Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL309868404M
Compliance #: HL309865603C

Date Concluded: October 26, 2023

Name, Address, and County of Licensee Investigated:

Majestic Pines Senior Living
1614 Golf Course Rd
Grand Rapids, MN 55744
Itasca County

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

Evaluator's Name:
Jana Wegener, RN, Special Investigator

Finding: Substantiated, facility responsibility

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

Initial Investigation Allegation(s):
The facility neglected a resident when they failed to provide supervision for a resident with severe cognitive impairment when he wandered outside to an enclosed patio area unsupervised. The resident required treatment for heat stroke at the emergency department.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility is responsible for the maltreatment. The resident wandered outside to the secured patio area on a hot summer afternoon, and remained outside unsupervised for approximately two and half hours before two staff brought the resident inside. The resident was unable to walk, hot to the touch, had a rapid heart rate, and respirations. The resident was transferred to the emergency department (ED) and received treatment for heat stroke.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member.

The investigation included review of ED, ambulance records, service agreement, assessment, care plan, individual abuse prevention plan (IAPP), progress notes, service delivery record, incident report, facility investigation, facility video surveillance footage, and facility policies and procedures. Also, the investigator observed the residents, staff, and patio area.

The resident resided in an assisted living memory care unit with diagnoses including frontotemporal dementia, diabetes type II, and hypertension.

The resident's service plan included assistance with dressing, bathing, grooming, toileting/incontinence care every two hours, and behavior management.

The resident's assessment, care plan, and IAPP indicated he was severely cognitively impaired with poor cognition and poor safety awareness. The resident was nonverbal, unable to communicate his needs or make himself understood, and unable to report pain or discomfort. The resident was at a risk for dehydration due to age, cognitive diagnosis, and decreased mobility. The resident required assistance to eat and drink and staff were directed to encourage fluid intake throughout the day and report signs of dehydration to nursing. The resident required direction from staff in an emergency and wandered/paced constantly within the locked memory care unit. The residents record lacked interventions or monitoring to ensure the resident was safe when wandering to the outdoor patio area. The resident record lacked any assessment regarding the resident's ability to safely access the outdoor patio space unsupervised.

A facility incident report indicated one day staff called 911 for possible heat stroke and the resident was transported to ED with fluids started in route to the hospital. The incident report indicated staff stated the resident was outside between 30-45 minutes sitting in the shade of the gazebo.

A resident progress note indicated when staff went to the outside secured patio to get the resident for dinner, he was unable to stand or walk. The resident was red, extremely warm to the touch, and was sent to the ED.

A post incident audit report indicated the resident went out to the secure patio area during extreme heat and remained outside for 45 minutes. The report indicated the patio door was updated and required staff assistance for residents to enter the outside patio area.

A local weather report from the day and the time of the incident indicated it was 94 degrees at the time.

A facility investigation indicated the resident was found on the memory care patio in a lethargic state. The Investigation indicated the resident was seen on security footage go outside at 1:40 p.m. then observed by staff outside on the patio area at 2:15 p.m. At 4:03 p.m. the resident was brought inside by two staff, and 911 was called. The facility investigative findings conclusion

indicated not all memory care residents had the cognitive ability to recognize the need to come inside during extreme weather.

The residents outside medical record indicated staff reported the resident was outside in the heat of the day for an unknown amount of time. The record indicated on arrival to the facility the resident was observed slouched forward, not responding, his skin was red, extremely hot to the touch, and diaphoretic with increased respiratory and pulse rate noted. Intravenous fluids were started to attempt internal cooling and the resident was transported to the ED. The record indicated the resident arrived at the ED for treatment of heat stroke after spending the day outside for an unknown duration of time. On admission to the ED the resident's temperature was 101.7, pulse rate was 131, he was very sweaty, and lethargic but responsive to pain. The record indicated the resident received intravenous fluids and was discharged back to the facility in stable condition and instructed to encourage hydration for the next couple of days.

When interviewed an unlicensed staff stated she toileted the resident at 1:15 p.m. and saw the resident going toward the patio area outside around 2:00 p.m. The staff stated it was very hot that day and the facility had no policy or procedure to guide staff to restrict resident access to the outdoor patio on days with inclement weather. The staff indicated the resident was not checked on or toileted every two hours as he should have been. The staff stated the resident would not understand if he needed to come inside to cool down or get a drink.

Another unlicensed staff stated she saw the resident was outside at 2:15 p.m. standing in the sun holding onto the fence. The staff stated she did not realize how hot it was because she did not open the door or go outside. The staff stated the resident was unable to recognize if he was too hot, thirsty, not feeling well, and needed to go inside. The staff member stated the resident was outside without staff and indicated that was usual practice. The staff stated the patio door automatically unlocked at 7:00 a.m. and locked at 7:00 p.m. and all residents could access the area unsupervised.

Another unlicensed staff stated she did not know the resident was outside until they started toileting residents before dinner. The staff stated it was a very hot day, almost 100 degrees outside, when she went outside to get the resident, but the resident refused to let go of the fence and come inside. The staff stated the resident appeared to be hot, sweaty, and was standing in the sun hanging onto the fence, but she did not think anything was concerning and left the resident outside. The staff stated a while later when they were bringing resident's in for dinner, she informed a coworker the resident was still outside and the two of them went to bring him in. The staff stated the resident was still standing in the sun holding onto the fence, but was unable to hold himself up or walk, his skin was red, hot to the touch, his shirt was drenched with sweat, and his ears and head looked sun burned. The staff stated the resident was not cognitively able to know if he was too hot or if he should come inside. The staff stated the facility had no process to restrict resident access to the outdoor patio area in inclement

weather. Staff stated they had no specific direction on how to monitor or supervise the residents using the outside patio area.

A licensed staff stated there was no process in place for staff to monitor or supervise resident's using the outside patio area. The staff stated the resident was completely dependent on staff to stay safe and meet his needs, and indicated the resident was unable to express if he was hot, thirsty, or in pain. The staff stated she saw the resident sometime after lunch but did not know how long he was outside. Staff stated when the resident was brought inside, he was semi-conscious, his skin was red and burning hot to the touch, and she called 911.

When interviewed facility leadership stated prior to the incident the secure memory care patio door was bypassed by staff so residents could come and go freely. Then just prior to the incident the facility installed a new door lock system which automatically unlocked the door at 7:00 a.m. and locked again at 7:00 p.m. at night. The leadership staff stated they had no process in place for inclement weather conditions including extremely hot days to direct staff to restrict access to the patio and/or to increase staff monitoring. Facility leadership stated it was common practice for residents to wander in and out of the patio area independently throughout the day, and indicated there was no specific process in place for staff to supervise or monitor the patio area when in use by residents. Leadership staff stated there was no assessment completed to determine if the residents who resided on the memory care unit were safe to access the patio area independently, and indicated the resident was severely cognitively impaired and did not have the awareness to understand if he was too hot and should go inside. Leadership staff stated the resident was outside for 45 minutes at the most.

A review of recorded facility provided video surveillance of the incident showed the resident wandering outside to the patio area at 1:40 p.m. At 2:15 p.m. one staff looked out the window to the patio area but did not go out to check on the resident. At 3:18 p.m. a staff member was seen go out to the courtyard and returned inside two minutes later. Then, 43 minutes later the same staff returned with another staff and at 4:03 p.m. the resident was observed slouched forward stumbling/shuffling his feet assisted by the two staff back into the facility two hours and 23 minutes after the resident went outside. Video footage was requested from the time the door was unlocked to determine if the resident was outside earlier that day but was not provided.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

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

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
Neglect means neglect by a caregiver or self-neglect.

(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: Did not respond to interview attempts.
Alleged Perpetrator interviewed: N/A

Action taken by facility:
Facility staff called 911 for the resident to get treatment of his heat stroke, barricaded the patio door to prevent other resident’s from wandering out to the outdoor patio area. The facility changed the patio door lock system to require a fob to let the resident’s in and out of the patio area.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:
https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Itasca County Attorney
Grand Rapids City Attorney
Grand Rapids Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30986	A. BUILDING: _____ B. WING _____	C 09/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAJESTIC PINES SENIOR LIVING	1614 GOLF COURSE ROAD GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******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: #HL309867509M/ #HL309864099C, #HL309867444M/ #HL309863957C, and #HL309868404M/ #HL309865603C On September 27, 2023, 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 94 residents receiving services under the provide's Assisted Living with Dementia Care license. The following correction orders are issued for #HL309867509M/ #HL309864099C, and #HL309867444M/ #HL309863957C tag identification 0620 and 0630, and 2360. The following correction orders are issued for #HL309868404M/ #HL309865603C, tag identification 2310 and 2360.	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.	
0 620 SS=D	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma	0 620		

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0 620	Continued From page 1 (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 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	0 620		

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0 620	Continued From page 2 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 report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment for two of two residents (R2, and R3) reviewed. The residents were neglected when the licensee failed to implement known interventions to prevent resident's from wandering into R3's room, and failed to identify and implement interventions to ensure safety with R2's wandering behaviors. As a result, R2 was harmed when he wandered into R3's room and R3 struck R2 in the head using his wheelchair pedal causing multiple head lacerations and a hematoma. 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	0 620		

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0 620	Continued From page 3 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings Include: A facility incident report titled "Other Injury" dated July 10, 2023, at 6:10 p.m. reviewed by registered nurse clinical manager (RNCM)-B indicated R2 had an open head injury after looking out the window in R3's room, R3 hit R2 in the head with his wheelchair pedal causing the wound. The incident report indicated when staff arrived R2 was holding down the wheelchair pedal so that R3 could not hit him with the pedal again. Staff separated the residents and R2 was sent to the ED for treatment. The resident received seven staples in his head to close the lacerations. The incident report identified R2 wandered into other resident's rooms frequently. However, at the time of the incident R2's assessment, care plan and IAPP, did not address R2's wandering behaviors or have actions implemented for monitoring, supervision, or redirection to ensure his safety. R2 was admitted to the facility on August 8, 2022, with diagnoses including vascular dementia with behavioral disturbance, and Alzheimer's Disease with depression. On July 10, 2023, at 7:39 p.m. R2's progress note indicated R2 was sent to the ED, and leadership staff were notified of the incident. On July 10, 2023, 9:01 p.m. R2's progress note indicated R2 was fearful when he returned to the facility after going to the ED and took 15-20	0 620		

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0 620	Continued From page 4 minutes to enter the building due to being fearful someone was going to kill him. On July 11, 2023, at 8:47 a.m. the day after the incident occurred (RNCM)-B documented R2 wandered into other rooms frequently. The progress note indicated staff reported R2 was in R3's apartment "looking out the window" when R3 became upset and hit R2 over the head with the pedal from his wheelchair. When staff arrived in R3's room, R2 was holding down the wheelchair pedal so that he did not get hit with it again. The note indicated R2 was sent to the ED and had seven staples placed in three separate lacerations on the left side of his scalp. R2 had a hematoma present under the largest of these lacerations. Although RNCM-B's documentation indicated the facility was aware R2 wandered into other resident rooms frequently R2's assessment, care plan, and IAPP at the time of the incident failed to address the behavior or have actions in place to supervise R2's wandering and ensure safety. R2's service plan dated August 9, 2022, included behavior management services added on October 27, 2022, for resistive, aggressive, physical and verbally abusive behaviors and indicated triggers were bathing, cares, other resident's and staff. The service plan failed to address failed to identify R2 wandered into other resident rooms prior to the incident. R2's assessment dated May 1, 2023, indicated R2 was cognitively impaired related to vascular dementia, and Alzheimer's Disease with depression diagnoses. The assessment indicated R2 was sometimes able to make his needs known and had a history of threatening physical violence toward residents and staff and indicated	0 620		

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0 620	Continued From page 5 staff were to offer a foot bath if R2 was agitated. The assessment indicated R2 wandered in and out of the building while at home but failed to identify R2 wandered into other resident rooms prior to the incident. R2's care plan updated on May 24, 2023, indicated R2 had moderately impaired cognition, was disoriented to time/place, and sometimes understood. The care plan indicated R2 had difficulty communicating due to cognitive impairment related to vascular dementia. R2's care plan indicated he was independent with mobility and walked without assistance. The care plan indicated R2 was at risk for elopement/wandering but provided no specific actions implemented for supervision, monitoring, or redirection other than the resident to resided in a secure memory care unit prior to the incident. R2's individual abuse prevention plan (IAPP) dated May 24, 2023, indicated R2 was disoriented to time, place, and had history of verbally abusive threatening behaviors towards residents and staff, and indicated R2 received medication to help control anxiety symptoms. The assessment IAPP failed to identify R2 wandered into other resident rooms, and had no interventions for supervision, monitoring, or redirection prior to the incident. R3 was admitted to the facility on October 11, 2022, with diagnoses including Wernicke-Korsakoff syndrome (alcoholic), emotional liability, behavioral disturbance, aggressive behavior, stroke, and traumatic brain injury. R3's service plan effective October 11, 2022, prior to the incident included assistance with dressing,	0 620		

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0 620	Continued From page 6 grooming, toileting, incontinence care, medication management and administration services, and transfer assistance using one staff. The service agreement lacked behavior management services at the time of the incident. R3's progress notes prior to the incident from October 10, 2022, to September 28, 2023, included documentation of verbally and physically aggressive behaviors toward other residents including grabbing another resident's arm and threatening to put resident's and family members "down in a military way". On December 12, 2023, at 4:12 p.m. R3's progress note indicated a female resident was heard yelling from R3's room, when staff entered the room R3 was observed grabbed and was holding onto another resident by the arm. On April 15, 2023, at 3:47 p.m. 86 days prior to the incident, R3's progress note documented an incident when R3 believed another resident had murdered his daughter and left her in a ditch, R3 was verbally threatening to kill the other resident. The progress note indicated the RN on call was notified and due to R3's delusions staff were to lock R3's door when he was in his room to prevent other residents from entering. However, the intervention to lock R3's door to prevent resident's from entering was not implemented. R3's assessment prior to the incident dated June 13, 2023, indicated R3 was cognitively impaired but usually made himself understood. The assessment identified R3 was verbally abusive towards other residents and members of their families and physically aggressive towards staff. The assessment identified R3 had delusions and accused staff of doing things to him that were not	0 620		

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0 620	Continued From page 7 reality, threatened other residents and their families, and would get upset and bang on other resident's doors for an unknown reason. The assessment indicated staff were to ensure resident safety and update the RN with any concerns. The assessment failed to identify R3 had a history of physically aggressive behaviors toward residents and had no specific interventions in place to manage R3's behaviors or ensure safety. R3's care plan prior to the incident dated June 13, 2023, indicated R3 was physically aggressive towards staff and had pushed/hit staff members. The care plan indicated R3 was verbally aggressive towards staff and residents and had threatened other residents and their families. The care plan indicated staff were to ensure resident safety and update the RN with any concerns. The care plan failed to identify R3 had a history of physically aggressive behaviors toward residents and had no specific interventions in place to manage R3's behaviors or ensure safety. R3's IAPP prior to the incident dated June 13, 2023, identified R3 had physically aggressive behaviors towards staff, and verbally aggressive threatening behaviors toward residents, families, and staff. The IAPP identified R3 had socially inappropriate behavior and yelled/banged on other resident's doors because he was upset for an unknown reason. The IAPP indicated R3 had agitated resistive behavior, mental illness, paranoia regarding other residents stealing his belongings, or believing they were going to do something bad. R3's IAPP failed to identify he had a history of physically aggressive behaviors toward residents and had no specific interventions in place to manage R3's behaviors or ensure safety.	0 620		

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0 620	Continued From page 8 A facility investigation form dated July 21, 2023, indicated the incident occurred R2 wandered into R3's apartment, then R3 hit R2 over the head with the pedal from his wheelchair. The incident was not witnessed and indicated staff responded heard R3 yelling and when they entered R3's room R2 was observed kneeling on the floor in front of R3's recliner holding one end of the wheelchair pedal and R3 had the other end. Staff reported R2 was bleeding from his head, they removed R2 from R3's room, and called for assistance. R2 was transported to the ED and received seven staples in his head. On September 27, 2023, 1:52 p.m. licensed assisted living director (LALD)-A stated she recalled being made aware of the incident the next day. LALD-A stated R2 wandered into R3's room then a short time later R3 struck R2 in the head with his wheelchair pedal, R3 yelled out and staff responded. LALD-A stated R3 had behaviors but no physical aggression prior to the incident, and indicated it was not uncommon for R2 to wander into R3's room. On September 27, 2023, at 1:52, p.m. RNCM-B indicated no interventions were in place to monitor wandering behaviors and ensure R2's safety other than routine every two-hour safety checks. RNCM-B stated R3 did not have any physical aggression toward other residents, and stated R2 did not wander into other resident rooms despite documenting in R2's progress notes and reviewing R2's incident report which identified R2 wandered into other resident rooms frequently. A review of R2's service delivery record failed to include every two hour safety checks, as a result there was no way to determine if the safety checks were completed.	0 620		

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	30986	A. BUILDING: _____ B. WING _____	C 09/27/2023

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0 620	Continued From page 9 On October 18, 2023, at 8:45 p.m. LPN-J stated R3 had threatened staff using his wheelchair foot pedal as a weapon during and incident when R3 was delusional and thought R2 murdered his daughter and left her in a ditch. LPN-J stated the incident was reported but no interventions were put in place to ensure safety until after the incident when R3 struck R2 in the head with his wheelchair foot pedal. On October 4, 2023, 4:56 p.m. an email communication from LALD-A indicated at the time of the incident leadership and quality assurance determined that a resident to resident incident did not constitute reporting, and indicated there was no documentation to support the decision not to report the incident to MAARC. Facility policy and procedure titled "Reporting, Documenting and Reviewing Incidents Involving Residents" reviewed June 2023, indicated in section 2. If the Incident must be reported MAARC the RN will make the report as soon as possible and no later than 24 hours after the incident consistent with the Vulnerable Adult Reporting Policy. Section 4. Indicated the RN would review the incident investigation report, implement any necessary interventions to prevent a future similar incident, update any necessary assessments, and update the service plan/care plan if needed with in 24-48 hours of the incident occurring. Facility policy titled "Vulnerable adult Reporting and Investigation Policy" reviewed July 2022, indicated the facility would immediately report no later than 24 hours after being made aware of the incident. Section 2, immediate steps when there was a witnessed incident or allegation of	0 620		

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0 620	Continued From page 10 maltreatment. The policy indicated staff was required to report to the MAARC when a resident has sustained a physical injury which is not reasonably explained. Such physical injuries may include, but are not limited to, unexplained bruises, skin tears, lacerations, or fractures. The agency RN or Executive Director will be notified of such unexplained injuries and conduct an internal investigation, as described below, to determine whether a report to the MAARC is required. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
0 630 SS=H	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement an individual abuse prevention plan to ensure safety for 3 of 3 residents (R1, R2, and R3) with	0 630		

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0 630	Continued From page 11 wandering and aggressive behaviors. The licensee failed to reassess and timely implement interventions following resident to resident altercations which caused harm to two of the three residents (R1, and R2). R2 was harmed when he wandered into R3's room and R3 struck R2 in the head with his wheelchair pedal causing multiple head lacerations and a hematoma. R2 required transfer to the emergency department (ED) and seven staples to close his head injury. Nine days later R1 was harmed when R2 wandered into R1's room and had an altercation which caused a bruising injury to R1's face and lip. This practice resulted in a level three violation (a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of clients are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly but is not found to be pervasive). Findings Include: R3 was admitted to the facility on October 11, 2022, with diagnoses including Wernicke-Korsakoff syndrome (alcoholic), emotional liability, behavioral disturbance, aggressive behavior, stroke, and traumatic brain injury. R3's service plan effective October 11, 2022, prior to the incident included assistance with dressing, grooming, toileting, incontinence care, medication management and administration services, and transfer assistance using one staff. The service	0 630		

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0 630	Continued From page 12 agreement failed to include behavior management services at the time of the incident. R3's progress notes prior to the incident from October 10, 2022, to September 28, 2023, included numerous documentation's of verbally and physically aggressive behaviors toward other residents including grabbing another resident's arm, punching another resident in the genitals, and threatening to put resident's and family members "down in a military way". On December 12, 2023, at 4:12 p.m. R3's progress note indicated a female resident was heard yelling from R3's room, when staff entered the room R3 was observed grabbed and was holding onto another resident by the arm. On April 15, 2023, at 3:47 p.m. 86 days prior to the incident, R3's progress note documented an incident when R3 believed another resident had murdered his daughter and left her in a ditch. The progress note indicated R3 was verbally threatening to kill the other resident. The progress note indicated the RN on call was notified and due to R3's delusions staff were to lock R3's door when he was in his room to prevent other residents from entering. However, the intervention to lock R3's door to prevent resident's from entering was not implemented on R3's care plan or IAPP. On September 17, 2023, at 10:00 a.m. R3's progress note indicated staff were escorting R3 to the dining room when another resident stepped in the way. The note indicated staff attempted to redirect another resident but R3 struck the resident with a closed fist in the genitals because he assumed the resident had stolen something from him.	0 630		

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0 630	Continued From page 13 R3's assessment prior to the incident dated June 13, 2023, indicated R3 was cognitively impaired but usually made himself understood. The assessment identified R3 was verbally abusive towards other residents and members of their families and physically aggressive towards staff. The assessment identified R3 had delusions and accused staff of doing things to him that were not reality, threatened other residents and their families, and would get upset and bang on other resident's doors for an unknown reason. The assessment indicated staff were to ensure resident safety and update the RN with any concerns. The assessment failed to identify R3 had a history of physically aggressive behaviors toward residents and had no specific interventions in place to manage R3's behaviors or ensure safety. A post incident assessment was requested, none was received. The facility provided a post ED return assessment 60 days after the incident occurred dated September 8, 2023, which indicated R3 had physically aggressive behaviors toward other residents and included the intervention for R3's apartment door to be locked to prevent other residents from wandering into his apartment. R3's care plan prior to the incident dated June 13, 2023, indicated R3 was physically aggressive towards staff and had pushed and hit staff members. The care plan indicated R3 was verbally aggressive towards staff and residents and had threatened other residents and their families. The care plan indicated staff were to ensure resident safety and update the RN with any concerns. The care plan failed to identify R3 had a history of physically aggressive behaviors toward residents and had no specific interventions in place to manage R3's behaviors	0 630		

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0 630	Continued From page 14 or ensure safety. R3's care plan was not updated following the incident to include R3's aggressive behavior toward resident's and interventions to lock R3's door was not added to the care plan until September 8, 2023, 60 days after the incident with R2 and R3 occurred. R3's IAPP prior to the incident dated June 13, 2023, identified R3 had physically aggressive behaviors towards staff, and verbally aggressive threatening behaviors toward residents, families, and staff. The IAPP identified R3 had socially inappropriate behavior and yelled/banged on other resident's doors because he was upset for an unknown reason. The IAPP indicated R3 had agitated resistive behavior, mental illness, paranoia regarding other residents stealing his belongings, or believing they were going to do something bad. R3's IAPP failed to identify he had a history of physically aggressive behaviors toward residents and had no specific interventions in place to manage R3's behaviors or ensure safety. R3's IAPP was not updated following the incident to include R3's aggressive behavior toward resident's and the intervention to lock R3's door was not added to the IAPP till September 8, 2023, 60 days after the incident occurred. R3's behavior plan indicated staff were to lock R3's apartment door to prevent other resident's from wandering into his apartment implemented on August 23, 2023, 44 days after the incident between R2 and R3 occurred, and 130 days after the intervention was identified. R3's service delivery record failed to include safety checks or task to ensure R3's door was locked.	0 630		

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0 630	Continued From page 15 R2 was admitted to the facility on August 8, 2022, with diagnoses including vascular dementia with behavioral disturbance, and Alzheimer's Disease with depression. R2's service plan dated August 9, 2022, included behavior management services added on October 27, 2022, for resistive, aggressive, physical and verbally abusive behaviors and indicated triggers were bathing, cares, other resident's and staff. The service plan indicated staff would provide distraction, redirection, as needed (PRN) medications, use another staff member, and give him time then re-approach. The service plan failed to address R2's wandering behaviors until July 24, 2023, fourteen days after the incident between R2 and R3 occurred. The service plan indicated staff should document times the resident was wandering and where he was at in the unit. The service plan failed to identify R2 wandered into other resident rooms, and had no interventions for supervision/monitoring, or redirection. R2's assessment prior to the incident dated May 1, 2023, indicated R2 was cognitively impaired related to vascular dementia, and Alzheimer's Disease with depression diagnoses. The assessment indicated R2 was sometimes able to make his needs known and had a history of threatening physical violence toward residents and staff and indicated staff were to offer a foot bath if R2 was agitated. The assessment indicated R2 wandered in and out of the building while at home but failed to identify R2 wandered into other resident rooms. R2's care plan prior to the incident updated on May 24, 2023, indicated R2 had moderately impaired cognition, was disoriented to time,	0 630		

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0 630	Continued From page 16 place, and was sometimes understood. The care plan indicated R2 had difficulty communicating due to cognitive impairment related to vascular dementia. R2's care plan indicated he was independent with mobility and walked without assistance. The care plan indicated R2 was at risk for elopement/wandering and indicated specific actions were for the resident to reside in a secure memory care unit. The care plan failed to identify R2 wandered into other resident rooms, and had no interventions for supervision/monitoring, or redirection. R2's individual abuse prevention plan (IAPP) prior to the incident dated May 24, 2023, indicated R2 was disoriented to time, place, and had history of verbally abusive threatening behaviors towards residents and staff, and indicated R2 received medication to help control anxiety symptoms. The IAPP failed to identify R2 wandered into other resident rooms, and had no interventions for supervision/monitoring, or redirection. R2's service delivery record failed to include every two hour safety checks. On July 11, 2023, at 8:47 a.m. the day after the incident occurred, registered nurse clinical manager (RNCM)-B documented in a progress note that R2 wandered into other resident rooms frequently. The progress note indicated staff reported R2 was in R3's apartment "looking out the window" when R3 became upset and hit R2 over the head with the pedal from his wheelchair. R2 was sent to the ED and had seven staples placed in three separate lacerations on the left side of his scalp. R2 had a hematoma present under the largest of these lacerations. The note indicated a reassessment would be completed on this date. However, the facility failed to complete	0 630		

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0 630	Continued From page 17 a reassessment until 21 days later on July 31, 2023, after a fall incident occurred. Although RNCM-B's documentation indicated the facility was aware R2 wandered into other resident rooms frequently R2's assessment, care plan, and IAPP at the time of the incident failed to address the behavior or have actions in place to supervise R2's wandering and ensure safety. A facility incident report titled "Other Injury" dated July 10, 2023, at 6:10 p.m. reviewed by RNCM-B indicated R2 had an open head injury after looking out the window in R3's room, R3 hit R2 in the head with his wheelchair pedal causing the wound. The incident report indicated when staff arrived R2 was holding down the wheelchair pedal so that R3 could not hit him with the pedal again. Staff separated the residents and R2 was sent to the ED for treatment. The resident received seven staples in his head to close the lacerations. The incident report identified R2 wandered into other resident's rooms frequently. However, at the time of the incident R2's assessment, care plan and IAPP, did not address R2's wandering behaviors or have actions implemented for monitoring, supervision, or redirection to ensure his safety. A facility investigation form dated July 21, 2023, indicated the incident occurred in R3's apartment, R2 was hit over the head with the pedal from R3's wheelchair. R3 was yelling and when staff entered the room R2 was observed kneeling on the floor in front of R3's recliner holding one end of the wheelchair pedal and R3 was holding the other end. Staff reported R2 was bleeding from his head, they removed R2 from R3's room and called for assistance. R2 was transported to the ED and had seven staples in his head. The facility investigation included an action plan which	0 630		

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0 630	Continued From page 18 indicated R3's apartment door would be locked at all times when he was in his room, and R3's wheelchair pedals were removed. However, the facility failed to include the intervention on R3's care plan or IAPP for staff to implement until 60 days after the incident occurred and was not added to R3's behavior plan until 44 days following the incident. A review of the facility provided security footage from September 10, 2023, an agitated male voice using profane language was heard while R2 wandered in the common area near R3's room. R3's door was open, and R2 was observed looking out the window in the common area. The next video R2 is not seen, but mumbled incoherent speech is heard. Staff then enters the room stated, "Is everybody", as she entered the room indicating she knew R3 was not alone in his room. Then staff is heard tell R3 "let go, let go, OH MY GOD, you did not!". R3 responded "This is my room!". Staff stated, "I cannot believe you did that!", then R3 responded "He was steeling my shit!". Staff removed R2 from R3's room and called for assistance. A care conference note dated July 21, 2023, at 12:42 p.m. regarding resident to resident abuse indicated leadership, R2, and R3's families met and agreed it was best to keep R2 and R3 away from each other as much as possible when they are not supervised. The intervention was not implemented on either resident's care plan or IAPP. Nine days after the incident with R2 and R3 another incident report dated July 19, 2023, at 9:10 p.m. updated on July 28, 2023, by licensed practical nurse (LPN)-J indicated R1 had a swollen upper lip on the left side with unknown	0 630		

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0 630	Continued From page 19 cause. The incident report indicated R1 was not a reliable reporter or historian due to dementia diagnoses of the incident and indicated she had several explanations of what happened after the incident occurred stating she was pushed, then hit something, and was hit by something, and that she was hit. The incident report indicated there were no witnesses of the incident. The incident report indicated family was notified the following morning. Actions taken indicated ice pack was applied for comfort, R1's door was locked, and the medication cart was moved to more common area for better oversite on the unit. Facility document titled "Internal Investigation of Suspected Maltreatment" signed on July 21, 2023, indicated on July 19, 2023, at approximately 8:50 p.m. R1 reported to ULP-J with a swollen lip. The resident stated "the man that comes into my room and won't leave just hit me in the face!" The incident report indicated the cause of R1's injury was unknown, but a review of the facility security footage indicated there may have been a struggle between R1 and R2 over R1's apartment door. The investigation indicated actions taken to prevent recurrence included R1's apartment door would be closed, locked, and checked during unit rounding every two hours. The licensee failed to ensure the intervention to lock R1's door was implemented timely on R1's care plan and IAPP. The facility provided security footage revealed a verbal altercation between a male and a female was heard, then a physical struggle over R1's apartment door was observed, followed by a loud bang. R2 was seen leaving R1's room, then a short time later R1 left her room with swelling observed on her left upper lip, no staff were present at the time of the incident.	0 630		

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0 630	Continued From page 20 R1 was admitted to the facility on February 20, 2023, with diagnoses including memory loss. R1's service plan effective March 4, 2023, included assistance with dressing, grooming, bathing, and medication administration services. R1's assessment dated June 12, 2023, indicated R1 was disoriented to place time, with sundown's but was disoriented throughout the day and night. The assessment indicated R1 had a pattern of wandering into others rooms but resided in a secure memory care unit. Two days after the incident with R1 and R2 a assessment dated July 21, 2023, included intervention for staff to lock R1's door and ensure the door is locked during safety rounds. However, the intervention was not implemented on R1's IAPP for staff to implement until 12 days later, and was not implemented on R1's care plan until August 29, 2023, 41 days after the incident. R1's care plan dated June 12, 2023, indicated R1 was moderately cognitively impaired and disoriented to time place, and was sometimes able to make herself understood but had difficulty finding her words. The care plan indicated R1 was unable to problem solve, and had no behavior concerns identified at the time of the incident. The care plan indicated R1 wandered inside, occasionally into other's rooms, but doesn't leave building. The care plan indicated there were no specific interventions to monitor, supervise or redirect R1 from wandering into other resident rooms other than R1 resided in a secure memory care unit. The care plan dated August 29, 2023, 41 days after the incident with R1 and R2, included the intervention to lock R1's apartment door and to check residents door lock	0 630		

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0 630	Continued From page 21 during safety checks. R1's IAPP dated June 12, 2023, indicated R1 had difficulty weighing advice and had impaired judgment related to cognitive decline and was unable to problem solve or weigh advice effectively. The IAPP identified R1 was at risk to be abused by other residents living in close proximity that may have behaviors. (physically, verbally, emotionally, financially, and/or sexually) and indicated specific measures should be implemented to minimize risk. The IAPP included a blanketed statement included on each IAPP reviewed that indicated staff trained to recognize and report abuse per vulnerable adult policy, but provided no specific interventions to reduce R1's risk for being abused. The licensee failed to update R1's IAPP following the incident until 12 days later on July 31, 2023. On September 27, 2023, 1:52 p.m. LALD-A stated R2 wandered into R3's room then a short time later R3 struck R2 in the head with his wheelchair pedal. R3 yelled out and staff responded. LALD-A R3 had behaviors but no physical aggression prior to the incident, and indicated it was not uncommon for R2 to wander into R3's room and indicater there was no other interventions other than routine every two hour safety checks. On September 27, 2023, at 1:52, p.m. RNCM-B indicated no interventions were in place to monitor wandering behaviors and ensure R2's safety with wandering other than routine ever two-hour safety checks. RNCM-B stated R3 did not have any physical aggression toward other residents, and stated R2 did not wander into other resident rooms despite doumenting in R2's progress notes and reviewing R2's incident report	0 630		

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	30986	A. BUILDING: _____ B. WING _____	C 09/27/2023

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0 630	Continued From page 22 which identified R2 wanderred into other resident rooms frequently. A review of R2's service delivery record failed to include every two hour safety checks, as a result there was no way to determine if the safety checks were completed for R2. RNCM-B stated after the incident R3's door was to be locked to prevent other residents from wandering in. RNCM-B indicated communication of changes implimented were communicated to staff verbally or in RTasks communication. A review of RTasks staff communication failed to include interventions for monitoring/redirecting R2 from wandering into other resident rooms, or interventions for R3's apartment door to be locked to prevent residents from entering were communicated to staff. On September 27, 2023, at 10:13 p.m. RN-C stated R2 wandered into R3's room and it appeared R3 hit R2 in the head with a pedal from his wheelchair. RN-C stated R2, and R3 had no physical aggression towards other residents prior to the incident. RN-C stated after the incidents R1, and R3's doors were to be locked to prevent other residents from wandering in. RN-C indicated wandering behaviors should be identified on the resident's care plan. On September 27, 2023, at 10:29 a.m. ULP-E since the incident with R2 and R3 staff now try and keep R2 and R3 separate, and R3's door locked. ULP-E stated R3 was agitated and aggressive toward staff but she did not recall if R3 had physical aggression toward other residents. ULP-E stated after R2 was injured by R3 he was more resistive, isolated in his room, refused to come out for meals, was withdrawn, fearful, and seemed hesitant to engage in activities on the unit. ULP-E stated after the	0 630		

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0 630	Continued From page 23 incident no interventions to supervise or redirect R2 from wandering into other resident rooms was implemented and R2 wandered into other resident rooms frequently. ULP-E stated R2 wandered into R1's room one evening and R1 ended up with an injury to her lip. On September 27, 2023, at 11:16 a.m. certified nursing assistant (CNA)-F stated one evening shift after supper, R2 was wandering which was his usual. CNA-F stated R3 was always easily agitated and the slightest thing could set him off and cause him to be aggressive. CNA-F stated R3 was brought to his room and was waiting to go to bed when R2 wandered into his room. CNA-F stated she heard R3 yelling, went to his room and saw R2 was kneeling next to R3's recliner holding down the pedal and R3 had hold of the other part of the pedal trying to pull it up. R2 said "he is trying to kill me" when I look down and there was a pillow covered with blood. R2 looked at me then I saw blood running down his face into his eye and mouth. CNA-F stated she asked R3 if she hit R2, and R3 responded "he was in my fucking room!" CNA-F stated for a couple of weeks after the incident R3 continued to cuss at R2 when he saw him, and after the incident R3 told his wife R2 was "looking out the window laughing, but he wasn't laughing anymore when I got done with him!" CNA-F stated R2 was unable to verbalize what happened after the incident but was more quiet, withdrawn, would not leave his room, and expressed being fearful about that man out there. CNA-F indicated R2 continued to wander into other resident rooms following the incident, then one night he wandered into R1's room and she came out with a busted up lip. On October 5, 2023, at 11:09 a.m. ULP-I stated	0 630		

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0 630	Continued From page 24 R3 had aggressive behaviors and tendencies before that incident with R2, and staff knew he did not like it when other residents wandered into his room. ULP-I stated after the incident R3's door was locked. ULP-I stated R2 wandered into other rooms frequently and had become aggressive with staff when redirected. ULP-I stated R2 wandered into R1's room and R1 ended up with an injury to her lip. ULP-I stated R1 was not a reliable reporter and was inconsistent with her statements after the incident. On October 9, 2023, at 10:08 a.m. ULP-J stated all residents including resident's who wander had safety checks every two hours but no other interventions were in place to monitor or redirect resident's from wandering into other resident rooms. ULP-J indicated if a resident was wandering and needed more frequent checks it would be on the service plan. On October 9, 2023, at 10:15 a.m. licensed practical nurse (LPN)-K stated R3 had aggressive unpredictable behaviors prior to the incident and the smallest thing could set him off, and indicated the other resident's were afraid of him. LPN-K stated after the incident with R2 and R3 staff locked R3's door to keep other residents from wandering in, and indicated no other interventions for wandering resident's were implemented other than routine every two hour safety checks. On October 4, 2023, 8:42 a.m. an email communication from RNCM-B indicated R2's assessment completed on July 31, 2023, was completed after R2 fell, and was not completed as a result of the incident on July 10, 2023, or following R2's subsequent ED visit and return to the facility. Post incident and post ED visit assessments for the residents involved in the July	0 630		

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0 630	Continued From page 25 10, 2023, and July 19, 2023, incidents were requested, none was provided. On October 18, 2023, at 8:45 p.m. LPN-J stated R3 had threatened staff using his wheelchair foot pedal as a weapon during and incident when R3 was delusional and thought R2 murdered his daughter and left her in a ditch. LPN-J stated the incident was reported but no interventions were put in place to ensure safety until after the incident when R3 struck R2 in the head with his wheelchair foot pedal. LPN-J indicated she was not aware of the need to lock R3's door following the incident with R2 because it was not on R3's services checklist for staff to implement. LPN-J stated staff go by the services check list for each resident to ensure the residents care plan and IAPP are implimented. LPN-J indicated unless specific tasks including monitoring, safety checks, and resident specific actions were implimented on a residents services check list staff would not know they needed to be completed and nursing would not be able to verify if something was done or not. The facility Policy and Procedure titled "Mood/Behavior Evaluation and Management" reviewed July 2021, indicated the facility would review target mood and behaviors on residents to assure that appropriate care and interventions for those residents were being implemented. This review will occur on a quarterly schedule unless a change of resident condition indicates that the review needs to occur more frequently. The policy indicated residents with known behaviors that place them at risk for injury will have an Individualized Abuse and Prevention Plan in place which will be individualized to the needs of the resident. The policy indicated a review of mood and behaviors within the resident assessment will	0 630		

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0 630	Continued From page 26 be completed by a registered nurse (RN) to assure that appropriate interventions remain in place in the resident's plan of care to decrease incidents of mood or behavioral problems. Facility policy and procedure titled "Reporting, Documenting and Reviewing Incidents Involving Residents" reviewed June 2023, section 4. Indicated the RN would review the incident investigation report, implement any necessary interventions to prevent a future similar incident, update any necessary assessments, and update the service plan/care plan if needed with in 24-48 hours of the incident occurring. Resident to resident incident reports were requested from March 2023 - current, however no other incidents were provided by the facility despite documentation in R3's resident record of a resident to resident incident where R3 struck another resident in the genitals. On October 17, 2023, at 11:08 a.m.LALD-A indicated in an email communication there were no other incidents of resident to resident altercations for the entire building other than the those investigated from July 10, 2023, and July 19, 2023. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 630		
02310 SS=I	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	02310		

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02310	Continued From page 27 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: The licensee failed to provide appropriate care, services, supervision, and monitoring for 1:1 residents (R4) who resided in a secure memory care unit with severe cognitive impairment and was harmed when R4 suffered heat stroke and was transferred to the emergency department by ambulance after he wandered out to a outdoor patio area and remained outside for two hours and 23 minutes unsupervised during an extremely hot day. The licensee failed to assess R4's ability to safely access the patio independently and had no policy, procedure, or process in place for staff to ensure the safety of the residents. This had the potential to affect all 22 residents who resided in the memory care unit. 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). Findings include: R4 was admitted to the facility on October 28, 2022, with diagnoses including frontotemporal dementia, diabetes mellitus Type II, and hypertension.	02310		

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02310	Continued From page 28 R4's service agreement dated December 23, 2022, included assistance with all activities of daily living (ADL)s including dressing, bathing, grooming, toileting, and behavior management services which included monitoring of anger, crying, and indicated staff would remove him from the situation, distract, and redirect the resident. R4's assessment prior to the incident dated August 18, 2023, indicated R4 was severely cognitively impaired, with poor cognition, and poor safety awareness. The assessment identified R4 was nonverbal, unable to communicate his needs or make himself understood, and unable to report pain or discomfort. The assessment identified R4 was at a risk for dehydration due to age, cognitive diagnosis, decreased mobility, and required staff assistance to eat and drink. The assessment indicated R4 was incontinent of bowel and bladder and required staff assistance with toileting/incontinence care every two hours. The assessment indicated staff would encourage fluid intake throughout the day and report signs of dehydration to nursing. The assessment indicated R4 required direction from staff in an emergency and wandered/paced constantly within the locked memory care unit. The assessment failed to address R4's ability to safely access the memory care patio area unsupervised. A post ED readmission assessment identified no changes implemented following the incident. R4's care plan prior to the incident dated August 28, 2023, identified R4 was at a risk for dehydration due to age and cognitive impairment and indicated staff would encourage R4 to drink fluids with meals and through out the day and report any signs of dehydration to nursing. The care plan indicated R4 was incontinent of bowel	02310		

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02310	Continued From page 29 and bladder and required toileting every two hours. The care plan indicated R4 was non verbal, unable to report pain, discomfort, was unable to call for assistance, and unable to evacuate in an emergency. The care plan indicated R4 was at risk to be abused by others living in close proximity who may have behaviors, and wandered/paced constantly with in the secure memory care unit but failed to include specific interventions for R4's wandering including supervision monitoring, and failed include R4's ability to safely access the outside in the patio area unsupervised. R4's care plan dated September 5, 2023, indicated no changes were implemented following the incident. R4's individual abuse prevention plan (IAPP) dated September 3, 2023, indicated R4 was severely cognitively impaired, not oriented to person place or time, was non verbal due to dementia progression and required full assistance from staff with ADL's including eating drinking. The IAPP indicated R4 was not able to communicate his needs, had impaired judgment, and difficulty weighing advice. The IAPP identified R4 was at risk to be abused by others living in close proximity who may have behaviors, and wandered/paced constantly with in the secure memory care unit but failed to include specific interventions for R4's wandering including supervision monitoring, and failed include R4's ability to safely access and utilize the outside in the patio area unsupervised. R4's IAPP post incident dated September 11, 2023, indicated no changes were implemented following the incident. On September 3, 2023, at 4:37 p.m. licensed practical nurse (LPN)-G documented R1 was outside, staff went to get him for dinner but R4 was unable to stand/walk. The progress note	02310		

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02310	Continued From page 30 indicated R4 was red, extremely warm to the touch, and was sent to the ED. A facility incident report titled "911 Call" dated September 3, 2023, at 4:40 p.m. indicated LPN-G called 911 for possible heat event, and R4 was transported to ED. The incident report indicated staff reported the resident was outside between 30-45 minutes sitting in the shade of the gazebo. The incident report indicated when resident was transferred to the ED staff blocked the courtyard door so no other residents could go outside until the door was locked by leadership at 7:30 p.m. and indicated staff now had to use a fob to access the patio area. An undated incident audit report form indicated the resident went out to the secure patio during extreme heat and remained outside for 45 minutes, then was sent to ED for heat stroke. The report indicated the patio door was updated to require staff assistance for residents to exit. A facility investigation dated September 27, 2023, indicated the resident was found on the memory care patio in a lethargic state. The investigation indicated the resident was seen on security footage go outside at 1:40 p.m., visualized by staff outside on the patio area at 2:15 p.m., and brought inside by two staff at 4:03 p.m., then 911 was called. The facility investigative findings conclusion indicated not all memory care residents had the cognitive ability to recognize the need to come inside during extreme weather. A local weather report from the day and the time of the incident indicated it was 94 degrees at the time of the incident. R4's outside medical record - emergency medical	02310		

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02310	Continued From page 31 services (EMS) run report indicated staff reported R4 was outside in the heat of the day for an unknown amount of time. The EMS report indicated on arrival to the facility R4 was observed slouched forward, unresponsive, with red skin, extremely hot to the touch, and diaphoretic with increased respiratory and pulse rate noted. The EMS report indicated intravenous fluids were started to attempt internal cooling, and the resident was transported to the ED. R4's ED record indicated R4 received treatment of heat stroke after spending the day outside for an unknown duration of time. On admission to the ED R4's temperature was 101.7, pulse rate was 131, he was very sweaty, and lethargic but responsive to pain. The record indicated the resident was discharged back to the facility in stable condition, with instructions to encourage hydration for the next couple of days. On October 16, 2023, at 3:30 p.m. unlicensed personnel (ULP)-I stated she toileted R4 at 1:15 p.m. then saw the R4 going toward the patio area outside around 2:00 p.m. ULP-I stated it was very hot that day and indicated the facility had no policy or procedure to guide them to restrict access to the outdoor patio on days with inclement weather. ULP-I stated R4 should have had a safety check and toileting around 3:00 p.m. (every two hours) but did not. ULP-I stated R4 would not understand if he needed to come inside to cool down or get a drink. On October 16, 2023, at 5:06 p.m. ULP- H stated she looked out the patio window and saw R4 was outside at 2:15 p.m. ULP-H stated R4 was standing in the sun holding onto the fence. ULP-H stated she did not realize how hot it was outside because she did not open the door or go outside. ULP-H stated R4 was unable to recognize if he	02310		

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02310	Continued From page 32 was too hot, thirsty, not feeling well, and needed to go inside. ULP-H stated R4 was outside without staff supervision and indicated that was usual practice, and further explained the patio door automatically unlocked at 7:00 a.m. and locked at 7:00 p.m. and all residents could access the patio anytime despite the weather unsupervised. On October 16, 2023, at 4:22 p.m. ULP- J stated she was not aware R4 was outside until staff started toileting residents before dinner. ULP-J stated it was a very hot day, almost 100 degrees outside when she went outside to get R4, but he refused to let go of the fence and come inside. ULP-J stated the resident appeared hot, sweaty, and was standing in the sun hanging onto the fence, but she did not think anything was concerning and left R4 there. ULP-J stated a while later when they were bringing resident's in for dinner, she informed a coworker the R4 was still outside and the two of them went to bring R4 inside. ULP-J stated R4 was still standing in the sun holding onto the fence, but was unable to hold himself up or walk back inside. ULP-J stated R4's skin was red, hot to the touch, his shirt was drenched with sweat, and his ears and head appeared sun burned. ULP-J stated the resident was not able to know if he was too hot, or should come inside, and indicated the facility had no process to restrict access to the patio area in inclement weather, or to identify if a resident could safely use the patio area unsupervised, and there was no specific monitoring or supervision of residents using the patio area. On September 27, 2023, at 1:52 p.m. licensed assisted living director (LALD)-A, and registered nurse clinical manager (RNCM)-B stated prior to the incident the secure memory care patio door	02310		

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02310	Continued From page 33 was bypassed by staff so residents could come and go freely. Then just prior to the incident the facility installed a new door lock system which that automatically unlocked the door at 7:00 a.m. and locked again at 7:00 p.m. at night. LALD-A and RNCM-B stated they had no process in place for inclement weather conditions including extremely hot days to direct staff to restrict access to the patio, and indicated it was common practice for residents to wander in and out of the patio area independently throughout the day. RNCM-B stated there was no specific process in place for staff to direct staff to supervise or monitor the patio area when in use by residents other than every two hour safety checks, and there was no assessment completed to determine if the residents who resided on the memory care unit were safe to access the patio area independently. RNCM-B stated R4 was severely cognitively impaired and did not have the cognitive awareness to understand if he was too hot and should go inside, and stated R4 was outside for 45 minutes at the most the day of the incident. On October 18, 2023, at 8:45 a.m. LPN- G stated there was no process in place for staff to monitor, or supervise resident's using the patio area. LPN-G indicated R4 was completely dependant on staff to stay safe and meet his needs. LPN-G indicated R4 was unable to express if he was hot, thirsty, or in pain. LPN-G stated she saw R4 sometime after lunch but did not know how long the resident was outside. LPN-G stated when staff brought R4 back inside he was semi conscious, his skin was red and burning hot to the touch, and she called 911. LPN-G stated staff complete things based on the services check list assigned each day and indicated specific tasks including monitoring, safety checks, and resident	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30986	A. BUILDING: _____ B. WING _____	C 09/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAJESTIC PINES SENIOR LIVING	1614 GOLF COURSE ROAD GRAND RAPIDS, MN 55744

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02310	Continued From page 34 specific actions should be implemented on a residents services check list to be implemented by staff. A review of facility provided video surveillance from September 3, 2023, showed R4 wandering out to the patio area at 1:40 p.m. At 2:15 p.m. ULP-H was observed looking out the window to the patio area but did not open the door or go outside to check on the residents. At 3:18 p.m. ULP-J was observed go out to the courtyard and returned inside two minutes later. Then, 43 minutes later ULP-J returned with another staff and at 4:03 p.m. and R4 was observed slouched forward, with his head hanging down, stumbling and shuffling his feet assisted by the two staff one staff on each side to walk back into the facility two hours and 23 minutes after he went outside. Additional video footage was requested from the time the door was unlocked that day to determine if the resident was outside at other times earlier that day but was not provided. R4's services delivered record for September 2023, was reviewed and failed to include safety checks every two hours, as a result there was no indication safety checks were completed. R4's services check list failed to include direction for staff to monitor R4 more frequently when wandering or when outside in the patio area to ensure safety. The undated facility policy and procedure titled "disclosure of policies for assisted living with dementia care" indicated section titled wandering and egress prevention indicated the facility would complete an assessment for risk of elopement upon admission and indicated the entrance and exit to the memory care unit was secure and electronically controlled. The policy indicated a	02310		

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02310	Continued From page 35 secure fenced patio was available for outdoor enjoyment. The policy indicated staff would document in a communication logbook when the resident left the building for any reason. The policy failed to indicated the electronically controlled exit door from the secure memory care unit to the attached patio area was bypassed and unlocked during the day from 7:00 a.m. to 7:00 p.m. The policy failed to include monitoring and supervision of residents utilizing the patio area. The facility policy titled "Emergency Planning and Disaster - Missing Resident Elopement Prevention" section on wandering and elopement prevention indicated a assessment for risk of elopement was completed on admission and updated quarterly with changes in the residents conditions and indicated interventions would be implemented to minimize risks of elopement. Entrance and exit to the secure memory care community was electronically controlled. The policy failed to indicated the electronically controlled exit door from the secure memory care unit to the attached patio area was bypassed and unlocked during the day from 7:00 a.m. to 7:00 p.m. The policy failed to include monitoring and supervision of residents utilizing the patio area. A facility policy and procedure for utilization and access to the secure memory care patio area was requested none was provided. The facility policies and procedures failed to address the secure memory care unit electronically controlled patio exit door which was bypassed and automatically unlocked from 7:00 a.m. to 7:00 p.m. for residents to have unrestricted access to the attached patio area. The facility had no process to assess the ability of residents to safely use the patio area unsupervised, and failed to address inclement weather conditions including	02310		

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02310	Continued From page 36 extreme temperatures and potential exposure concerns for residents with cognitive impairment. Although after the incident with R4 the facility locked the secure memory care unit electronically controlled patio door requiring staff to use a fob to let residents out to the patio area, the door automatically locks when closed, locking resident outside. The facility had no specific process policy or procedure to monitor or supervise the residents utilizing the patio area to ensure safety. No further information 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, 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 interview and document review, the facility failed to ensure 4 of 4 residents reviewed, (R1, R2, R3, and R4) were free from maltreatment. R1, R2, R3, and R4 were neglected. 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		

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02360	Continued From page 37 No plan of correction is required for this tag.	02360		