DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL310687482M
Compliance #: HL310682866C

Date Concluded: February 11, 2025

Name, Address, and County of Licensee Investigated:
Marywood
915 Kenwood Ave
Duluth, MN 55811
St. Louis 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 resident was neglected when the facility failed to provide appropriate care and services for end-of-life care and pressure ulcers. The resident was found lying with dried incontinent bowel movement (BM) stuck to her body, and new pressure ulcers.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The resident was bedridden, actively dying, and dependent on staff for mobility and incontinence care every 2 hours. The resident received a suppository on the evening shift and staff failed to assist the resident with incontinence care for 7 hours. In addition, the facility failed to provide weekly pressure ulcer monitoring as assessed and failed to implement interventions including repositioning to help prevent new or worsening pressure ulcers. The resident's coccyx pressure ulcer worsened, and the resident developed new pressure ulcers on her scapula and foot.

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 the resident record(s), death record, hospital records, hospice records, facility internal investigation, staff schedules, related facility policy and procedures. Also, the investigator observed resident's and staff at the facility.

The resident resided in an assisted living facility with diagnoses including chronic kidney disease stage 3, Parkinson's Disease, reduced mobility, spondylosis, chronic pain, and anxiety disorder.

On October 21 a change of condition assessment indicated the resident was readmitted to the facility after a hospital stay and was receiving end-of-life care related to decompensation of Parkinson's Disease. The assessment indicated the resident was no longer able to assist with transfers and was dependent on staff for mobility. The assessment indicated the resident required assistance with toileting, and indicated staff were to check the resident for incontinence and change her every 2 hours. The assessment indicated the resident had no new skin issues or pressure ulcers, but indicated the resident required daily dressing changes and weekly wound monitoring. The assessment failed to identify the resident was at risk for or had pressure ulcers and required assistance with bed mobility and repositioning. The assessment failed to identify how staff should position the resident and the frequency to reduce the resident's risk for new or worsening pressure ulcers.

The resident's wound care assessments and ongoing pressure ulcer monitoring was requested from the onset of the resident's coccyx pressure ulcer until the resident's death, but none was provided. Email correspondence with facility leadership indicated any wound assessment or monitoring including wound measurements would be documented in the resident's progress notes.

On October 22 the resident's progress notes included treatment orders for a coccyx pressure ulcer. The progress notes contained no documentation of a coccyx pressure ulcer prior to that day and there was no assessment of the pressure ulcer to include size, measurements, description, or stage. In addition, there was no indication any interventions were implemented to prevent new or worsening pressure ulcers.

On November 19, the residents progress note indicated the resident's coccyx pressure ulcer had gotten worse and indicated hospice would provide an air bed. On November 29, a progress note indicated the resident's coccyx dressing was changed and noted to be 100% saturated through to the resident's brief. Then, on December 2, a progress note indicated the resident developed 2 new pressure areas on her scapula with redness present, but lacked any assessment to include size, description, or stage. On December 14, a progress note indicated the coccyx pressure ulcer had a large tunnel forming at the 5 o'clock position down the resident's right leg. The note also indicated the resident had developed another new pressure ulcer on her right foot from being positioned with her feet touching at 9:30 a.m. and was not moved until 12:45 p.m. (3.25 hours later). There was no corresponding assessment of the new pressure ulcer.

A facility investigation failed to indicate an incident was reported by two nurses who found/ witnessed the resident in dried BM. The facility investigation documentation included interviews with some staff but did not include any interview/statement from the nurses who witnessed and reported the incident. Although the staff interviews indicated they had not provided care to the resident every 2 hours as assessed, the investigation summary indicated the resident's service plan was followed, and incontinence care and repositioning were provided every 2 hours with no concerns.

A review of the resident's service plan indicated the resident utilized hospice for end-of-life care. The service plan identified the resident had impaired mobility and required extensive assistance with dressing and grooming twice daily but failed to indicate the resident needed assistance with bed mobility and lacked direction for the resident to be repositioned to prevent new or worsening pressure ulcers. Although the service plan indicated the resident required staff to check for incontinence and change the resident if she was incontinent scheduled every 2 hours, 12 times daily. There was no indication staff were to provide repositioning when the resident was checked for incontinence. The service plan failed to include weekly wound monitoring as assessed, as a result there was no indication any wound assessment or monitoring of the resident's pressure ulcers was completed by the facility.

A review of the resident's medication administration record (MAR) and service delivery of care record from the time of the incident (November 30 to December 1) indicated the resident had received a suppository on the evening shift at 2:41 p.m. The service delivery record indicated the resident received mobility assistance on November 30, at 11:15 p.m., then did not receive mobility assistance again until December 1, at 12:09 p.m. (12 hours and 54 minutes later). The service delivery record indicated the resident was provided incontinence care on December 1, at 1:23 a.m., then was not checked or provided incontinence care again until 5:06 a.m. (4 hours later), and again at 12:07 p.m. (7 hours later) indicating the resident had not received checks and incontinence care every 2 hours as assessed or indicated on the resident's service plan. The service record failed to include interventions to reduce the resident's risk for new or worsening pressure ulcers including clear direction for staff to reposition the resident frequently, or with scheduled incontinence check and change.

When interviewed a hospice registered nurse (RN) indicated she was seeing the resident on a daily basis at the time the incident occurred because the resident was actively dying. The nurse indicated the resident was not responsive, was dependent on staff for bed mobility, repositioning, and incontinence care. The nurse stated when she entered the resident's room with a facility nurse, the smell was overwhelming of someone who had been left in incontinence for a long time. The nurse stated the resident had odor from a necrotic infected coccyx pressure ulcer but indicated the smell that day was very different. The nurse stated when they pulled the covers back the resident's BM and wound drainage had leaked from her brief onto her bedding and gown and dried stuck onto her body with a large dried dark ring underneath the resident. The nurse stated the resident appeared to be in pain and was moaning, and grimacing when the

nurses touched and moved the resident to provide cares and change the resident's dressing. The nurse stated the resident appeared to be in the exact same position as the previous afternoon when they administered her suppository and indicated the resident appeared to be untouched. The nurse stated the facility nurse was visibly upset and crying while providing care to the resident due to the state the resident was found in, and indicated there was "no way" anyone had checked, changed, or repositioned the resident. The nurse stated when they turned the resident, the resident had 2 new pressure ulcers on her scapula area as a result of not being repositioned. The nurse stated hospice provided wound care orders and supplies but indicated the facility was responsible for dressing changes and ongoing assessment/monitoring of the resident's pressure ulcers.

When interviewed a facility nurse stated the resident was actively dying and required extensive assistance with incontinence cares and repositioning. The nurse indicated the resident's coccyx pressure ulcer was severe, and the drainage was not being contained in the dressing and was saturated each day she changed it. The nurse indicated the first thing she noticed was the smell when entering the resident's room and stated although the indicator lines on the resident's brief showed she was dry, the resident had no intake and was not urinating at that time. The nurse indicated when she pulled back the covers, she instantly noticed a very obvious dark dried ring of BM and wound drainage on the soaker pad several inches past the resident's body. The nurse explained the resident's brief had leaked saturating the resident's bedding and gown, then dried and was stuck onto the resident's body. The nurse stated when they rolled the resident over, she was completely soiled, and incontinent stool was dried onto the resident's skin. The nurse indicated the resident had 2 new pressure ulcers on her scapula that were red and non-blanching the size of her thumb from not being repositioned. The nurse stated the resident appeared to be in the same position as the previous day when she administered a suppository to the resident. The nurse stated if staff had actually turned and repositioned the resident or pulled back the covers, they would have noticed she was incontinent. The nurse stated she was under the impression staff had provided care to the resident, but it was obvious no cares had been provided for a long time for it to dry onto the resident's body. The nurse stated the incident was horrible, unfortunate, and it made her cry to find the resident that way and reported the concern immediately to the clinical manager and wrote up a statement and gave it to leadership.

The facility nurses' interview and statement she provided to the facility were not provided for the investigator to review.

Interviews with unlicensed staff indicated they utilized assigned tasks to provide cares to the resident's and indicated if the task or service was not assigned, they would not know to provide that service. The staff indicated the resident was bedridden, required incontinence check/change, and repositioning due to having pressure ulcers.

When interviewed a facility RN indicated a resident who was actively dying would need frequent incontinence checks, changing, and repositioning. The RN indicated the services should

be on the resident's service plan and assigned for staff to implement. The RN indicated if the task was not assigned to staff, they would not know what services the resident would need. The RN indicated she had never assessed or monitored the resident's coccyx pressure ulcer because hospice was doing the wound assessments and measurements.

When interviewed facility leadership indicated they were not involved in the investigation of the neglect concern reported, and indicated the clinical manager was in charge of the investigation and found no concerns that neglect occurred. Leadership staff indicated the clinical manager should have filled out an investigation packet but indicated that documentation had not been reviewed because the clinical manager unexpectedly resigned after the investigator was onsite. Leadership stated the clinical manager was not responding to phone calls or questions.

The facility investigation packet was not provided.

When interviewed the resident's family member indicated a nurse had expressed concern the resident had not been cared for or repositioned properly, and the resident's brief had not been changed for a long time.

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: No, deceased
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: N/A

Action taken by facility:
The facility interviewed staff about the incident.

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
St. Louis County Attorney
Duluth City Attorney
Duluth Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31068	A. BUILDING: ____ B. WING ____	C 01/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARYWOOD	915 KENWOOD AVENUE DULUTH, MN 55811

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0 000	Initial Comments	0 000		

Initial Comments

******ATTENTION******

HOME CARE PROVIDER/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:

#HL310687482M/#HL310682866C

On January 3, 2025, 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 45 residents receiving services under the provider's Assisted Living with Dementia Care license.

The following correction order is issued/orders are issued for #HL310687482M/#HL310682866C, tag identification 0620, 0730, 2310, and 2360.

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 Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.

THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.

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0 620 SS=F	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma	0 620		

(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.

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(d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.
(e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c.

This MN Requirement is not met as evidenced by:
Based on interview and record review the licensee failed to comply with the requirements for reporting maltreatment for one of one vulnerable adults (R1) after a licensee nurse, and hospice nurse reported concern that incontinence care and repositioning were neglected for R1 resulting in a new pressure ulcer. The licensee failed to identify any neglect and subsequently failed to report the concern of maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC).

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to

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0 620	Continued From page 3 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 of the residents). Findings include: R1 was admitted to the licensee on September 29, 2022, with diagnoses including chronic kidney disease stage 3, Parkinson's Disease, reduced mobility, spondylosis, chronic pain, and anxiety disorder. On October 21, 2024, a change of condition assessment indicated R1 was readmitted to the facility after a recent hospital stay, then admitted to hospice for end-of-life care related to decompensation of Parkinson's Disease. The assessment indicated R1 was no longer able to assist with transfers and was dependent on staff for mobility. The assessment indicated R1 required assistance with toileting, and indicated staff were to check R1 for incontinence and change her every 2 hours. The assessment indicated R1 had no new skin issues or pressure ulcers but indicated R1 required daily dressing changes and weekly wound monitoring. The assessment failed to identify R1 was at risk for or had pressure ulcers and required assistance with bed mobility and repositioning to help prevent new or worsening pressure ulcers. A review of R1's service plan dated November 20, 2024, indicated R1 utilized hospice for end-of-life care. The service plan identified R1 had impaired mobility and required extensive assistance with dressing and grooming twice daily but failed to indicate R1 needed assistance with bed mobility and lacked direction for R1 to be repositioned to	0 620		

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prevent new or worsening pressure ulcers. Although the service plan indicated R1 required staff to check for incontinence and change R1 if she was incontinent scheduled every 2 hours, 12 times daily. There was no indication staff were to provide repositioning when R1 was checked for incontinence. In addition, the service plan failed to include weekly wound monitoring as assessed, as a result there was no indication any wound assessment or monitoring was completed for R1.

An undated facility investigation document indicated an incident was reported by a licensee nurse Licensed Practical Nurse (LPN)-D who found R1 laying in dried incontinent fecal matter. The investigation included interviews with staff but did not include an interview/statement from LPN-D who witnessed and reported the incident. Although the staff interviews indicated they had not provided care every 2 hours as assessed, the investigation summary indicated R1's service plan was followed, and incontinence care and repositioning were provided every 2 hours with no concerns for neglect identified.

However, a review of R1's Medication and Treatment Administration Record (MAR/TAR) and service delivery of care record from the time of the incident (November 30, 2024, to December 1, 2024) reported by LPN-D indicated R1 had received a suppository on the evening shift at 2:41 p.m. The service delivery record indicated R1 received mobility assistance on November 30, 2024, at 11:15 p.m., then did not receive mobility assistance again until December 1, 2024, at 12:09 p.m. (12 hours and 54 minutes later). The service delivery record indicated R1 was provided incontinence care on December 1, 2024, at 1:23 a.m., then was not checked or provided incontinence care again until 5:06 a.m. (4 hours

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0 620	Continued From page 5	0 620		

later), and again at 12:07 p.m. (7 hours later) indicating R1 had not received checks and incontinence care every 2 hours as assessed or indicated on R1's service plan.

On December 2, 2024, at 5:44 p.m. a progress note the day after the incident involving R1 was reported, indicated RN-A documented she had completed a dressing change and R1 had 2 new pressure areas on her scapula with redness present with instructions to change a dressing on the area every 3 days.

On January 3, 2025, at 9:51 a.m. when interviewed the Licensed Assisted Living Director (LALD)-H and Interim Registered Nurse Director of Nurses (IRNDON)-K stated they were not involved in the investigation of the neglect concern reported by 2 nurses, and indicated the former clinical manager (RNDON)-J was in charge of the investigation and found no concerns that neglect occurred, so the incident was not reported to MAARC by the licensee. LALD-H and IRNDON-K indicated RNDON-J should have completed an investigation packet but indicated that documentation had not been reviewed because RNDON-J had unexpectedly resigned after the investigator was onsite with no explanation and failed to respond to phone calls or questions. The investigation packet documents were requested, no additional information was provided.

On January 21, 2025, at 2:21 when interviewed a Hospice Registered Nurse (HRN)-G indicated she was seeing R1 on a daily basis at the time the incident occurred because R1 was actively dying. The nurse indicated R1 was not responsive, was dependent on staff for bed mobility, repositioning, and incontinence care at

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0 620	Continued From page 6 the time the incident occurred. HRN-G stated when she entered R1's room the day of the incident with facility nurse LPN-D, the smell was overwhelming of someone who had been left in incontinence for a long time. HRN-G stated R1 had odor from a necrotic infected coccyx pressure ulcer but indicated the smell that day was very different. HRN-G described the smell as a pungent smell of old incontinent fecal matter and wound drainage. HRN-G stated when they pulled the covers back R1's incontinent fecal matter and wound drainage had leaked from her brief onto her bedding and gown and dried stuck onto her body with a large dried dark ring visible underneath R1. The nurse stated R1 was very painful, moaning, and grimacing when the nurses touched and moved R1 to provide cares and change R1's dressing. The nurse stated R1 appeared to be in the exact same position as the previous afternoon when they administered her suppository and indicated R1 appeared to be untouched. The nurse stated LPN-D appeared visibly upset and was crying while providing care to R1 due to the state R1 was found in, and indicated there was no way anyone had checked on, changed, or repositioned R1. The nurse stated when they turned R1, she had 2 new pressure ulcers on her scapula area as a result of not being repositioned. The nurse stated hospice provided wound care orders and supplies but indicated the facility was responsible for dressing changes and ongoing assessment/monitoring of R1's pressure ulcers. On January 17, 2024, at 11:44 a.m. when interviewed LPN-D stated R1 was actively dying and required extensive assistance with incontinence cares and repositioning at the time the incident occurred. LPN-D stated R1's coccyx pressure ulcer was severe, drainage was not	0 620		

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0 620	Continued From page 7	0 620		

being contained in the dressing, and the dressing was saturated each day she changed it. LPN-D stated the first thing she noticed when entering R1's room was the smell and stated although the indicator lines on R1's brief showed she was dry, R1 had no intake and was not urinating at that time the incident occurred. LPN-D stated when she pulled back the covers, she instantly noticed a very obvious dark dried ring of fecal matter and wound drainage visible on the soaker pad several inches past R1's body. LPN-D explained R1's brief had leaked saturating R1's bedding and gown, then dried and was stuck onto R1's body. LPN-D stated when they (LPN-D and HRN-G) rolled R1 over, she was completely soiled, and incontinent fecal matter was dried onto R1's skin. LPN-D stated R1 had 2 new pressure ulcers on her scapula that were red and non-blanching the size of her thumb from not being repositioned. LPN-D stated R1 appeared to be in the same position as the previous day when she administered a suppository to R1. LPN-D stated if staff had actually turned and repositioned R1 or pulled back the covers, they would have noticed she was incontinent. LPN-D stated she was under the impression staff had provided care to R1, but it was obvious no cares had been provided for a long time for it to dry onto R1's body. LPN-D stated the incident was horrible, unfortunate, and it made her cry to find R1 that way and reported the concern of neglect immediately to RNDON-J and wrote up a statement and gave it to leadership. LPN-D's facility interview and statement were not provided for the investigator to review.

On January 21, 2024, at 1:53 p.m. R1 family member indicated a nurse (unknown) had expressed concern R1 had not been cared or repositioned properly, and R1's brief had not

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0 620	Continued From page 8 been changed for a long time. A facility policy and procedure titled "Vulnerable Adult Reporting and Investigation" revised July 2021, indicated the purpose of the policy and procedure was to create an environment and process identify, prevent, and mitigate maltreatment of vulnerable adults. The policy would establish guidelines for internal and external reporting of potential maltreatment of vulnerable adults. Immediate steps to witnessed incident or allegation of maltreatment included A: The staff person will intervene to stop the maltreatment while it is occurring if possible without the staff person endangering him or herself. B: The staff shall take appropriate steps to get the vulnerable adult(s) to a place of safety. C: Call 911 immediately if the situation appears violent or is escalating and likely to become violent, or if a crime is occurring or is suspected. D. If the alleged perpetrator will not leave the premises, police will be called to escort the person out. E: If the victim has been injured, staff will provide first aid and/or call 911 as appropriate. F: Staff will also immediately notify the LALD and or RN in charge. G: If a staff person the alleged perpetrator, the staff person will be directed to leave the building immediately and will be instructed not to come to work until further notice. H: If a crime has occurred or is suspected, staff will take steps to preserve any evidence that may be needed in a police investigation and will contact 911/law enforcement. Section 4. indicated any staff person who witnesses or suspects maltreatment of a vulnerable adult will report the incident immediately to their supervisor, a nurse, or the Assisted Living Director, and that person will complete an incident report. a. If the incident appears to be suspected abuse, neglect or	0 620		

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0 620	Continued From page 9 financial exploitation, LALD or designee will immediately make a report to MAARC. "Immediately" means as soon as possible, but no longer than 24 hours from the time the LALD or designee received initial knowledge that the incident occurred. B. If it is unclear based whether maltreatment has occurred, and investigation into the incident will begin immediately. c. If within the 24 hours following the initial incident report, it is still unclear whether reportable maltreatment has occurred, a report will be made to the Minnesota Adult Abuse Reporting Center (MAARC). d. If it appears that a crime may have been committed, LALD or designee will immediately contact the police if the witness has not already done so. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health	0 730		

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

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to the needs of the resident, services provided as assessed/indicated in an up to date service plan, and according to accepted health care standards for one of one resident's (R1) who was bed bound and received hospice end of life care with a coccyx pressure ulcer. Harm occurred for R1 when the licensee failed to implement wound assessment/monitoring as assessed, and R1's service plan failed to include interventions for staff to implement to reduce R1's risk of new or worsening pressure ulcers including assistance with mobility and repositioning. R1 was found lying in incontinent fecal matter that had dried onto R1's body after staff failed to provide incontinence cares or repositioning for 7 hours. R1's coccyx pressure ulcer worsened, and she developed new pressure ulcers on her scapula and foot from not being repositioned.

This practice resulted in a level two violation (a violation that did not harm a residents health or safety but had the potential to have harmed a residents health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

Findings include:

R1 was admitted to the licensee on September 29, 2022, with diagnoses including chronic kidney disease stage 3, Parkinson's Disease, reduced mobility, spondylosis, chronic pain, and anxiety disorder.

On October 21, 2024, a change of condition assessment indicated R1 was readmitted to the facility after a recent hospital stay, then admitted

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to hospice for end-of-life care related to decompensation of Parkinson's Disease. The assessment indicated R1 was no longer able to assist with transfers and was dependent on staff for mobility. The assessment indicated R1 required assistance with toileting, and indicated staff were to check R1 for incontinence and change her every 2 hours. The assessment indicated R1 had no new skin issues or pressure ulcers but indicated R1 required daily dressing changes and weekly wound monitoring. The assessment failed to identify R1 was at risk for or had pressure ulcers and required assistance with bed mobility and repositioning to help prevent new or worsening pressure ulcers.

A review of R1's service plan dated November 20, 2024, indicated R1 utilized hospice for end-of-life care. The service plan identified R1 had impaired mobility and required extensive assistance with dressing and grooming twice daily but failed to indicate R1 needed assistance with bed mobility and lacked direction for R1 to be repositioned to prevent new or worsening pressure ulcers. Although the service plan indicated R1 required staff to check for incontinence and change R1 if she was incontinent scheduled every 2 hours, 12 times daily. There was no indication staff were to provide repositioning when R1 was checked for incontinence. In addition, the service plan failed to include weekly wound monitoring as assessed, as a result there was no indication any wound assessment or monitoring was completed for R1.

An undated facility investigation document indicated an incident was reported by a licensee nurse Licensed Practical Nurse (LPN)-D who found R1 laying in dried incontinent fecal matter. The investigation included interviews with staff but did not include an interview/statement from

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LPN-D who witnessed and reported the incident. Although the staff interviews indicated they had not provided care every 2 hours as assessed, the investigation summary indicated R1's service plan was followed, and incontinence care and repositioning were provided every 2 hours with no concerns for neglect identified.

A review of R1's Medication and Treatment Administration Record (MAR/TAR) and service delivery of care record from the time of the incident (November 30, 2024, to December 1, 2024) reported by LPN-D indicated R1 had received a suppository on the evening shift at 2:41 p.m. The service delivery record indicated R1 received mobility assistance on November 30, 2024, at 11:15 p.m., then did not receive mobility assistance again until December 1, 2024, at 12:09 p.m. (12 hours and 54 minutes later). The service delivery record indicated R1 was provided incontinence care on December 1, 2024, at 1:23 a.m., then was not checked or provided incontinence care again until 5:06 a.m. (4 hours later), and again at 12:07 p.m. (7 hours later) indicating R1 had not received checks and incontinence care every 2 hours as assessed or indicated on R1's service plan. The service record failed to include interventions to reduce R1's risk for new or worsening pressure ulcers including clear direction for staff to reposition R1 frequently with scheduled incontinence check and change.

R1's weekly wound/pressure ulcer assessments and monitoring were requested from the onset of R1's coccyx pressure ulcer until R1's death, but none was provided.

On January 7, 2025, and 9:41 a.m. email correspondence with the licensee's regional

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0 730	Continued From page 14 Licensed Assisted Living Director (LALD)-I indicated any wound assessment or monitoring including wound measurements would be documented in R1's progress notes. A policy for wound assessment and monitoring was requested, none was provided. On January 22, 2025, at 8:58 a.m. email communication with (LALD)-H indicated the facility did not have a specific policy for wound care, as they were not required to have wound care policies in the assisted living setting. LALD-H also indicated if another agency was managing the wound, it was expected to have a weekly note coordinating care and progress/status of the wound. A review of R1's progress notes lacked any documentation of ongoing assessment or monitoring of R1's pressure ulcers to include wound measurements (size/depth), and description of the wounds including drainage, odor, and peri wound area. Although the lack of documentation in R1's record made it unable to determine the onset stage and progression of R1's pressure ulcers, the progress notes indicated R1's coccyx pressure ulcer worsened and R1 developed new pressure ulcers on her scapula and foot. On October 22, 2024, at 4:11 p.m. a progress note indicated Registered Nurse (RN)-A documented treatment orders for a coccyx pressure ulcer wound in R1's progress notes. The progress note had no mention of a coccyx pressure ulcer prior to that day. The progress note lacked any assessment of the pressure ulcer to include size, measurements, description, or stage. In addition, there was no indication any interventions were implemented to prevent new	0 730		

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or worsening pressure ulcers including assistance with repositioning and bed mobility.

On November 19, 2024, at 10:51 a.m. a progress note indicated RN-A documented R1's coccyx pressure ulcer had gotten worse and indicated hospice would provide an air bed. The progress notes had no assessment of the pressure ulcer to include size, measurements, description, or stage. In addition, there was no indication interventions including assistance with repositioning and bed mobility were implemented to prevent new or worsening pressure ulcers.

On December 2, 2024, at 5:44 p.m. a progress note the day after the incident involving R1 was reported, indicated RN-A documented she had completed a dressing change and R1 had 2 new pressure areas on her scapula with redness present, and instructions to change a dressing on the area every 3 days. The progress note had no assessment of the coccyx pressure ulcer, or new pressure ulcers to include size, measurements, description, or stage. In addition, there was no indication interventions including assistance with repositioning and bed mobility were implemented to prevent new or worsening pressure ulcers.

On December 14, 2024, at 6:12 p.m. LPN-D documented in a progress note that R1's coccyx pressure ulcer had developed a large tunnel forming at the 5 o'clock position down R1's right leg. The note also indicated R1 had developed another new pressure ulcer on her right foot from being positioned with her feet touching at 9:30 a.m. and was not moved until 12:45 p.m. (3.25 hours) later. R1's progress notes had no assessment of the new pressure ulcer to include size, description, or stage. In addition, there was no indication interventions including assistance

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with repositioning and bed mobility were implemented to prevent new or worsening pressure ulcers.

On January 3, 2025, at 9:51 a.m. when interviewed the Licensed Assisted Living Director (LALD)-H and Interim Registered Nurse Director of Nurses (IRNDON)-K stated they were not involved in the investigation of the neglect concern reported by 2 nurses, and indicated the former clinical manager (RNDON)-J was in charge of the investigation and found no concerns that neglect occurred, so the incident was not reported to MAARC by the licensee. LALD-H and IRNDON-K indicated RNDON-J should have completed an investigation packet but indicated that documentation had not been reviewed because RNDON-J had unexpectedly resigned after the investigator was onsite with no explanation and failed to respond to phone calls or questions. The investigation packet documents were requested, no additional information was provided.

On January 3, 2025, at 10:46 a.m. Registered Nurse (RN)-A stated a resident who was actively dying would need frequent incontinence check, change, and repositioning. RN-A stated the services should be on R1's service plan and assigned to staff to implement. RN-A indicated if the task was not assigned to staff, they would not know what services the resident would need. RN-A stated she had never assessed or monitored R1's coccyx pressure ulcer because hospice was doing the wound assessments and measurements.

A review of the facility provided hospice visit notes lacked any indication ongoing wound assessment and monitoring to include size,

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measurements, description, or stage was being completed by hospice for R1.

On January 3, 2025, at 11:20 a.m. during an interview unlicensed personnel (ULP)-C stated staff utilized an assigned task list to direct them on what cares and services the resident's needed. ULP-C indicated R1 received hospice end of life care, and was bed bound, and required assistance with repositioning and incontinence cares. ULP-C stated R1 had a coccyx pressure ulcer that drained a lot, was open, and the nurses changed the dressing on it.

On January 3, 2025, at 11:51 a.m. during an interview ULP-B stated R1 declined very quickly when she was readmitted from the hospital. ULP-B stated staff went by assigned tasks to know how to provide care for R1 and indicated R1 needed wound care and repositioning. ULP-B indicated if a service was not assigned on the task list, they would not know to provide that care or service.

On January 3, 2025, at 11:31 a.m. ULP-E stated she was not assigned to R1 but had assisted staff with cares and repositioning when R1 was actively dying. ULP-E stated R1 had a coccyx pressure ulcer that had a strong odor, leaked, and needed changing.

On January 21, 2025, at 2:21 when interviewed a Hospice Registered Nurse (HRN)-G indicated she was seeing R1 on a daily basis at the time the incident occurred because R1 was actively dying. The nurse indicated R1 was not responsive, was dependent on staff for bed mobility, repositioning, and incontinence care at the time the incident occurred. HRN-G stated when she entered R1's room the day of the

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incident with facility nurse LPN-D, the smell was overwhelming of someone who had been left in incontinence for a long time. HRN-G stated R1 had odor from a necrotic infected coccyx pressure ulcer but indicated the smell that day was very different. HRN-G described the smell as a pungent smell of old incontinent fecal matter and wound drainage. HRN-G stated when they pulled the covers back R1's incontinent fecal matter and wound drainage had leaked from her brief onto her bedding and gown and dried stuck onto her body with a large dried dark ring visible underneath R1. The nurse stated R1 was very painful, moaning, and grimacing when the nurses touched and moved R1 to provide cares and change R1's dressing. The nurse stated R1 appeared to be in the exact same position as the previous afternoon when they administered her suppository and indicated R1 appeared to be untouched. The nurse stated LPN-D appeared visibly upset and was crying while providing care to R1 due to the state R1 was found in, and indicated there was no way anyone had checked on, changed, or repositioned R1. The nurse stated when they turned R1, she had 2 new pressure ulcers on her scapula area as a result of not being repositioned. The nurse stated hospice provided wound care orders and supplies but indicated the facility was responsible for dressing changes and ongoing assessment/monitoring of R1's pressure ulcers.

On January 17, 2024, at 11:44 a.m. when interviewed LPN-D stated R1 was actively dying and required extensive assistance with incontinence cares and repositioning at the time the incident occurred. LPN-D stated R1's coccyx pressure ulcer was severe, drainage was not being contained in the dressing, and the dressing was saturated each day she changed it. LPN-D

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stated the first thing she noticed when entering R1's room was the smell and stated although the indicator lines on R1's brief showed she was dry, R1 had no intake and was not urinating at that time the incident occurred. LPN-D stated when she pulled back the covers, she instantly noticed a very obvious dark dried ring of fecal matter and wound drainage visible on the soaker pad several inches past R1's body. LPN-D explained R1's brief had leaked saturating R1's bedding and gown, then dried and was stuck onto R1's body. LPN-D stated when they (LPN-D and HRN-G) rolled R1 over, she was completely soiled, and incontinent fecal matter was dried onto R1's skin. LPN-D stated R1 had 2 new pressure ulcers on her scapula that were red and non-blanching the size of her thumb from not being repositioned. LPN-D stated R1 appeared to be in the same position as the previous day when she administered a suppository to R1. LPN-D stated if staff had actually turned and repositioned R1 or pulled back the covers, they would have noticed she was incontinent. LPN-D stated she was under the impression staff had provided care to R1, but it was obvious no cares had been provided for a long time for it to dry onto R1's body. LPN-D stated the incident was horrible, unfortunate, and it made her cry to find R1 that way and reported the concern of neglect immediately to RNDON-J and wrote up a statement and gave it to leadership. LPN-D's facility interview and statement were not provided for the investigator to review.

On January 21, 2024, at 1:53 p.m. R1 family member indicated a nurse (unknown) had expressed concern R1 had not been cared or repositioned properly, and R1's brief had not been changed for a long time.

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0 730	Continued From page 20 A facility policy and procedure titled "Initial and Ongoing Assessment of the Residents" revised August 1, 2021, indicated assessments are completed by a registered nurse based upon the required assessment schedule and as needed based upon resident condition. An RN would complete a comprehensive assessment of the resident's physical, mental, and cognitive needs as required on preadmission, initial assessment completed before the start of services, 14-day after start of services, and ongoing every 90 days and with a change in resident condition. The policy and procedure indicated a comprehensive assessment would include activities of daily living, including: 1. toileting pattern, bowel, and bladder control, 2. dressing, grooming, bathing, and personal hygiene, 3, mobility, including ambulation, transfers, and assistive devices. Section D: physical health status, including relevant history and current health conditions including, medical diagnoses. Section H: pain, location, frequency, intensity, duration, and effectiveness of interventions medications and non-medications alternatives for pain. Section I: skin conditions. Section K: list of treatments including type, frequency, and level of assistance needed. Section L: nursing needs including potential to receive delegated services. Section M: risk indicators. The policy and procedure indicated the resident's service plan would be updated as necessary based on the resident's needs. The policy failed to indicate the licensee would assess the resident's bed mobility, or pressure ulcers/risk for pressure ulcers. A facility policy and procedure titled " Monitoring of Resident's and Their Service Plan" revised August 1, 2021, indicated to assure resident's needs are provided as agreed upon on the service plan, the RN would monitor resident	0 730		

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0 730	Continued From page 21 needs and services on an ongoing basis to determine if the services are appropriate to the residents needs or if changes in the service plan are needed. The RN would identify any problems or resident concerns; evaluate the effectiveness of the services, medications and treatments; and identify any changes in condition or new symptoms. Section 5 A. indicated the RN would determine if the services provided are appropriate to meet the resident's needs. B. Determine if the treatments or interventions are effective and whether any changes are needed. If the RN determines that changes are needed in either treatments or services requiring an order, the RN will communicate these changes to the provider or other licensed health professional. C. Identify any new vulnerability that the resident may have or any new risk that the resident may pose to other vulnerable adults and identify interventions to address these issues. Document all changes and intervention in the resident record and communicate changes to associates that provide services to the resident. A facility policy and procedure titled "Service Plan Policy" revised August 1, 2021, indicated 1.A proposed service plan is established after completion of an individualized, initial assessment. 2. The Assisted Living provider shall finalize a written service plan within 14 days after the initiation of Assisted Living services to a resident. 3. The service plan and any revisions must include a signature or other authentication by the facility and by the resident or the resident's representative documenting agreement on the services to be provided. 4. The service plan must be revised, if needed, based on the results of required resident monitoring and/or reassessments. 5. The Assisted Living provider must implement and provide all services required	0 730		

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by the current service plan. 6. The service plan and any revised service plans must be entered into the resident's record. 7.Associates providing services must be informed of the current written service plan. 8. Service Plans are communicated to assist associates in understanding the resident's person-centered daily needs and tasks. 9. The service plan must include all of the following required elements: 10. A description of the services to be provided, the fees for services (including any changes to the provider's fee for services), and the frequency of each service, according to the resident's current review or assessment and resident preferences. 11. The identification of the type staff (RN/LPN, Therapists, Unlicensed Personnel, etc.) that will provide the services. 12. The schedule and methods of monitoring reviews or assessments of the resident. 13. The frequency of sessions of supervision of staff and type of personnel who will supervise staff. 14. A contingency plan that includes: a. the action to be taken by the Assisted Living provider and by the resident or resident's representative if the scheduled service cannot be provided; b. information and method for a resident or resident's representative to contact the Assisted Living provider. The policy and procedure indicated whenever changes are needed to the services to be provided because of a change in resident condition, after receipt of new revised orders from provider or other prescribing provider, following an incident, and/or return from hospital or skilled nursing facility.

Policy and procedure for contents of the resident record was requested, a policy for resident record retention was provided. No further information was provided.

TIME PERIOD FOR CORRECTION: Seven (7)

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0 730	Continued From page 23 days.	0 730		
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed assess, monitor, and ensure interventions were implemented according to and up to date service plan and accepted health care standards for one of one resident's (R1) who was bed bound and received hospice end of life care with a coccyx pressure ulcer. Harm occurred for R1 when she was found lying in incontinent fecal matter that had dried onto R1's body after staff failed to provide incontinence care or repositioning for 7 hours. R1's coccyx pressure ulcer worsened and she developed new pressure ulcers on her scapula and foot from not being repositioned. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings include:	02310		

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The National Pressure Ulcer Advisory Panel (NPUAP) resource dated 2016, defined a pressure injury as localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. NPUAP defined a stage 1 pressure injury as non-blanchable erythema (redness) of intact skin with a localized area of non-blanchable erythema. A stage 2 pressure injury is defined as partial-thickness skin loss with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. A stage 3 pressure injury is defined as full-thickness skin loss in which adipose (fat) tissue is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. A stage 4 pressure injury is defined as full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage, or bone in the ulcer.

R1 was admitted to the licensee on September 29, 2022, with diagnoses including chronic kidney disease stage 3, Parkinson's Disease, reduced mobility, spondylosis, chronic pain, and anxiety disorder.

On October 21, 2024, a change of condition assessment indicated R1 was readmitted to the

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facility after a recent hospital stay, then admitted to hospice for end-of-life care related to decompensation of Parkinson's Disease. The assessment indicated R1 was no longer able to assist with transfers and was dependent on staff for mobility. The assessment indicated R1 required assistance with toileting, and indicated staff were to check R1 for incontinence and change her every 2 hours. The assessment indicated R1 had no new skin issues or pressure ulcers but indicated R1 required daily dressing changes and weekly wound monitoring. The assessment failed to identify R1 was at risk for or had pressure ulcers and required assistance with bed mobility and repositioning to help prevent new or worsening pressure ulcers.

A review of R1's service plan dated November 20, 2024, indicated R1 utilized hospice for end-of-life care. The service plan identified R1 had impaired mobility and required extensive assistance with dressing and grooming twice daily but failed to indicate R1 needed assistance with bed mobility and lacked direction for R1 to be repositioned to prevent new or worsening pressure ulcers. Although the service plan indicated R1 required staff to check for incontinence and change R1 if she was incontinent scheduled every 2 hours, 12 times daily. There was no indication staff were to provide repositioning when R1 was checked for incontinence. In addition, the service plan failed to include weekly wound monitoring as assessed, as a result there was no indication any wound assessment or monitoring was completed for R1.

An undated facility investigation document indicated an incident was reported by a licensee nurse Licensed Practical Nurse (LPN)-D who found R1 laying in dried incontinent fecal matter. The investigation included interviews with staff

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02310	Continued From page 26 but did not include an interview/statement from LPN-D who witnessed and reported the incident. Although the staff interviews indicated they had not provided care every 2 hours as assessed, the investigation summary indicated R1's service plan was followed, and incontinence care and repositioning were provided every 2 hours with no concerns for neglect identified. A review of R1's Medication and Treatment Administration Record (MAR/TAR) and service delivery of care record from the time of the incident (November 30, 2024, to December 1, 2024) reported by LPN-D indicated R1 had received a suppository on the evening shift at 2:41 p.m. The service delivery record indicated R1 received mobility assistance on November 30, 2024, at 11:15 p.m., then did not receive mobility assistance again until December 1, 2024, at 12:09 p.m. (12 hours and 54 minutes later). The service delivery record indicated R1 was provided incontinence care on December 1, 2024, at 1:23 a.m., then was not checked or provided incontinence care again until 5:06 a.m. (4 hours later), and again at 12:07 p.m. (7 hours later) indicating R1 had not received checks and incontinence care every 2 hours as assessed or indicated on R1's service plan. The service record failed to include interventions to reduce R1's risk for new or worsening pressure ulcers including clear direction for staff to reposition R1 frequently with scheduled incontinence check and change. R1's weekly wound/pressure ulcer assessments and monitoring were requested from the onset of R1's coccyx pressure ulcer until R1's death, but none was provided. On January 7, 2025, and 9:41 a.m. email	02310		

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correspondence with the licensee's regional Licensed Assisted Living Director (LALD)-I indicated any wound assessment or monitoring including wound measurements would be documented in R1's progress notes. A policy for wound assessment and monitoring was requested, none was provided.

On January 22, 2025, at 8:58 a.m. email communication with (LALD)-H indicated the facility did not have a specific policy for wound care, as they were not required to have wound care policies in the assisted living setting. LALD-H also indicated if another agency was managing the wound, it was expected to have a weekly note coordinating care and progress/status of the wound.

A review of R1's progress notes lacked any documentation of ongoing assessment or monitoring of R1's pressure ulcers to include wound measurements (size/depth), and description of the wounds including drainage, odor, and peri wound area. Although the lack of documentation in R1's record made it unable to determine the onset stage and progression of R1's pressure ulcers, the progress notes indicated R1's coccyx pressure ulcer worsened and R1 developed new pressure ulcers on her scapula and foot.

On October 22, 2024, at 4:11 p.m. a progress note indicated Registered Nurse (RN)-A documented treatment orders for a coccyx pressure ulcer wound in R1's progress notes. The progress note had no mention of a coccyx pressure ulcer prior to that day. The progress note lacked any assessment of the pressure ulcer to include size, measurements, description, or stage. In addition, there was no indication any

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interventions were implemented to prevent new or worsening pressure ulcers including assistance with repositioning and bed mobility.

On November 19, 2024, at 10:51 a.m. a progress note indicated RN-A documented R1's coccyx pressure ulcer had gotten worse and indicated hospice would provide an air bed. The progress notes had no assessment of the pressure ulcer to include size, measurements, description, or stage. In addition, there was no indication interventions including assistance with repositioning and bed mobility were implemented to prevent new or worsening pressure ulcers.

On December 2, 2024, at 5:44 p.m. a progress note the day after the incident involving R1 was reported, indicated RN-A documented she had completed a dressing change and R1 had 2 new pressure areas on her scapula with redness present, and instructions to change a dressing on the area every 3 days. The progress note had no assessment of the coccyx pressure ulcer, or new pressure ulcers to include size, measurements, description, or stage. In addition, there was no indication interventions including assistance with repositioning and bed mobility were implemented to prevent new or worsening pressure ulcers.

On December 14, 2024, at 6:12 p.m. LPN-D documented in a progress note that R1's coccyx pressure ulcer had developed a large tunnel forming at the 5 o'clock position down R1's right leg. The note also indicated R1 had developed another new pressure ulcer on her right foot from being positioned with her feet touching at 9:30 a.m. and was not moved until 12:45 p.m. (3.25 hours) later. R1's progress notes had no assessment of the new pressure ulcer to include size, description, or stage. In addition, there was

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no indication interventions including assistance with repositioning and bed mobility were implemented to prevent new or worsening pressure ulcers.

On January 3, 2025, at 9:51 a.m. when interviewed the Licensed Assisted Living Director (LALD)-H and Interim Registered Nurse Director of Nurses (IRNDON)-K stated they were not involved in the investigation of the neglect concern reported by 2 nurses, and indicated the former clinical manager (RNDON)-J was in charge of the investigation and found no concerns that neglect occurred, so the incident was not reported to MAARC by the licensee. LALD-H and IRNDON-K indicated RNDON-J should have completed an investigation packet but indicated that documentation had not been reviewed because RNDON-J had unexpectedly resigned after the investigator was onsite with no explanation and failed to respond to phone calls or questions. The investigation packet documents were requested, no additional information was provided.

On January 3, 2025, at 10:46 a.m. Registered Nurse (RN)-A stated a resident who was actively dying would need frequent incontinence check, change, and repositioning. RN-A stated the services should be on R1's service plan and assigned to staff to implement. RN-A indicated if the task was not assigned to staff, they would not know what services the resident would need. RN-A stated she had never assessed or monitored R1's coccyx pressure ulcer because hospice was doing the wound assessments and measurements.

A review of the facility provided hospice visit notes lacked any indication ongoing wound

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assessment and monitoring to include size, measurements, description, or stage was being completed by hospice for R1.

On January 3, 2025, at 11:20 a.m. during an interview unlicensed personnel (ULP)-C stated staff utilized an assigned task list to direct them on what cares and services the resident's needed. ULP-C indicated R1 received hospice end of life care, and was bed bound, and required assistance with repositioning and incontinence cares. ULP-C stated R1 had a coccyx pressure ulcer that drained a lot, was open, and the nurses changed the dressing on it.

On January 3, 2025, at 11:51 a.m. during an interview ULP-B stated R1 declined very quickly when she was readmitted from the hospital. ULP-B stated staff went by assigned tasks to know how to provide care for R1 and indicated R1 needed wound care and repositioning. ULP-B indicated if a service was not assigned on the task list, they would not know to provide that care or service.

On January 3, 2025, at 11:31 a.m. ULP-E stated she was not assigned to R1 but had assisted staff with cares and repositioning when R1 was actively dying. ULP-E stated R1 had a coccyx pressure ulcer that had a strong odor, leaked, and needed changing.

On January 21, 2025, at 2:21 when interviewed a Hospice Registered Nurse (HRN)-G indicated she was seeing R1 on a daily basis at the time the incident occurred because R1 was actively dying. The nurse indicated R1 was not responsive, was dependent on staff for bed mobility, repositioning, and incontinence care at the time the incident occurred. HRN-G stated

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02310	Continued From page 31 when she entered R1's room the day of the incident with facility LPN-D, the smell was overwhelming of someone who had been left in incontinence for a long time. HRN-G stated R1 had odor from a necrotic infected coccyx pressure ulcer but indicated the smell that day was very different. HRN-G described the smell as a pungent smell of old incontinent fecal matter and wound drainage. HRN-G stated when they pulled the covers back R1's incontinent fecal matter and wound drainage had leaked from her brief onto her bedding and gown and dried stuck onto her body with a large dried dark ring visible underneath R1. The nurse stated R1 was very painful, moaning, and grimacing when the nurses touched and moved R1 to provide cares and change R1's dressing. The nurse stated R1 appeared to be in the exact same position as the previous afternoon when they administered her suppository and indicated R1 appeared to be untouched. The nurse stated LPN-D appeared visibly upset and was crying while providing care to R1 due to the state R1 was found in, and indicated there was no way anyone had checked on, changed, or repositioned R1. The nurse stated when they turned R1, she had 2 new pressure ulcers on her scapula area as a result of not being repositioned. The nurse stated hospice provided wound care orders and supplies but indicated the facility was responsible for dressing changes and ongoing assessment/monitoring of R1's pressure ulcers. On January 17, 2024, at 11:44 a.m. when interviewed LPN-D stated R1 was actively dying and required extensive assistance with incontinence cares and repositioning at the time the incident occurred. LPN-D stated R1's coccyx pressure ulcer was severe, drainage was not being contained in the dressing, and the dressing	02310		

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02310	Continued From page 32 was saturated each day she changed it. LPN-D stated the first thing she noticed when entering R1's room was the smell and stated although the indicator lines on R1's brief showed she was dry, R1 had no intake and was not urinating at that time the incident occurred. LPN-D stated when she pulled back the covers, she instantly noticed a very obvious dark dried ring of fecal matter and wound drainage visible on the soaker pad several inches past R1's body. LPN-D explained R1's brief had leaked saturating R1's bedding and gown, then dried and was stuck onto R1's body. LPN-D stated when they (LPN-D and HRN-G) rolled R1 over, she was completely soiled, and incontinent fecal matter was dried onto R1's skin. LPN-D stated R1 had 2 new pressure ulcers on her scapula that were red and non-blanching the size of her thumb from not being repositioned. LPN-D stated R1 appeared to be in the same position as the previous day when she administered a suppository to R1. LPN-D stated if staff had actually turned and repositioned R1 or pulled back the covers, they would have noticed she was incontinent. LPN-D stated she was under the impression staff had provided care to R1, but it was obvious no cares had been provided for a long time for it to dry onto R1's body. LPN-D stated the incident was horrible, unfortunate, and it made her cry to find R1 that way and reported the concern of neglect immediately to RNDON-J and wrote up a statement and gave it to leadership. LPN-D's facility interview and statement were not provided for the investigator to review. On January 21, 2024, at 1:53 p.m. R1 family member indicated a nurse (unknown) had expressed concern R1 had not been cared or repositioned properly, and R1's brief had not been changed for a long time.	02310		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 33	02310		

A facility policy and procedure titled "Initial and Ongoing Assessment of the Residents" revised August 1, 2021, indicated assessments are completed by a registered nurse based upon the required assessment schedule and as needed based upon resident condition. An RN would complete a comprehensive assessment of the resident's physical, mental, and cognitive needs as required on preadmission, initial assessment completed before the start of services, 14-day after start of services, and ongoing every 90 days and with a change in resident condition. The policy and procedure indicated a comprehensive assessment would include activities of daily living, including: 1. toileting pattern, bowel, and bladder control, 2. dressing, grooming, bathing, and personal hygiene, 3, mobility, including ambulation, transfers, and assistive devices. Section D: physical health status, including relevant history and current health conditions including, medical diagnoses. Section H: pain, location, frequency, intensity, duration, and effectiveness of interventions medications and non-medications alternatives for pain. Section I: skin conditions. Section K: list of treatments including type, frequency, and level of assistance needed. Section L: nursing needs including potential to receive delegated services. Section M: risk indicators. The policy and procedure indicated the resident's service plan would be updated as necessary based on the resident's needs. The policy failed to indicate the licensee would assess the resident's bed mobility, or pressure ulcers/risk for pressure ulcers.

A facility policy and procedure titled " Monitoring of Resident's and Their Service Plan" revised August 1, 2021, indicated to assure resident's needs are provided as agreed upon on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31068	A. BUILDING: ______ B. WING ______	C 01/03/2025

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02310	Continued From page 34 service plan, the RN would monitor resident needs and services on an ongoing basis to determine if the services are appropriate to the residents needs or if changes in the service plan are needed. The RN would identify any problems or resident concerns; evaluate the effectiveness of the services, medications and treatments; and identify any changes in condition or new symptoms. Section 5 A. indicated the RN would determine if the services provided are appropriate to meet the resident's needs. B. Determine if the treatments or interventions are effective and whether any changes are needed. If the RN determines that changes are needed in either treatments or services requiring an order, the RN will communicate these changes to the provider or other licensed health professional. C. Identify any new vulnerability that the resident may have or any new risk that the resident may pose to other vulnerable adults and identify interventions to address these issues. Document all changes and intervention in the resident record and communicate changes to associates that provide services to the resident. A facility policy and procedure titled "Service Plan Policy" revised August 1, 2021, indicated 1.A proposed service plan is established after completion of an individualized, initial assessment. 2. The Assisted Living provider shall finalize a written service plan within 14 days after the initiation of Assisted Living services to a resident. 3. The service plan and any revisions must include a signature or other authentication by the facility and by the resident or the resident's representative documenting agreement on the services to be provided. 4. The service plan must be revised, if needed, based on the results of required resident monitoring and/or reassessments. 5. The Assisted Living provider	02310		

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02310	Continued From page 35 must implement and provide all services required by the current service plan. 6. The service plan and any revised service plans must be entered into the resident's record. 7.Associates providing services must be informed of the current written service plan. 8. Service Plans are communicated to assist associates in understanding the resident's person-centered daily needs and tasks. 9. The service plan must include all of the following required elements: 10. A description of the services to be provided, the fees for services (including any changes to the provider's fee for services), and the frequency of each service, according to the resident's current review or assessment and resident preferences. 11. The identification of the type staff (RN/LPN, Therapists, Unlicensed Personnel, etc.) that will provide the services. 12. The schedule and methods of monitoring reviews or assessments of the resident. 13. The frequency of sessions of supervision of staff and type of personnel who will supervise staff. 14. A contingency plan that includes: a. the action to be taken by the Assisted Living provider and by the resident or resident's representative if the scheduled service cannot be provided; b. information and method for a resident or resident's representative to contact the Assisted Living provider. The policy and procedure indicated whenever changes are needed to the services to be provided because of a change in resident condition, after receipt of new revised orders from provider or other prescribing provider, following an incident, and/or return from hospital or skilled nursing facility. Policy and procedure for contents of the resident record was requested, a policy for resident record retention was provided. No further information was provided.	02310		

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02310	Continued From page 36 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 interviews and document review, the licensee failed to ensure one of one residents (R1) reviewed was free from maltreatment. R1 was 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		