

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL30745003M
Compliance #: HL30745004C

Date Concluded: January 18, 2022

Name, Address, and County of Licensee

Investigated:

Lino Lakes Assisted Living
725 Town Center Pkwy
Lino Lakes, MN 55014
Anoka County

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

Evaluator's Name: Yolanda Dawson, RN
Special Investigator

Finding: Substantiated, facility responsibility

Nature of Visit

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

Allegation(s): Staff members neglected resident #3 and resident #4 and all residents when they did not answer call lights within a reasonable amount of time, leaving the residents unattended for several hours when they needed assistance.

Investigative Findings and Conclusion:

Neglect of supervision was substantiated. The licensee was responsible for the maltreatment. Management, staff members and residents confirmed that residents often experienced wait times up to an hour for needed assistance putting the health, safety, and comfort of all residents at risk.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. In addition, the investigator contacted law enforcement. The investigator also interviewed agency skilled nursing staff. The investigator reviewed resident call light history, resident records, policies and procedures, and incident reports.

Resident #3's medical record was reviewed. Resident #3's medical diagnosis included dermatomyositis (inflammatory disease characterized by muscle weakness). Resident #3's service plan indicated Resident #3 received assistance with medication management, skin care, bathing, dressing, grooming, transfer and positioning assistance, toileting, and safety checks. Resident #3 was wheelchair bound and utilized an electric wheelchair.

Resident #4's medical record was reviewed. Resident #4's medical diagnoses included mild cognitive impairment, recurrent falls, and episodic dysphagia. Resident #4's service plan indicated Resident #4 received assistance with medication management, skin care, bathing, dressing, grooming, transfer assistance, and safety checks.

During an interview, resident #3 stated he did not like staff taking him out of his chair once he was in it because it was painful to move. Resident #3 stated he was able to recline his wheelchair to take pressure off his backside and preferred to do this rather than staff transferring him to bed every two hours. Resident #3 stated staff transferred him two to three times a day to change him but he often had to wait two to three hours.

During an interview, a skilled nursing agency staff member stated resident #3 had wounds on his backside that required staff to off load the resident every two hours. The staff member stated resident #3 reported that he often had to wait several hours for a staff member to answer his call light. The staff member stated clinicians had to wait a half-hour to an hour for the licensee's staff members to be available to receive report regarding the care of resident #3.

During an interview, resident #4 stated he pulled the wall cord while he was in the bathroom and needed assistance. Resident #4 stated he waited for three hours before someone answered his call light. Resident #4 stated he pushed his button yesterday evening at 5:00 p.m. because he did not receive his dinner, and nobody came. Resident #4 stated he received his dinner four hours later.

During the investigator tour of the building three residents on the 2nd floor and one resident on the 1st floor stated staff members answered their call light in approximately twenty minutes to an hour, or not at all.

During an interview, a staff member stated residents had to wait long periods of time for assistance and some staff will not answer the call light of people they do not want to help.

During an interview, an Administrator stated they did not have a call light policy, but staff are to answer in ten minutes or less and that did not happen all the time.

During an interview, a Director stated there was no call light policy however staff should answer call lights in approximately twelve minutes. The Director stated staff do take a longer time to get to the call lights, and a half an hour is a long time, and it continues to be a problem, but they are working on it.

In conclusion, neglect of supervision was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.

“Substantiated” means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17

"Neglect" means:

- (a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
 - (1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
 - (2) which is not the result of an accident or therapeutic conduct.
- (b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Vulnerable Adult interviewed: Yes

Family/Responsible Party interviewed: Yes

Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:

Staff meetings to reeducate staff.

Action taken by the Minnesota Department of Health:

The responsible party will be notified of their right to appeal the maltreatment finding.

cc:

The Office of Ombudsman for Long-Term Care

The Office of Ombudsman for Mental Health and Developmental Disabilities

Anoka County Attorney

Lino Lakes City Attorney

Lino Lakes Police Department

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30745	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/07/2021
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0 000	<p>Initial Comments</p> <p>Initial comments *****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p>#HL30745002C/#HL30745001M#HL30745004C/#HL30745003M/#HL30745006C/#HL30745005M</p> <p>On December 6, 2021 through December 7, 2021, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 100 residents receiving services under the provider's Assisted Living with Dementia Care license.</p> <p>The following correction orders are issued for #HL30745002C/#HL30745001M #HL30745004C/#HL30745003M/#HL30745006C/#HL30745005M, tag identification 0510, 0800, 1430, and 1500.</p> <p>The following correction orders were issued related to HL30745004C/#HL30745003M only:</p>	0 000	<p>The Minnesota Department of Health documents the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that 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.</p> <p>Per Minnesota Statute §144G.30, Subd. 5 (c), the home care provider must document any action taken to comply with the correction order. A copy of the provider's records documenting those actions may be requested for follow-up surveys. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider's Plan of Correction."</p> <p>The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144G.31, Subd. 2 and 3.</p>	
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Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Minnesota Department of Health

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0 000	Continued From page 1 2310 and 2360. The following correction orders were issued related to HL30745006C/#HL30745005M only: 1620.	0 000		
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 effective COVID-19 infection control program to comply with accepted health care, medical, and nursing standards for infection control. 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).	0 510		

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0 510	<p>Continued From page 2</p> <p>The findings include:</p> <p>Personal Protective Equipment (PPE): Eye Protection</p> <p>The Centers for Disease Control and Prevention (CDC) COVID-19, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, dated September 10, 2021, indicated eye protection (i.e., goggles or a face shield that covers the front and sides of the face) should be worn during all patient care encounters.</p> <p>The facility failed to ensure staff wore required eye protection while working direct care with residents.</p> <p>On December 6, 2021, at 9:02 a.m., the surveyor observed unlicensed personnel (ULP)-B and home care staff (HCS)-O were in room 216 performing care with resident. During the observation neither ULP-B nor HCS-O wore eye protection when performing direct care with resident and being within six feet of the resident.</p> <p>During an interview on December 7, 2021, at 4:03 p.m., the Executive Director (ED) stated all staff are required to wear eye protection when providing direct cares with resident.</p> <p>During an interview on December 29, 2021, at 3:00 p.m., ULP-P stated she wears gloves for PPE during direct cares when the resident is not COVID- positive. ULP-P stated if the resident is COVID-positive then she wears a gown, foot</p>	0 510		

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0 510	Continued From page 3 coverings, mask, and gloves for PPE. ULP-P stated she wears eye protection when providing direct cares for COVID-positive residents. The facility-provided document titled Contingency Standards of Care grid for COVID-19 PPE for congregate care settings dated June 15, 2020, indicated staff members should wear eye protection while providing cares for or having face-to-face contact with COVID-negative residents No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 800 SS=E	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including bathrooms and bed furnishings in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents as required by MN Statute 144G.45 subd.2(a)(4).	0 800		

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0 800	<p>Continued From page 4</p> <p>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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).</p> <p>The findings include:</p> <p>A request for the housekeeping schedule received via email on December 17, 2021 at 3:14 p.m., indicated the following cleaning days: Friday reserved for rooms not completed through the week with daily tidying done by unlicensed personnel (ULP). 1st floor Monday, 2nd Floor Tuesday, memory care Wednesday, and 3rd floor Thursday.</p> <p>During an interview on December 6, 2021, at 11:17 a.m., the investigator observed R2's room had the overwhelming smell of urine. R2 was in bed and the investigator observed that his brief was saturated. The investigator observed the toilet in R2's bathroom. The toilet was dirty with urine and feces with a ring at the waterline. A soiled brief was in the shower. The investigator obtained photos.</p> <p>During an interview on December 6, 2021 at 11:50 a.m., the investigator observed R1's room had the overwhelming smell of urine. R1 was in bed with urine-soaked clothes. ULP-H assisted R1 out of the bed and removed the sheet. The investigator observed multiple urine rings covered the mattress from side to side. ULP-H verified the deficient condition and called housekeeping to</p>	0 800		
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0 800	<p>Continued From page 5</p> <p>clean the mattress. The investigator obtained a photo.</p> <p>During a facility tour on December 7, 2021, at 12:00 p.m., the investigator observed the smell of urine in the hallway on the second floor and identified the room where it was coming from. Once in the room the smell of urine was overwhelming. R5 was lying in bed with no clothing on his bottom half. A wet brief was on the floor. The investigator observed R5 laying on a wet mattress with several dry rings of urine on the sheets. There was a trashcan in the shower that contained urine. ULP-I stated the trash can was there because the tub faucet leaked, however, the investigator examined the content, and it was yellow and smelled like urine. ULP-I verified the deficient condition and stated she would attend to R5. The investigator obtained photos.</p> <p>During a facility tour on December 7, 2021, at 12:05 p.m., the investigator observed the deficient condition of the toilet in R6's bathroom. The toilet was very dirty with urine and feces and a ring at the waterline. R6 stated it had been a while since housekeeping had cleaned his bathroom. the investigator obtained a photo.</p> <p>During a facility tour on December 7, 2021, at 12:20 p.m., the investigator observed the deficient condition of the bathroom in R7's room. R7's bathroom was cluttered with two mechanical lifts and two large boxes. R7 stated staff used the bathroom for storage and used the shower room down the hall to give her a shower. R7 complained that she was unable to get to the sink to wash her hands and face. The investigator obtained photos.</p> <p>During interviews with two ULPs and a</p>	0 800		

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0 800	Continued From page 6 conversation with the executive director, they verified housekeeping vacuumed and mopped the floors and cleaned the toilets, and ULPs removed the garbage daily. No further information provided. TIME PERIOD FOR CORRECTION: Seven days	0 800		
01430 SS=F	144G.62 Subd. 3 Supervision of staff (a) Staff who only provide assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), must be supervised periodically where the services are being provided to verify that the work is being performed competently and to identify problems and solutions to address issues relating to the staff's ability to provide the services. The supervision of the unlicensed personnel must be done by staff of the facility having the authority, skills, and ability to provide the supervision of unlicensed personnel and who can implement changes as needed, and train staff. (b) Supervision includes direct observation of unlicensed personnel while the unlicensed personnel are providing the services and may also include indirect methods of gaining input such as gathering feedback from the resident. Supervisory review of staff must be provided at a frequency based on the staff person's competency and performance. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure documentation of direct supervision of unlicensed personnel (ULP) for four of four employees (ULP-D, ULP-E, ULP-F,	01430		

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01430	<p>Continued From page 7</p> <p>ULP-G) with employee records reviewed. Interviews indicated the licensee did not conduct direct supervision of ULPs for any of the sixty-five employees listed on the employee hire date roster.</p> <p>This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, 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 the potential to affect a large portion or all the residents).</p> <p>The findings include:</p> <p>ULP-D had a hire date of March 9, 2021. ULP-D's employee record lacked documentation of direct supervision to verify the ULP performed competently and to identify problems and solutions to address issues relating to the staff's ability to provide the services.</p> <p>ULP-E had a hire date of June 30, 2020. ULP-E's employee record lacked documentation of direct supervision to verify the ULP performed competently and to identify problems and solutions to address issues relating to the staff's ability to provide the services.</p> <p>ULP-F had a hire date of September 28, 2021. ULP-F's employee record lacked documentation of direct supervision to verify the ULP performed competently and to identify problems and solutions to address issues relating to the staff's ability to provide the services.</p> <p>ULP-G had a hire date of July 10, 2018. ULP-G's</p>	01430		

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01430	<p>Continued From page 8</p> <p>employee record lacked documentation of direct supervision to verify the ULP performed competently and to identify problems and solutions to address issues relating to the staff's ability to provide the services.</p> <p>On December 7, 2021, at 1:15 p.m., the Executive Director confirmed the requested records did not exist and the records of all sixty-five current employee's lacked documentation of direct supervision.</p> <p>The licensee's Supervisory Visits policy, dated January 2014, indicated the RN will periodically supervise unlicensed personnel performing delegated nursing tasks as defined in Rule 4668.0825, subpart 3. This must be completed 14 days after initiation of services and every 62 days thereafter, or more frequently if indicated, by clinical assessment and client's individual service agreement.</p> <p>TIME PERIOD FOR CORRECTION: Seven days</p>	01430		
01500 SS=F	<p>144G.63 Subd. 5 Required annual training</p> <p>(a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include:</p> <p>(1) training on reporting of maltreatment of vulnerable adults under section 626.557;</p> <p>(2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;</p>	01500		

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01500	<p>Continued From page 9</p> <p>(3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases;</p> <p>(4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders;</p> <p>(5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and</p> <p>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.</p> <p>(b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:</p> <p>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication;</p> <p>(2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or</p> <p>(3) information about strategies and technology that may enhance communication and</p>	01500		

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01500	<p>Continued From page 10</p> <p>involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received at least eight hours of annual training for each 12 months of employment for two of four staff files (ULP-F, ULP-G) reviewed. Interviews indicated the licensee did not complete annual training for any of the twenty-nine staff members.</p> <p>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 the residents).</p> <p>Findings Include:</p> <p>ULP-F and ULP-G personnel record lacked evidence of up-to-date annual training to include:</p> <ul style="list-style-type: none"> *Reporting of maltreatment of vulnerable adults under section 626.557 *Review of the assisted living (AL) bill of rights (BOR) *Review of infection control techniques *Effective approaches to use to problem solve when working with a resident's challenging behaviors *Review of the facility's policies and procedures *Principles of person-centered planning and service delivery 	01500		

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01500	<p>Continued From page 11</p> <p>Review of an employee hire date roster indicated twenty-nine staff members had hire dates before 2021 requiring annual training in 2021.</p> <p>During a conversation on December 7, 2021, at 1:15 p.m., with the Executive Director (ED), the investigator requested proof of annual training for ULP-F and ULP-G. The ED stated there were no documents for these staff members because annual training had not occurred for any of the employees since the beginning of COVID. The ED stated employees were trained face to face, and to avoid the spread of COVID this training did not take place.</p> <p>The policy titled Annual Training, dated July 13, 2021, indicated all staff will complete annual education to keep knowledge and skills current to provide quality care to residents. 3. Direct care staff will complete eight hours of annual training for each 12 months of employment.</p> <p>TIME PERIOD FOR CORRECTION: Seven days</p>	01500		
01620 SS=D	<p>144G.70 Subd. 2 Initial reviews, assessments, and monitoring</p> <p>(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.</p> <p>(d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an</p>	01620		

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01620	<p>Continued From page 12</p> <p>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.</p> <p>(e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted reassessments and resident education regarding sexual behavior, and update to documents to include all areas required on the 90-day assessment service plan for one of two residents (R1) with records reviewed. R1 and R2 were reportedly engaging in a sexual relationship, and the licensee failed to document assessments regarding the capacity to consent, education on risks and safety, and care conferences.</p> <p>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).</p> <p>The findings included:</p>	01620		

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01620	<p>Continued From page 13</p> <p>Review of R1's medical record was reviewed. R1's diagnoses included neurocognitive disorder and anxiety. R1's service plan dated November 19, 2021, indicated R1 received assistance with medication management, dressing and grooming, shower and toileting assistance, escorts, safety checks, and behavior management.</p> <p>Review of R1's Individual Abuse Prevention Plan, edited November 19, 2021, indicated R1 was susceptible to sexual abuse due to the lack of understanding of sexuality. Specific measures to minimize risk of abuse indicated staff to do safety checks every two hours. R1 was also susceptible to physical abuse due to the inability to identify potentially dangerous situations, lack of community orientation skills, and inappropriate interactions with others.</p> <p>Review of R1's nursing progress notes indicated on 8/7/21 R1 was found in another residents bed sleeping naked and staff redirected. On 8/8/21 staff found R1 and R2 in R1's room smoking, and staff redirected. On 8/12/21 staff found R1 showering in R2's room and staff redirected. On 8/14/21 staff found R1 sleeping in R2's bed and staff redirected. On 9/19/21 staff found R1 sleeping on R2's floor and staff redirected. On 10/28/21 staff found R1 had slept overnight in R2's bed and R2 slept in chair. On 11/27/21 staff found R2 in R1's room and he refused to leave, and staff redirected. The nursing notes lacked documentation of communication with R1's provider and family regarding concerns of sexual activity or education for R1 to understand her sexual behavior, or interventions other than staff to redirect.</p> <p>Review of R1's 90-day service plan dated August</p>	01620		

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01620	<p>Continued From page 14</p> <p>24, 2021, indicated #60 Vulnerable Assessment, no new interventions required. Behavior management indicated R1 demonstrated anxiety, disruptive and obsessive behavior requiring additional attention. Comments indicated R1 was sexual towards male residents and staff. This document lacked staff instruction to redirect R1, or progressive interventions as the behaviors continued.</p> <p>R2's medical record was reviewed. R2's diagnoses included anxiety, bipolar disorder, and dementia. R2's service plan dated February 16, 2021, indicated R2 received assistance with medication management, dressing and grooming, bathing assistance, safety checks and behavior monitoring.</p> <p>Review of R2's Individual Abuse Prevention Plan dated October 18, 2021, indicated R2 did not have vulnerabilities for sexual or physical abuse.</p> <p>Review of R2's nursing progress notes indicated on 8/8/21 staff found R1 and R2 in R1's room smoking, and staff redirected. On 8/12/21 staff found R1 showering in R2's room and staff redirected. On 8/14/21 staff found R1 sleeping in R2's bed and staff redirected. On 10/28/21 staff found R1 had slept overnight in R2's bed and R2 slept in chair. On 11/27/21 staff found R2 in R1's room and he refused to leave, and staff redirected. The nursing progress notes lacked documentation of a care conference with R2's family and the case manager regarding the complaint of his sexual activity with R1.</p> <p>During an interview on December 6, 2021, at 11:17 a.m. R2 stated that R1 was not his girlfriend but just a friend. R2 stated R1 had slept</p>	01620		

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01620	<p>Continued From page 15</p> <p>in his bed. R2 stated they were not intimate.</p> <p>During an interview on December 6, 2021, at 11:50 a.m., when asked if R2 was her boyfriend R2 answered yes, he's old, in his twenties. R1 stated she was 30 something, born in 1973. R1 stated R2 came to stay in her room, and she would go and sleep in his. When asked if she had sex with R2 and if he asked her to have sex R1 answered yes, and it was consensual. When asked what month and what season R1 answered incorrectly.</p> <p>During an interview on December 7, 2021, at 3:01 p.m., the Director of Nursing (DON) stated R1 was at times able to consent to sexual activity. The DON stated it was his understanding that staff were redirecting R1 when she demonstrated sexual behavior. The investigator asked if there was enough staff to ensure staff redirected R1, the DON stated at times.</p> <p>During an interview on December 17, 2021, at 4:01 p.m., a physician stated she did not receive a report that R1 and R2 were sexually active. The physician stated she was aware that R1 and R2 were friends and R2 saw himself as R1's caregiver. The physician stated she found R1 in R2's bed with her clothes on and had not witnessed sexual encounters or malicious behavior. The physician stated R1 was probably not able to consent to sexual activity. The physician stated because of R1 and R2's cognitive diagnoses they probably did not understand what they are doing.</p> <p>During an interview on January 10, 2022, at 3:42 p.m., the Executive Director (ED) stated staff made a complaint that R1 was being taking advantage of. The ED stated an internal</p>	01620		

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01620	<p>Continued From page 16</p> <p>investigation revealed that R1 was the predator and she entered male residents rooms. The ED stated R2 had become attached to R1 and wanted to take care of her, and they allowed R2 to do that. The ED stated everyone said R1 and R2 had sex. The ED stated they had a care conference with the family of R2 regarding the situation, however there was no documentation. The ED stated R2 had erectile dysfunction, and R2 stated to her he never had a sexual encounter with R1. The ED stated she had a conversation with the family of R1 regarding her sexual behavior, however it was not documented. The ED stated management instructed staff to direct R1 and R2 to keep their visiting to the common area.</p> <p>A policy titled "Minnesota Bill of Rights for Assisted Living Residents" dated August 1, 2021, indicated 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.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) Days</p>	01620		
02310 SS=F	<p>144G.91 Subd. 4 Appropriate care and services</p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by:</p>	02310		

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02310	<p>Continued From page 17</p> <p>Based on observations, interviews, and document review, the licensee failed to ensure adequate supervision for two residents (R3, R4), in accordance with accepted health care standards, when staff members did not respond to resident call lights within a reasonable amount of time. This had the ability to impact the health, safety, and comfort of all residents.</p> <p>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).</p> <p>Findings include:</p> <p>R3's medical record was reviewed. R3's medical diagnosis included dermatomyositis (inflammatory disease characterized by muscle weakness). R3's service plan dated October 29, 2021, indicated R3 received assistance with medication management, skin care, bathing, dressing, grooming, transfer and positioning assistance, toileting, and safety checks. R3 was wheelchair bound and utilized an electric wheelchair.</p> <p>R4's medical record was reviewed. R4's medical diagnoses included mild cognitive impairment, recurrent falls, episodic dysphagia. R4's service plan dated October 5, 2021, indicated R4 received assistance with medication management, skin care, bathing, dressing, grooming, transfer assistance, and safety checks.</p> <p>During an interview on December 7, 2021, at 8:33</p>	02310		

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02310	<p>Continued From page 18</p> <p>a.m., R3 stated he did not like staff taking him out of his chair once he was in it because it was painful to move. R3 stated he was able to recline his wheelchair to take pressure off his backside and preferred to do this rather than staff transferring him to bed every two hours. R3 stated staff transferred him two to three times a day to change him, but often he had to wait two to three hours.</p> <p>During an interview, R4 stated he pulled the wall cord while he was in the bathroom and needed assistance. R4 stated he waited for three hours before someone answered his call light. R4 stated he pushed his button the preceding evening at 5:00 p.m. because he did not receive his dinner, and nobody came. R4 stated he received his dinner four hours later.</p> <p>During the investigator's tour of the building on December 7, 2021, between 11:45 a.m. and 12:30 p.m., three residents on the 2nd floor and one resident on the 1st floor stated staff members answered their call light in approximately twenty minutes to an hour, or not at all.</p> <p>During an interview on December 12, 2021, at 2:34 p.m., Unlicensed Personnel (ULP-C) stated residents had to wait long periods of time for assistance and some staff will not answer the call light of people they do not want to help.</p> <p>During an interview, on January 3, 2022, at 8:22 a.m., a skilled nursing agency staff member stated R3 had wounds on his backside that required staff to off-load the resident every two hours. The staff member stated R3 reported that he often had to wait several hours for a staff member to answer his call light. The staff member stated agency clinicians had to wait a</p>	02310		

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02310	<p>Continued From page 19</p> <p>half-hour to an hour for the licensee's staff members to be available to receive report regarding the care of R3.</p> <p>During an interview on January 3, 2022, at 2:53 p.m., an Administrator stated they did not have a call light policy, but staff are to answer in ten minutes or less and that did not happen all the time.</p> <p>During an interview on January 10, 2022, at 3:42 p.m., an Executive Director (ED) stated there was no call light policy however staff should answer call lights in approximately twelve minutes. The ED stated staff do take a longer time to get to the call lights, and a half an hour is a long time, and it continues to be a problem, but they are working on it.</p> <p>Review of the resident call light history on January 10, 2022, at 1:31 p.m., indicated staff answered the call lights of the following residents in the listed minutes and seconds. patient #3 23:38 patient #24 22:26 patient #34 41:66 patient #41 59:54.</p> <p>The ED informed the investigator the system only retained history for 24 hours. The document was a screen shot of the computer screen and indicated residents activated the system 100 times, however, only 11 residents showed on the screen. The ED stated this was her first time reviewing the system and could not explain the number difference.</p> <p>A document titled "April All Staff" dated April 15, 2021, indicated Call Light-12 minutes.</p> <p>A policy titled "Minnesota Bill of Rights for</p>	02310		

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02310	Continued From page 20 Assisted Living Residents", dated August 1, 2021, indicated, #5 residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. TIME PERIOD FOR CORRECTION: SEVEN (7) days.	02310		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: Based on observations, interviews, and document review, the facility failed to ensure two of two residents reviewed (R3 and R4) were free from maltreatment. R3 and R4 were neglected. Findings include: On January 18, 2022, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	