to lock it. On November 27, 2023, at 12:15 p.m., a computer with residents' private health information and access to the licensee's EHR for its residents was observed to be unlocked and visible near the community dining room in the assisted living unit. On November 30, 2023, at 4:30 p.m., licensed assisted living director (LALD)-D confirmed staff should be locking the computer when not in use to protect resident private health information. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 700		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring	01290		

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MAPLE WOODS ASSISTED LIVING	40170 COUNTY ROAD 257 COHASSET, MN 55721

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01290	Continued From page 39 self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study (BGS) was submitted and a clearance received in affiliation with the assisted living licensee's current health facility identification (HFID) for one of one employees (unlicensed personnel (ULP)-E). This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-E was hired September 1, 2020. The licensee's employee roster dated November 27, 2023, indicated ULP-E was a current employee and worked in the kitchen and in maintenance at two locations operated by the licensee. ULP-E's employee record lacked evidence of a	01290		

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01290	Continued From page 40 completed background study for the Cohasset location. ULP-E's employee record contained a background study disqualification for a different location operated by the licensee dated October 24, 2023. The Background Study Division reviewed available information and determined ULP-E posed a risk of harm and the employee was "disqualified from any position with direct contact, or access to people that receive services from all entities under your organization." The notice indicated "you may allow him to provide direct contact services pending a possible reconsideration decision." ULP-E requested reconsideration of the disqualification on November 6, 2023, and the request was still in process as of December 4, 2023. A review of the licenee's roster of completed background studies on the Minnesota Department of Health and Human Services NetStudy 2.0 website on December 1, 2023, indicated ULP-E was affiliated with the roster on November 30, 2023, after the background study was requested. On December 1, 2023, LALD-D provided the licensee's most recent roster with NetStudy 2.0. The roster indicated ULP-E was affiliated with the Cohasset HFID on November 30, 2023, and supervision of the employee was required while it was in process. On December 4, 2023, at 11:05 a.m., LALD-D stated it was a mistake that ULP-E was not affiliated with the current HFID and confirmed he did periodically work at the location. LALD-D stated the employee was always supervised while working. LALD-D was asked if the employee was supervised on a day a resident had eloped from the building and he assisted with bringing the	01290		

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01290	Continued From page 41 resident back inside. LALD-D stated the on-call nurse, who was not on site at the time, was supervising ULP-E. LALD-D stated "it's up to us if we want to wait out and see if they're [the disqualification] set aside or if they don't need supervision, you have to know the person as well." No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective	01620		

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01620	Continued From page 42 resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident reassessment within the required time frames for two of six residents (R1, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's record contained an assessment dated August 16, 2023. The next assessment completed was on November 21, 2023, 97 days later. R3's record contained an assessment dated June 20, 2023. The next assessment completed was on September 19, 2023, 91 days later. On November 29, 2023, at 9:35 a.m., clinical nurse supervisor (CNS)-A stated if she doesn't check the dashboard for their electronic medical record every day to see what assessments are due, "it'll slip my mind." CNS-A stated she has been working on making sure to check the dashboard daily to ensure assessments are completed on time.	01620		

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01620	Continued From page 43 On December 1, 2023, at 9:30 a.m., registered nurse (RN)-H stated she is responsible for overseeing assessments and making sure they are done by the nurse on time. RN-H stated she will assist with completing assessments if needed but will send reminders to CNS-A to ensure they are completed. The licensee's Initial and On-Going Nursing Assessment of Residents policy, last updated July 5, 2023, indicated the RN would complete a comprehensive nursing assessment periodically but no less than every 90 days. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
01640 SS=G	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan	01640		

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01640	Continued From page 44 must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan was implemented per the resident's assessments for one of one resident (R2). The licensee failed to ensure daily documentation of the placement of R2's wanderguard was complete and failed to implement hourly safety checks. The documentation of placement of R2's wanderguard was discontinued and no documentation on the wander guard was entered for 16 days and R2 was not wearing a wanderguard when the issue was identified by the investigator. In addition, R2's hourly safety checks were not completed as directed and the licensee failed to complete hourly safety checks over a four hour period of time during which the resident eloped from the facility. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ELOPEMENT R2's diagnoses included dementia, cognitive	01640		

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01640	Continued From page 45 dysfunction, altered mental status, psychosis, and anxiety. R2's most recent assessment dated November 21, 2023, indicated the resident had a history of traumatic brain injury and had difficulty concentrating or paying attention, was easily disoriented, and had impaired judgment. The resident had a history of eloping and wandering. The assessment indicated the resident had "difficulty weighing advice, impaired judgment and can be impulsive." R2's service plan dated September 15, 2022, indicated the resident had safety checks 24 times per day (hourly) and received behavior management services. R2's record contained a VA [vulnerable adult] Maltreatment Report & Investigation Summary dated September 20, 2023. The investigation indicated the "family of another resident had multiple family members/friends come to the facility on 9/10/23. Family let resident out of door and re-set alarm." The incident was noted to have happened on September 10, 2023, at 12:30 p.m. A description of the incident indicated the door did not alarm as a family member had entered the code. The resident was "escorted back to the building by a different family member unharmed. Family did not report this to the facility until the following week when they came to visit again." On December 1, 2023, at 10:45 a.m., unlicensed personnel (ULP)-E stated he was out mowing the lawn on September 10, 2023, and saw R2 leave the building. ULP-E stated it wasn't uncommon for people to take him out for a walk on nice days and since someone was with R2, he wasn't too concerned. ULP-E stated a little while later, he	01640		

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01640	Continued From page 46 saw R2 and a family member again but this time the person with him was frantically waving his arms trying to get his attention. ULP-E stated he approached them and the family member asked him "did you lose someone?" ULP-E stated he told the family member he'd take the resident from there and brought R2 back to the building and notified ULP-C that the resident had gotten out and a family member brought him back. ULP-E stated he assumed since he reported the incident to someone working in nursing, they would handle the situation from there. Time cards for September 10, 2023, the day the resident eloped, indicated ULP-E was mowing the lawn from 1 p.m. to 2 p.m., and the unlicensed personnel he reported the elopement to was working until 2:52 p.m. Two ULP were working at the time of the elopement but from 3:00 p.m. to 7:00 p.m., only one person was working. R2's service recap summary for hourly safety checks on September 10, 2023, the day he eloped, were completed as follows: -6:30 a.m. completed at 6:09 a.m. -7:30 a.m. completed at 7:42 a.m. -8:30 a.m. completed at 7:43 a.m., one minute after the most recent safety check -9:30 a.m. completed at 8:11 a.m. -10:30 a.m. completed at 9:01 a.m. -11:30 a.m. completed at 10:11 a.m. -12:30 p.m. completed at 2:39 p.m., more than four hours after the most recent safety check -1:30 p.m. completed at 2:39 p.m., the same time as the prior safety check -2:30 p.m. completed at 2:47 p.m., eight minutes after the most recent safety check -3:30 p.m. completed at 7:28 p.m., approximately five hours after the most recent safety check	01640		

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01640	Continued From page 47 -4:30 p.m. completed at 7:28 p.m. -5:30 p.m. completed at 7:27 p.m. -6:30 p.m. completed at 7:27 p.m. -7:30 p.m. completed at 7:49 p.m. -8:30 p.m. completed at 8:43 p.m. -9:30 p.m. completed at 10:25 p.m. -10:30 p.m. completed at 10:26 p.m., one minute after his most recent safety check -11:30 p.m. completed at 11:27 p.m. -12:30 a.m. completed at 12:07 a.m. WANDER GUARD CHECKS AND HOURLY SAFETY CHECKS R2's progress notes indicated a wander guard was placed to the resident's left ankle on September 25, 2023, as an intervention related to the September 10, 2023, elopement. The note indicated, "Services added to check placement and skin integrity each shift. Staff to notify nursing of any concerns." R2's service recap summary for placement of the resident's wander guard was reviewed on November 28, 2023. The recap summary indicated staff had been checking placement daily from September 26, 2023, through November 13, 2023. The following notes were entered when the wander guard was noted to not be in place. -November 13, 2023, registered nurse (RN)-H documented "resident ripped off, on his bed side table, RN to be updated." No additional documentation on the placement of the wander guard was entered after November 13, 2023. -November 12, 2023, "resident had off but nurse used fishing wire to clasp piece he tore off." -November 10, 2023, the wander guard was in place but the resident "keeps trying to take it off" -November 8, 2023, the wander guard was noted to have been removed and on the resident's dresser	01640		

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01640	Continued From page 48 -November 2, 2023, the wander guard was "on and working but he keeps trying to get it off, very agitated after 1 a.m." -October 29, 2023, the wander guard was on but "he keeps trying to get it off though" -October 27, 2023, overnight staff documented "heard it was broke" -October 27, 2023, day shift staff documented "new one was applied on." -October 26, 2023, overnight and evening shift documented the wander guard was broken and not on. -October 25, 2023, the resident refused to let staff check placement -October 24, 2023, evening and overnight staff documented the wander guard was broken and not on. -October 23, 2023, overnight staff documented the wander guard was broken -October 22, 2023, day shift staff documented the wander guard was broken and the "nurses aware" -October 21, 2023, day shift staff documented the wander guard was "still broken, not fixed yet" and evening and overnight staff documented the resident would not allow them to check placement. -October 20, 2023, evening staff documented the wander guard was still broken, day shift staff documented it was in place -October 19, 2023, overnight and evening staff documented the wander guard was broken and not on, "is it not fixed yet??" -October 18, 2023, day and evening staff documented the wander guard was not on, "I think it's still broken." -October 17, 2023, day shift staff documented it was in place, evening and overnight staff documented the wander guard was not on and getting fixed.	01640		

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01640	Continued From page 49 -October 16, 2023, day shift staff documented it was in place, evening and overnight staff documented the wander guard was not on. "He broke the strap so nurse [licensed assisted living director (LALD)-D] has it and is aware. so he DOES NOT HAVE ONE ON." -October 15, 2023, evening staff documented the resident "would not let me put on. is laying on his dresser in his room." -October 1, 2023, overnight and evening staff documented the wander guard was not on as the resident refused to wear it. -September 30, 2023, overnight staff documented "resident had it off when I came on my shift. Found it in his pocket. Refuse to put it back on." R2's service recap summary for hourly safety checks were inconsistently completed during the time the resident was not wearing a wander guard. -November 25, 2023, hourly checks were done as follows: -12:30 a.m. completed at 12:56 a.m. -1:30 a.m. completed at 1:56 a.m. -2:30 a.m. completed at 2:57 a.m. -3:30 a.m. completed at 3:31 a.m. -4:30 a.m. completed at 4:50 a.m. -5:30 a.m. completed at 5:32 a.m. -6:30 a.m. completed at 6:31 a.m. -7:30 a.m. completed at 8:35 a.m., two hours after the resident was last checked on -8:30 a.m. completed at 8:36 a.m., one minute after the prior safety check was completed -9:30 a.m. completed at 10:35 a.m., two hours after the resident was last checked on -10:30 a.m. completed at 10:35 a.m., the same time as the prior safety check -11:30 a.m. completed at 11:01 a.m. -12:30 p.m. completed at 1:00 p.m., two hours after the resident was last checked on	01640		

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01640	Continued From page 50 -1;30 p.m. completed at 1:00 p.m., the same time as the prior safety check -2:30 p.m. completed at 1:00 p.m., the same time as the prior two safety checks -no documented safety checks between 3:30 p.m. and 6:30 p.m. -6:30 p.m. completed at 7:55 p.m. -7:30 p.m. completed at 7:55 p.m., the same time as the prior safety check -8:30 p.m. completed at 8:28 p.m. -9:30 p.m. completed at 8:56 p.m. -10:30 p.m. completed at 9:53 p.m. -11:30 p.m. completed at 11:57 p.m., almost two hours after the resident was last checked on -November 22, 2023, hourly safety checks were done as follows: -12:30 a.m. completed at 12:38 a.m. -1:30 a.m. completed at 1:47 a.m. -2:30 a.m. completed at 2:54 a.m. -3:30 a.m. completed at 4:10 a.m. -4:30 a.m. completed at 6:52 a.m., almost three hours after the resident was last checked on -5:30 a.m. completed at 7:46 a.m. -6:30 a.m. completed at 7:46 a.m., the same time as the prior safety check -no documented safety checks between 6:30 a.m. and 2:30 p.m. -3:30 p.m. completed at 5:27 p.m., approximately nine hours after the resident was last checked on -4:30 p.m. completed at 5:27 p.m., the same time as the prior safety check -5:30 p.m. completed at 5:27 p.m., the same time as the prior two safety checks -6:30 p.m. completed at 9:06 p.m., approximately three and a half hours after the resident was last checked on -7:30 p.m. completed at 9:06 p.m., the same	01640		

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01640	Continued From page 51 time as the prior safety check -8:30 p.m. completed at 9:08 p.m., the same time as the prior two safety checks -9:30 p.m. completed at 9:08 p.m., the same time as the prior three safety checks -10:30 p.m. completed at 10:33 p.m. -11:30 p.m. completed at 11:31 p.m. -12:30 a.m. completed at 12:36 a.m. On November 29, 2023, at 9:30 a.m., clinical nurse supervisor (CNS)-A stated they had to switch the band R2 was using for a wander guard as he "kept ripping it and breaking it and we couldn't replace just the band, the whole device had to be replaced." CNS-A stated they currently have a different type of band and were hoping it'd be more successful. CNS-A stated the resident currently had a wander guard to his right ankle. CNS-A stated for the times the resident did not wear his wander guard, they relied on hourly safety checks as an intervention to prevent elopements. On November 29, 2023, at 4:30 p.m., licensed assisted living director (LALD)-D confirmed staff did not document the placement of the wander guard after November 13, 2023, and was not sure why. LALD-D confirmed registered nurse (RN)-H had last documented on November 13 that the resident had removed his wander guard. LALD-D confirmed staff resumed documentation on November 28, 2023, after it was identified by the investigator the resident was not wearing a wander guard. LALD-D stated the resident had hourly safety checks so there would have been an intervention in place to prevent elopements. On December 1, 2023, at 9:15 a.m., RN-H confirmed after her documentation of R2's wander guard being off on November 13, 2023,	01640		

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	30666	A. BUILDING: _____ B. WING _____	C 11/27/2023

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01640	Continued From page 52 no additional documentation on the wander guard was entered until the evening of November 28, 2023. RN-H stated she had personally told CNS-A about the wander guard being off and was not sure if she put it back on or why the task to check placement disappeared. RN-H stated the resident was on hourly checks so even if the wander guard wasn't on, he would have been checked on every hour. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01640		
02070 SS=I	144G.81 Subd. 4 Awake staff requirement An assisted living facility with dementia care providing services in a secured dementia care unit must have an awake person who is physically present in the secured dementia care unit 24 hours per day, seven days per week, who is responsible for responding to the requests of residents for assistance with health and safety needs, and who meets the requirements of section 144G.41, subdivision 1, clause (12). This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one or more persons were physically present and available 24 hours a day, seven days a week, who were responsible for responding to requests for assistance with health and safety needs of residents in two of two secured units. This had the potential to affect all residents residing in the facility.	02070		

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02070	Continued From page 53 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). This practice resulted in an immediate order on November 27, 2023, at approximately 10:30 a.m. The immediacy was removed on December 4, 2023, however noncompliance remained at a lowered scope and severity of F. The findings include: The licensee held an Assisted Living with Dementia Care license with a capacity of 30 residents and had a current census of 18 residents (ten residents residing in the memory care secured unit, eight residents residing in the assisted living secured units.) The physical layout of the facility included two separate units, a locked memory care unit which included units B and C, and a locked assisted living unit, unit A. Key pads were present at all doors and a code was required to enter or leave the building and/or the individual locked units. On November 27, 2023, at 7:45 a.m., the MDH investigator rang the doorbell to the facility's memory care unit, no one answered the door. The investigator called the phone number listed for the facility, no one answered. The investigator walked around to the assisted living side of the facility and rang the doorbell with no answer. At 7:47 a.m., the investigator observed a staff	02070		

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02070	Continued From page 54 member in the kitchen and knocked on the window. Unlicensed personnel (ULP)-B let the investigator in the building. On November 27, 2023, at 7:58 a.m., the MDH investigator walked down to the secure memory care unit. ULP-C was interviewed by the investigator and stated she was just finishing her shift as she worked overnights and was going to be leaving. ULP-C exited the building, leaving the investigator alone in the locked memory care unit with no other facility staff present. The investigator was approached by two residents asking if they could have breakfast. On November 27, 2023, at 8:10 a.m., ULP-C came back in the building. A resident requested breakfast. ULP-C brought the resident to his room and assisted him with putting pants on and then left the locked unit, leaving the unit unstaffed again. From 8:15 a.m. to 8:30 a.m., there were no staff present on the locked memory care unit. On November 27, 2023, at 8:30 a.m., clinical nurse supervisor (CNS)-A arrived. CNS-A was asked by the investigator if she knew how long the memory care unit had been left unstaffed. CNS-A stated the staff member was in her car in the parking lot and should have only been gone a few minutes. CNS-A was advised the unit had been left unstaffed twice for approximately 15 minutes each time. CNS-A stated it was possible ULP-C was nervous or scared. CNS-A stated they normally staff one ULP per unit with a float sometimes and she felt the staffing levels were sufficient to meet resident care needs. On November 27, 2023, at 9:57 a.m., ULP-B	02070		

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02070	Continued From page 55 exited the locked assisted living unit, leaving no staff present on the locked unit. A resident from the locked memory care unit was observed walking through the assisted living unit. ULP-B returned to the locked assisted living unit at 10:04 a.m., ULP-B left the unit again at 10:09 a.m. and returned to the unit at 10:15 a.m., leaving the unit unstaffed. On November 27, 2023, at 11:50 a.m., CNS-A confirmed both units were left unstaffed at times. CNS-A stated the locked assisted living unit would be left unstaffed at times but since it was not the memory care unit and was the assisted living side, it was not required to have staff there 24/7. CNS-A confirmed not all the residents on assisted living knew the code to exit the building. The licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA), dated May 1, 2023, indicated two direct care staff would be scheduled per shift. The licensee's Direct-Care Staffing Plan, last revised November 20, 2023, indicated when residents require a two-person assist, there would be a minimum of two staff available at all times. The plan indicated, "because of the number of resident service hours required on NOC (overnight) shift, the secured doorways between units will be open and not locked in order to create one unit for a single staff person to manage. The entire building is secured thereby mitigating elopement risk for the traditional secured units B and C." The plan further indicated "If there are call ins from staff and the organization must utilize two staff, the doors between secured units B and C will be unlocked creating one unit and one staff person will manage these two units." The staffing plan did	02070		

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02070	Continued From page 56 not address how unit A, the locked assisted living unit, would be staffed. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	02070		
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for one of one resident (R4) who utilized bed rails. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4's diagnoses included dementia, memory loss, late onset Alzheimer's disease without behavioral disturbance.	02310		

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02310	Continued From page 57 R4's service plan, dated November 30, 2022, indicated the resident received assistance with dressing, grooming, medication administration, toileting, transfers with a mechanical lift, and wound care. On November 27, 2023, at 7:55 a.m., R4 was observed sitting at the foot of her bed, between the end of the bed rail and footboard. A fall mat was tucked under the resident's bed. The resident's bed was pushed up against a wall on the rightside and the left side had a full length bed rail. The bed rail was one long rail that spanned almost the entire length of the bed. On November 27, 2023, at 8:35 a.m., R4 was observed sitting at the foot of her bed, between the end of the bed rail and footboard. A fall mat was tucked under the resident's bed. Clinical nurse supervisor (CNS)-A entered the room with the investigator and observed the resident sitting at the foot of her bed and confirmed the fall mat was underneath the bed. The resident's most recent assessment, dated October 12, 2023, indicated the resident had a partial side rail at the head of bed and foot of bed. The assessment did not identify which side of the bed the bed rail was located. The assessment indicated the resident used the bed rail to "assist in mobility/safety/reminder of bed perimeter...staff to provide hourly safety check due to history of self transferring...staff to ensure resident is center in the bed with each safety check and assist as needed." The rational for bed rails included several reasons, including fall prevention and reminder of bed perimeter. "Resident needs side rails for family preference, hospice recommendation, aid in turning/repositioning, fall	02310		

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02310	Continued From page 58 prevention, safety and reminder of bed perimeter." Staff were to ensure a fall mat was in place while the resident was in bed. The assessment also indicated the nurse would "communicate with family and hospice in regards to a 14 inch gap between rails and the risk involved. Would be beneficial to get one long full bed rail instead of two separate ones." On November 29, 2023, at 9:30 a.m., CNS-A stated she felt using bed rails for fall prevention was an appropriate use. CNS-A stated, "We aren't using as a restraint we're using it as fall prevention and we were looking at clinical guidance and implementation of bed rails and per our interpretation and hospice, it was to help prevent falls and not used as a restraint." CNS-A confirmed R4 had been observed at the end of the bed trying to get out of bed but stated "she's not always like that, she's usually somnolent most days but she's kind of a wiggler." On November 29, 2023, at 11:50 a.m., licensed assisted living director (LALD)-D stated it would not be appropriate to use a bed rail as a fall prevention measure. LALD-D stated R4 started using a full length bed rail because "it was a nice barrier for her so she could feel the edge of the bed and it helps with repositioning her and gives her something to hold on to." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQs), last updated August 7, 2023, indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for	02310		

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02310	Continued From page 59 entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail. - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail. - The resident's bed rail use/need assessment: - Risk vs. benefits discussion (individualized to each resident's risks): - The resident's preferences: - Installation and use according to manufacturer's guidelines: - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". The licensee's Bed Rail use policy, last updated September 5, 2023, indicated staff would follow FDA guidelines for bed rail safety and assess whether the device was appropriate for the individual. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days.	02310		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

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02360	Continued From page 60 sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one residents reviewed (R2) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No plan of correction is required for this tag.	
02370 SS=F	144G.91 Subd. 9 Right to come and go freely Residents have the right to enter and leave the facility as they choose. This right may be restricted only as allowed by other law and consistent with a resident's service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure residents not residing in memory care had the right to come and go freely. This had the potential to affect all residents who did not reside in the dementia care unit and visitors of 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, but was not likely to cause serious injury, impairment, or death), and	02370		

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02370	Continued From page 61 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an Assisted Living with Dementia Care license for a resident capacity of 30 residents and current census of 18 residents (ten residents residing in the memory care secured unit, eight residents residing in the assisted living secured units.) Per Minnesota Assisted Living: Chapter 144G, 144G.08, Subd. 62, "Secured dementia care unit" means a designated area or setting designed for individuals with dementia that is locked or secured to prevent a resident from exiting, or to limit a resident's ability to exit, the secured setting. A secured dementia care unit is not solely an individual resident's living area. The physical layout of the facility included two separate units, a locked memory care unit which included units B and C, and a locked assisted living unit, unit A. Key pads were present at all doors and a code was required to enter or leave the building and/or the individual locked units. On November 27, 2023, at 7:45 a.m., the MDH investigator rang the doorbell to the facility's memory care unit, no one answered the door. The investigator called the phone number listed for the facility, no one answered. The investigator walked around to the assisted living side of the facility and rang the doorbell with no answer. At 7:47 a.m., the investigator observed a staff member in the kitchen and knocked on the window. Unlicensed personnel (ULP)-B let the	02370		

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02370	Continued From page 62 investigator in the building. On November 27, 2023, at 8:45 a.m., R3 stated she knew the code but only because she overheard staff saying it one day otherwise they wouldn't be given the code. R3 stated the facility had recently changed the code and it could be hard to remember what code was for what door since exit doors and doors connecting the units had different codes. On November 27, 2023, at 11:50 a.m., clinical nurse supervisor (CNS)-A confirmed both the memory care and assisted living units required a code to exit and the code was not provided to residents. CNS-A confirmed not all the residents on assisted living knew the code to exit the building. On November 27, 2023, at 12:30 p.m., licensed assisted living director (LALD)-D stated the assisted living side "wasn't a locked unit but it was secured." LALD-D confirmed the residents typically were not given the codes but they could ask staff at any time to let them in or out. The licensee Minnesota Bill of Rights for Assisted Living Residents indicated residents have the right to enter and leave the facility as they choose. This right may be restricted only as allowed by other law and consistent with a resident's service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) Days	02370		

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02480	Continued From page 63	02480		
02480 SS=D	144G.91 Subd. 20 Grievances and inquiries Residents have the right to make and receive a timely response to a complaint or inquiry, without limitation. Residents have the right to know, and every facility must provide the name and contact information of the person representing the facility who is designated to handle and resolve complaints and inquiries. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to respond to grievances of two of two resident (R3, R5) reviewed for grievances. 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On November 27, 2023, the investigator requested the licensee's grievances for the past three months. Two partially filled out grievance forms from R3 were provided. R3 A grievance form dated October 30, 2023, indicated R3 made a complaint in person regarding an incident on October 29, 2023. The complaint alleged another resident "started an argument with me, she has been saying this to me ever since I became a resident here." The complaint further indicated the other resident told	02480		

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02480	Continued From page 64 a staff member she would get them fired if they took R3 out to smoke. The resident wrote "My anxiety was high I was getting angry with what was going on...I'm tired of her verbal abuse and singling me out on a daily basis..." Sections for signature of person receiving complaint, description of investigation, date investigation completed, resolution, date/method of resolution communicated to client were left blank. A grievance form dated November 1, 2023, indicated R3 made a complaint in person regarding an incident on October 31, 2023. The resident wrote, "I am sick and tired of being harassed by [resident]. I'd like a copy of this and the other one I wrote up. I'd also appreciate it if I could speak with someone about this." Sections for signature of person receiving complaint, description of investigation, date investigation completed, resolution, date/method of resolution communicated to client were left blank. R3's record lacked any documentation of follow up related to the two grievances. On November 27, 2023, at 8:45 a.m., R3 stated she had submitted two grievances but the issue had not been resolved yet and due to the ongoing issues with the other resident, "I'm ready to stay in my room and that's not fair. I've told them that." R3 stated she didn't get any forms back or any update on the situation or what the resolution would be. On November 27, 2023, at 9:40 a.m., clinical nurse supervisor (CNS)-A stated she had received the initial grievances and gave the forms to the licensed assisted living director (LALD). CNS-A stated she had not taken any action on the forms as that was the LALD's responsibility.	02480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30666	A. BUILDING: _____ B. WING _____	C 11/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE WOODS ASSISTED LIVING	40170 COUNTY ROAD 257 COHASSET, MN 55721

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02480	Continued From page 65 CNS-A stated she didn't think they had a typical timeframe to resolve grievances and this was the first resident to resident grievance she had dealt with so wasn't sure how to handle it and left it up to the LALD. On November 29, 2023, at 4:00 p.m., licensed assisted living director (LALD)-D confirmed she had not documented anything about R3's grievances because "it's not completed yet, it's taking longer than usual, I'm looking at someone triggered by anxiety, trying to weigh it out." LALD-D stated she meets with both residents weekly and has been trying to resolve it but had not documented any of the encounters with either resident or finished the grievance form. LALD-D stated they had not involved other parties like an ombudsman and had been trying to resolve it themselves. R5 R5's record lacked evidence a grievance was completed or that the resident had voiced concerns to staff about rough treatment. Documentation of R5's grievance was requested on November 30, 2023, at 12:00 p.m., but not provided. A VA (vulnerable adult) Maltreatment Report & Investigation summary dated November 17, 2023, was provided. The summary indicated on November 11, 2023, R5 alleged a ULP was rough with putting on a sweater. The resident was seen in the emergency room on November 17, 2023, for shoulder pain. The investigation indicated the resident had requested to go to bed but the ULP had to help some other residents first. The conclusion was the "resident did not report pain or incident until a week post incident. Residents behaviors have increased since reduction in Depakote (a medication to treat psychiatric disorders including bipolar)..." No	02480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30666	A. BUILDING: _____ B. WING _____	C 11/27/2023

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02480	Continued From page 66 maltreatment was suspected. The form lacked evidence the resident or family member was updated on the situation or the outcome. On November 30, 2023, at 9:40 a.m., family member (FM)-F stated he was told by CNS-A she'd investigate the situation but had not heard back on what was found out or what they decided. FM-F stated he was told by R5 that she had asked to be pushed back to her room after lunch but staff took another resident out to smoke first. R5 decided to wheel herself back to her room and got a sweater stuck while trying to take it off herself, causing her to scream out for help. FM-F stated R5 had told him the staff member who came to help was "upset and kinda maybe a bit aggressive and she hurt her arm and shoulder." On December 1, 2023, at 9:00 a.m., CNS-A stated a grievance form was not initiated and she just went straight to an internal investigation. CNS-A was asked if the staff member investigated for rough treatment had been disciplined or reeducated or if there was any documentation showing follow up with the staff member. CNS-A stated she had only talked to the staff member and that person is not supposed to work alone with R5 and should "buddy up with someone" or swap with another staff member so she doesn't provide care alone to the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02480		