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 #: HL314171663M **Date Concluded:** October 25, 2022

Compliance #: HL314173245C

Name, Address, and County of Licensee Investigated:
Elmore Assisted Living
202 North Street East
Elmore, MN 56027
Faribault County

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

Evaluator's Name: Erin Johnson-Crosby, RN
Special Investigator

Finding: Substantiated, facility responsibility

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

Initial Investigation Allegation(s):
The facility neglected residents (Resident #1, Resident #2, Resident #3, Resident #4, Resident #5, Resident #6) when multiple resident-to-resident altercations occurred and the facility failed to monitor, assess, and implement interventions to protect the health and safety of the residents.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to provide supervision to protect the residents' (Resident #1, Resident #2, Resident #3, Resident #4, Resident #5 and Resident #6) health and safety following multiple resident-to-resident altercations. The facility was aware

An equal opportunity employer.

several residents exhibited violent and aggressive behavior and failed to identify and implement interventions to mitigate future incidents.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of police, employee, and resident records. The investigator also observed the memory care unit and resident and staff interactions.

Resident #1

Resident #1 resided in a memory care facility with current diagnoses including vascular dementia with behavioral disturbance, repeated falls, and seizure disorders. Resident #1's service plan indicated Resident #1 required assistance with dressing, bathing, grooming, and was independent with ambulation. The service plan also directed staff to complete hourly safety checks and monitor the resident for agitation, anxiety, and behaviors.

Resident #1's progress notes indicated within a three-month timespan, Resident #1 hit five residents. One resident required treatment in the emergency room after sustaining a facial laceration. The progress notes further indicated Resident #1 was hit by two other residents. Resident #1 was sent to the emergency room after sustaining a contusion (bruise) to the left chest wall, facial contusion, and abrasion (a deep cut or tear in the skin).

At the time of the onsite investigation, Resident #1 was observed with bruising of the eyes, in various stages of healing, from an incident which occurred two weeks prior to the onsite visit.

Facility staff did not consistently conduct assessments following each incident to identify vulnerabilities, susceptibilities to abuse, or new risks of harm to others. Existing interventions were not evaluated, and no new interventions were implemented to prevent future incidents.

Resident #2

Resident #2 resided in a memory care facility with current diagnoses including schizoaffective disorder, dementia, and post-traumatic stress disorder. Resident #2's service plan indicated Resident #2 required assistance with dressing, grooming, bathing, medication administration, and was independent with ambulation and transfers. The service plan further indicated Resident #2 had severe confusion, required safety checks every shift and had a history of wandering into other resident rooms.

Resident #2's progress notes indicated within the last three months the following incidents had occurred: Resident #2 was hit on the head by another resident; A resident hit Resident #2 on the head with a coffee cup which resulted in an emergency room visit and a head laceration to be closed with tissue glue; Another resident shoved a sandwich in Resident #2's face causing redness and scratches to Resident #2's face.

Facility staff did not consistently conduct assessments following each incident to identify vulnerabilities, susceptibilities to abuse, or new risks of harm to others. Existing interventions were not evaluated, and no new interventions were implemented to prevent future incidents.

Resident #3

Resident #3 resided in a memory care unit with current diagnoses including dementia with behavioral disturbance, stroke, and delirium. Resident #3's service plan indicated Resident #3 required assistance with toileting, dressing, medications, and safety checks to be completed twice per shift. The service plan also indicated Resident #3 was independent with ambulation, transfers, and bed mobility. The service plan further identified Resident #3 had a history of hitting out at others when frustrated. The interventions included on the service plan to address the resident's behaviors included: walking away, removing other residents from the situation, and utilizing as-needed (PRN) medications.

Resident #3's incident report indicated Resident #3 was found on another resident's floor. The other resident stated Residents #3 hit him and they were wrestling on the ground.

Facility staff did not conduct an assessment following the incident to identify vulnerabilities, susceptibilities to abuse, or new risks of harm to others. Existing interventions were not evaluated, and no new interventions were implemented to prevent future incidents.

Resident #4

Resident #4 resided in a memory care unit with current diagnoses including dementia, stroke, delusions, aphasia (loss of ability to understand or express speech) and impulse disorder. Resident #4's service plan indicated Resident #4 required assistance with medications, hourly safety checks, and monitoring of medication refusals and anxiety. Resident #4 was independent with transfers, and bed mobility.

Resident #4's progress notes indicated on three separate occasions other residents attempted to go into Resident #4's room. The first time, Resident #4 attempted to kick a resident. The second time, Resident #4 and the other resident took a swing at each other but did not make contact. Two additional incidents involving Resident #4 were also identified which indicated Resident #4 shoved the resident(s) out of his room and threatened to beat them up.

Facility staff did not consistently conduct assessments following each incident to identify vulnerabilities, susceptibilities to abuse, or new risks of harm to others. Existing interventions were not evaluated, and no new interventions were implemented to prevent future incidents.

Resident #5

Resident #5 resided in a memory care unit with current diagnoses including alcohol dependence, low back pain and moderate intellectual disabilities. Resident #5's service plan indicated Resident #5 received hourly checks, medication administration, and monitoring for

agitation and wandering. Resident #5 was independent with bed mobility, transfers, and ambulation.

Resident #5's progress notes indicated Resident #5 slapped the back of his roommate's wheelchair. An hour later, staff heard a resident yelling and observed Resident #5 pushing the resident out of his room. The progress notes also indicated Resident #5 pushed another resident in a hard and forceful manner. Another incident indicated staff heard a resident yelling in agony and observed Resident #5 attempting to slam the resident into the wall with his door. A further incident indicated staff heard a resident screaming outside of Resident #5's room. Staff noticed redness by the other resident's eye and Resident #5 admitted he punched the resident. The most recent incident indicated staff heard a commotion and Resident #5 was on top of Resident #1. Resident #1 had a hold of Resident #5's beard. Staff separated the residents and Resident #5 stated, "looks like the mother fucker wants to go again." Resident #1 had bruising under his eye and was taken to the emergency room.

Facility staff did not consistently conduct assessments following each incident to identify vulnerabilities, susceptibilities to abuse, or new risks of harm to others. Existing interventions were not evaluated, and no new interventions were implemented to prevent future incidents.

Resident #6

Resident #6 resided in the memory care unit with current diagnoses including dementia with behavioral disturbance, aphasia, and hemiplegia. Resident #6's service plan indicated Resident#6 required hourly safety checks related to falls, smoking escorts, and medication management. Resident #6 also required staff assistance with transfers and ambulation. In addition, the service plan directed staff to monitor for behaviors.

Resident #6's progress notes indicated Resident #6 pushed another resident out of his way. Staff reminded Resident #6 not to hit other residents. The notes included another incident where Resident #6 was hit in the face and grabbed on the arm by another resident.

Facility staff did not consistently conduct assessments following each incident to identify vulnerabilities, susceptibilities to abuse, or new risks of harm to others. Existing interventions were not evaluated, and no new interventions were implemented to prevent future incidents.

During interviews, multiple unlicensed staff (ULP)s members stated they did not have adequate training on mental health or handling violent and aggressive residents. The ULPs stated interventions to protect residents included to watch the residents more closely but stated this was difficult due to low staffing levels. One ULP stated sometimes there were only two staff on the memory care unit for 20 residents, so staff were unavailable to monitor the common areas where most of the resident-to-resident altercations occurred.

During an interview, a registered nurse (RN) stated the facility accepted residents they were not able to care for and the facility was "biting off more than we can chew." The RN stated the

interventions to prevent resident-to-resident altercations were to provide closer watch to the residents that wandered. The RN also stated after the altercation involving Resident #1 and Resident #5, Resident #5's smoking privileges were taken away and he was not eligible to attend activities or outings due to the aggressive behavior.

During an interview, additional RN staff stated they were behind on charting and the resident's individual abuse prevention plans (IAPP) and assessments were not up to date due to staffing concerns. The RN's stated they were at a loss on what to do with the aggressive residents. The RN's stated they have tried moving resident rooms and some adjustments were made to medications but that was not effective. The RN's further indicated staff did not have enough training to care for some of the residents.

During an interview, nursing administration confirmed resident-to-resident altercations were not consistently reviewed or reported, IAPP's were not appropriately updated, and new interventions were not implemented following each incident. Nursing administrative staff stated the facility was not tracking or trending resident-to-resident altercations or identifying the root cause of the incidents prior to the investigator's onsite visit.

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

Vulnerable Adult interviewed: Resident #1-No, due to cognitive impairment;
Resident #2- No, due to cognitive impairment; Resident #3-No, resident deceased;
Resident #4- No, due to cognitive impairment; Resident #5- Yes;
Resident #6- No, due to cognitive impairment;
Family/Responsible Party interviewed:

Resident #1- Attempts to reach were unsuccessful;
Resident #2-Yes;
Resident #3- Yes;
Resident #4- Refused;
Resident #5- Attempts to reach were unsuccessful;
Resident #6- Yes;
Alleged Perpetrator interviewed: Not Applicable (N/A)

Action taken by facility:
The facility attempted room changes and medication adjustments for two of the six involved residents.

Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31417	A. BUILDING: ______ B. WING ______	C 09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMORE ASSISTED LIVING	**202 EAST NORTH STREET ELMORE, MN 56027**

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0 000	Initial Comments Initial comments ******ATTENTION****** HOME CARE PROVIDER/ASSISTED LIVING PROVIDER LICENSING 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: HL314173281C/HL314171682M HL314173245C/HL314171663M On September 7 and September 8, 2022, 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 49 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for HL314173245C/HL314171663M, tag identification 0470, 0490, 0630, 2170, 2310, 2360.	0 000	Assisted Living Provider 144G. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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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0 470	Continued From page 1	0 470		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop, implement, and post a staffing plan as required, potentially affecting all 49 residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 470		

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0 470	Continued From page 2 safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: The licensee held an assisted living with dementia care license and was licensed for 72 residents and had a current census of 49 residents. The licensee lacked a staffing plan that: - included an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; - ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and - ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; - ensures that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: - awake; - located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; - capable of communicating with residents; - capable of providing or summoning the	0 470		

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0 470	Continued From page 3	0 470		

appropriate assistance; and
- capable of following directions.

On September 7, 2022, at 12:50 p.m., a staffing plan was not posted in the facility.

On September 8, 2022, at 1:05 p.m., the director of nursing (DON)-F confirmed a staffing plan was not developed, implemented or posted with the required information.

The licensee's Staffing Plan Policy dated August 1, 2021, indicated the facility would be adequately staffed to allow prompt response time to residents needs. The plan also indicated a ratio was 1 staff member to 12 residents, and a minimum of 2 staff are required at all times.

The licensee's 4.06 Staffing & Scheduling policy dated August 1, 2021, indicated the licensee will assure qualified employees will be scheduled to meet operation requirements and the needs of the residents. The policy directed the clinical nurse supervisor will develop and implement a written staffing plan that provides an adequate number of qualified direct-care staff to meet the resident's needs 24-hours a day, seven-days a week. The policy indicated the staffing levels would be based on resident's needs, acuity level, ability of staff to meet needs timely, and also be based on staff experience, training and competency. Additionally, the policy indicated the daily work schedule for direct care staff showing work shifts and days and hours worked, would be posted at beginning of each work shirt in a central location.

TIME PERIOD TO CORRECT: Twenty-one (21) Days

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0 490	Continued From page 4	0 490		
0 490 SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (ii) weekly housekeeping; (iii) weekly laundry service; (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to have a daily program of social and recreational activities. This had the potential to affect all 49 residents receiving assisted living services and 20 residents that resided in the locked memory care unit. This practice resulted in a level two violation (a	0 490		

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0 490	Continued From page 5	0 490		

violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

The licensee lacked a program of daily social and recreational activities.

During observation on September 7, 2022, at 12:45 p.m., there was not an activity schedule posted in the assisted living facility.

On September 7, 2022, from 12:30 p.m., to 5:30 p.m., structured activities were not observed on the third floor memory care locked unit.

On September 7, 2022, at 4:55 p.m., R5 and R9 stated they were bored and there were no activities on the locked unit.

On September 7, 2022, at 5:07 p.m., registered nurse (RN-C) stated there were no structured activities and stated there was an activity schedule but it was not followed. RN-C also verified there were no structured activities that day.

On September 8, 2022, at 11:15 a.m., RN-D and RN-E stated there were not structured activities on the third floor locked unit and if there were structured activities it may decrease the male resident's aggression and the resident's may feel more joy. RN-D and RN-E stated the residents are constantly stating they are bored and have

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0 490	Continued From page 6 nothing to do. RN-E and RN-E stated the unlicensed personnel (ULP)s do not have enough time to complete cares and activities. On September 8, 2022, at 2:45 p.m., activities director (AD)-G stated staffing has been difficult over the last few months and AD-G confirmed he was not aware of the need for any individual activity plans for the residents. On September 8, 2022 at 3:05 p.m., director of nursing (DON)-F stated her expectation would be for an activity evaluation and plan be completed and shared with the activities director. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 490		
0 630 SS=F	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 observation, interview, and record review the facility failed to develop an individualized abuse prevention plan (IAPP) to	0 630		

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0 630	Continued From page 7 assess and identify specific interventions related to resident susceptibility to abuse and risk for abuse to others for each known vulnerability and failed to update the IAPP after resident to resident altercations occurred for six of six residents (R1, R2, R3, R4, R5, R6) with records review. This had the potential to harm all six residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 resided in a memory care facility with current diagnoses including vascular dementia with behavioral disturbance, repeated falls, and seizure disorders. R1's service plan dated January 5, 2022, indicated R1 required assistance with dressing, bathing, and grooming and was independent with ambulation. The service plan directed staff to complete hourly safety checks and monitor for agitation, anxiety, and behaviors. The service plan was updated on June 24, 2022, and indicated R1 may hit out at staff or other residents. The interventions included: use a calm approach, walk away, remove other residents from the situation and administer as needed medications. The service plan did not include interventions to protect R1 from other aggressive residents.	0 630		

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0 630	Continued From page 8 R1's individual abuse prevention plan (IAPP) dated June 5, 2022, indicated R1 was at risk for physical, emotional, financial, and verbal abuse. The assessment indicated R1 would swear, hit, kick or punch. The interventions listed included to administer as needed medications and provided one to one redirection. The assessment indicated R7 punched R1 in the left cheek a few times. R1 attempted to defend himself and backed away. R9 stated "this is your fault I told you to get him the hell out of here, call the cops, call them." Facility staff sent R1 to the emergency room (ER) and returned with contusions to his left chest wall. The assessment further indicated R1 had identified areas of potential vulnerability but there were no signs of abuse or neglect. The assessment indicated the interventions were listed on the care plan/service plan. During an observation on September 7, 12:45 p.m., R1 was sleeping and light purple bruising was observed around both of R1's eyes. R1's progress and provider notes indicated the following: - June 5, 2022, R7 assaulted R1. R1 was sent to the emergency department for a contusion to the left chest wall. Police were called. R7 was taken into police custody and returned to the facility two days later. -June 16, 2022, R1 punched another resident in the face; sent a message to the provider and requested an increase in Olanzapine (antipsychotic medication). - June 22, 2022, The provider increased Olanzapine to 10 milligrams (mg). -July 7, 2022, R1 assaulted three other residents last evening.	0 630		

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-July 9, 2022, R1 hit another resident with a coffee mug and the resident had to go to the emergency room (ER). The other resident punched him back.
-August 25, 2022, tried to hit another resident in the face.
-August 26, 2022, provider started R1 on Sertraline (antidepressant)
-August 26, 2022, staff heard a loud commotion and saw R5 on top or R1. R1 had R5 by the beard and R1 was bleeding from his face. R1 was sent to the ER and returned with diagnoses of facial contusion and abrasions.
-August 29, 2022, bruising to R1's eyes on the inner corner, dark purple in color .5 x .5 centimeter (cm) and a scab on the bridge of the nose. No intracranial injury noted after testing.

R1's IAPP dated August 29, 2022, indicated R1 was at risk for physical, emotional, financial, and verbal abuse, but did not include interventions to prevent these vulnerabilities or minimize the risk of abuse. The assessment indicated R1 was cognitively impaired and would swing at others, kick, punch, and hit people. Interventions listed were to administer as-needed medication for behaviors and redirect the resident to another area. The assessment indicated R1 had areas of vulnerability, but no displayed no signs of abuse or neglect. The IAPP did not include review or interventions to protect R1 from abuse or protect others from abuse by R1.

R2

R2 resided in a memory care facility with diagnoses including schizoaffective disorder, dementia with Lewy bodies, and post-traumatic stress disorder (PTSD). R2's service plan dated

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February 28, 2022, indicated R2 required assistance with dressing, grooming, bathing, medications, and was independent with ambulation and transfers. The service plan also indicated R2 had severe confusion, required safety checks every shift and had a history of wandering into other resident rooms.

R2's vulnerability assessment dated January 12, 2021, indicated R2 was disoriented to time, place and situation and was not able to give accurate information consistently. The assessment indicated R2 was unable to report abuse or neglect and R2 had areas of potential vulnerability but displayed no signs of abuse or neglect. The assessment also indicated R2 may pose a risk to others but did not include R2's susceptability to abuse or neglect.

R2's progress notes indicated:

-July 7, 2022, at 7:30 p.m., R2 came out of the bathroom and R1 hit R2 on the head.
-July 9, 2022, at 8:00 p.m., R2 was sent to the ER due to a severe head wound by another resident with a coffee cup. R2 punched R1. R2's head wound was closed with tissue glue.
-July 28, 2022, at 10:34 p.m., another resident shoved a sandwich forcefully in R2's face, there was redness to the right side of R2's face and five scratches on the end of his nose.
-August 7, 2022, late entry written on August 31, 2022, indicated facility staff conducted a skin assessment and noted a 13cm x 1 cm scratch on R2's back that was painful to touch. It was unknown how R2 received this scratch. The scratch was measured as 3 cm x 1 cm later that day.

R2's IAPP was not updated following the above

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incidents which were identified in R2's progress notes and the IAPP did not include review or interventions to protect R2 from abuse or protect others from abuse by R2.

R3

R3 resided in a memory care unit with diagnoses including dementia with behavioral disturbance, stroke, and delirium. R3's service plan dated June 29, 2022, indicated R3 required assistance with toileting, dressing, medications, safety checks twice a shift, had a history of wandering and hitting out when frustrated and during refusals of toileting. Staff was directed to use caution and walk away, remove other residents and provide as- needed medications. The service plan also indicated R3 was independent with ambulation, transfers, and bed mobility.

R3's IAPP dated June 30, 2022, indicated R3 was at risk from abuse, but did not include interventions to prevent the abuse.

Incident reports:

-July 7, 2022 @ 10:00 p.m., R3 was found in another resident's room. The other resident stated R3 hit him, and they were wrestling around on the ground.

R3's IAPP was not updated following the above incident which were identified in R3's progress notes and the IAPP did not include review or interventions to protect R3 from abuse or protect others from abuse by R3.

The facility' discharged and deceased resident roster indicated R3 passed away on August 31, 2022.

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0 630	Continued From page 12 R4 R4 resided in a memory care unit with current diagnoses including dementia, stroke, delusions, aphasia (loss of ability to understand or express speech) and impulse disorder. R4's service plan dated March 15, 2022, indicated R4 required assistance with medications, anxiety, and hourly safety checks. R4 was independent with transfers and bed mobility.R4 required staff to monitor behaviors which included medication refusals. R4's IAPP dated February 23, 2021, indicated R4 was disoriented, forgetful and unable to give accurate information. Staff were to perform 30 minute checks due to R4's elopement risk. The IAPP indicated the resident did not pose a physical violence risk to others. R4's progress notes identified the following incidents: -June 14, 2022, at 2:43 p.m., another resident attempted to get into R4's room, R4 attempted to kick the other resident. -June 16, 2022, at 5:00 p.m., a resident attempted to go into R4's room, R4 told the other resident to get out and the residents swung at each other but didn't make contact. -July 5, 2022, at 6:59 p.m., staff found a 27 cm x 5 cm scratch in the middle of R4's back during a skin assessment that occurred on the weekend when R3 and R4 were found in R4's room. R3 was on the floor and the tray table was broken. Staff separated the residents and a bruise was found on R3 over the weekend. -July 22, 2022, at 2:23 a.m., R4 shoved	0 630		

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another resident out of his room. The other resident was not injured and seemed not bothered by the confrontation.
-July 28, 2022, R4 was yelling at another resident for coming into his room. R4 told the other resident he was going to "kick his ass," and stated he would kick his ass so bad he would have to go to the hospital. The residents were separated.
-August 11, 2022, at 11: 38 p.m., R4 pushed another resident in the doorway of his room and again threatened to beat the other resident up. Staff separated the residents.

R4's IAPP was not updated following the above incidents which were identified in R4's progress notes and the IAPP did not include review or interventions to protect R4 from abuse or protect others from abuse by R4.

R5

R5 resided in a memory care unit with current diagnoses including alcohol dependence, low back pain and moderate intellectual disabilities. R5's service plan dated February 21, 2022, indicated R5 received hourly checks, medications, and monitoring for agitation and wandering. R5 was independent with bed mobility, transfers, and ambulation.

R5's progress notes identified the following incidents:

-November 2021 to May of 2022, three vulnerable adult reports were completed related to resident-to-resident altercations with R5 as the aggressor.
-May 19, 2022, at 10:17 p.m., staff saw R5 slap the back of his roommate's wheelchair while

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their roommate was in the chair. After an hour, staff heard a resident yelling and saw R5 push another resident out of his room.
-June 1, 2022, at 6:22 p.m., R5 pushed another resident extremely hard and forceful.
-June 12, 2022, at 3: 30 p.m., Staff heard another resident yelling in agony and saw R5 attempting to slam/squish another resident into the wall with his room door.
-July 23, 2022, at 7:26 p.m., staff saw R5 in his room charging towards his roommate with aggression and rose his arm over another resident in a wheelchair about to swing down. Staff blocked him from hitting the other resident. The other resident had fear in his eye and R5 stated that the other resident
kept changing the channel.
-July 28, 2022, at 8:45 p.m., staff heard screaming and found another resident standing outside of R5's room. The staff noticed redness by the resident's eye and R5 admitted he punched the other resident in the eye.
-August 9, 2022, at 4:57 p.m., R5 was punched by another resident with no injury.
-August 26, 2022, at 8:00 p.m., staff heard commotion and R5 was on top of R1 with his fist raised. R1 had a hold of R5's beard. Staff separated the residents and R5 stated "looks like the mother fucker wants to go again." R1 had bruising under his eyes and was taken to the ER.
-August 30, 2022, staff requested R5's provider for a medication review due to an increase in behaviors.

R5's IAPP dated August 29, 2022, indicated the R5 was at risk for abusing others but did not include interventions s to protect R5 from abuse or protect others from abuse by R5.

On September 8, 2022 at 1:38 p.m., R5 stated

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R1 grabbed his beard and was pulling on it so R5 punched him in the eye. R5 stated there were not any staff around. R5 stated the licensee is short staffed.

R6

R6 resided in the memory care unit with current diagnoses including dementia with behavioral disturbance, aphasia,and hemiplegia. R6's service plan dated February 8, 2022, indicated R6 required hourly safety checks related to falls, smoking escorts, medication management, transfers, and ambulation. The service plan also included for staff to monitor for behaviors.

R6's Progress notes:

- August 7, 2022 at 6:02 p.m., R6 took a broom and dust pan and was pushing another resident with it to get the other resident out of the way. Facility staff reminded R6 he could not hit people.
- August 26, 2022, 10:30 a.m., Another resident hit R6 in the face and grabbed his arm. No bruising or pain.

R6's IAPP dated August 16, 2021, indicated R6 was not able to give reliable information due to dementia. The IAPP indicated there were identified areas of potential vulnerability, but no signs of abuse or neglect and the client may pose a risk to other vulnerable adults, but did not include his susceptibility of abuse by others. The IAPP was not reviewed or updated follwing the August 26, 2022 incident.

On September 7, 2022, at 5:07 p.m., registered nurse (RN)-C stated the licensee is taking residents they are not able to care for and the

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licensee is "biting off more than we can chew." RN-C stated the interventions to attempt to prevent resident to resident altercations are to watch the residents that wander. RN-C also stated after the altercation with R1 and R5, R5's smoking privileges were taken away and he was not allowed to attend activities due to the altercation.

On September 8, 2022, at 11:06 a.m., RN-D and RN-E stated they were behind on charting and the resident's individual abuse prevention plans (IAPP) were not updated due to staffing concerns. RN-D and RN-E stated they were at a loss on what to do with the aggressive residents. RN-D and RN-E stated they tried moving a couple resident rooms, but that did not help. RN-D and RN-E stated staff did not have enough training to care for some of these residents.

On September 8, 2022, at 1:10 p.m., the director of nursing (DON)-F confirmed all resident to resident altercations should be reported and the IAPP should be updated after incidents and every 90 days. The DON also stated interventions should be implemented to attempt to prevent future resident to resident altercations.

The licensee's Individual Abuse Prevention Plan dated August 1, 2021, indicated the licensee will develop and implement an IAPP for each vulnerable adult. The IAPP will include 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 or other vulnerable adults.

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0 630	Continued From page 17 TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a	02170		

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resident's ability to ambulate or move; and
(8) outdoor activities.

This MN Requirement is not met as evidenced by:
Based on observation, interview and record review, the licensee failed to have an evaluation for an activity plan for six of six residents (R1, R2, R3, R4, R5, R6) who resided in the assisted living with dementia care licensed facility.

This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

The licensee had a current assisted living with dementia care license. 20 residents resided in the memory care unit.

R1 resided in a memory care facility with current diagnoses including vascular dementia with behavioral disturbance, repeated falls, and seizure disorders.

R1's record lacked evidence that the resident had been evaluated for activities according to the licensing rules of the facility, to include the following:
- past and current interests;
- current abilities and skills;
- emotional and social needs and patterns;
- physical abilities and limitations;

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- adaptations necessary for the resident to participate; and
- identification of activities for behavioral interventions.

R1's record lacked the development of an individualized activity plan.

R2

R2 resided in a memory care facility with current diagnoses including schizoaffective disorder, dementia with Lewy bodies, and post-traumatic stress disorder.

R2's record lacked evidence that the resident had been evaluated for activities according to the licensing rules of the facility, to include the following:
- past and current interests;
- current abilities and skills;
- emotional and social needs and patterns;
- physical abilities and limitations;
- adaptations necessary for the resident to participate; and
- identification of activities for behavioral interventions.

R2's record lacked the development of an individualized activity plan.

R3

R3 resided in a memory care unit with current diagnoses including dementia and delirium.

R3's record lacked evidence that the resident had been evaluated for activities according to the licensing rules of the facility, to include the

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following:
- past and current interests;
- current abilities and skills;
- emotional and social needs and patterns;
- physical abilities and limitations;
- adaptations necessary for the resident to participate; and
- identification of activities for behavioral interventions.

R3's record lacked the development of an individualized activity plan.

R4

R4 resided in a memory care unit with current diagnoses including dementia, stroke, delusions, aphasia (loss of ability to understand or express speech) and impulse disorder.

R4's record lacked evidence that the resident had been evaluated for activities according to the licensing rules of the facility, to include the following:
- past and current interests;
- current abilities and skills;
- emotional and social needs and patterns;
- physical abilities and limitations;
- adaptations necessary for the resident to participate; and
- identification of activities for behavioral interventions.

R4's record lacked the development of an individualized activity plan.

R5

R5 resided in a memory care unit with current diagnoses including alcohol dependence, low

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back pain and moderate intellectual disabilities.

R5's record lacked evidence that the resident had been evaluated for activities according to the licensing rules of the facility, to include the following:
- past and current interests;
- current abilities and skills;
- emotional and social needs and patterns;
- physical abilities and limitations;
- adaptations necessary for the resident to participate; and
- identification of activities for behavioral interventions.

R5's record lacked the development of an individualized activity plan.

R6

R6 resided in a memory care unit with diagnoses of dementia, hemiplegia, and aphasia.

R6's record lacked evidence that the resident had been evaluated for activities according to the licensing rules of the facility, to include the following:
- past and current interests;
- current abilities and skills;
- emotional and social needs and patterns;
- physical abilities and limitations;
- adaptations necessary for the resident to participate; and
- identification of activities for behavioral interventions.

On September 8, 2022, at 2:30 p.m., the activities director (AD)-G stated the activity plan was not posted and staffing for activities has been difficult the last few months. AD-G was not aware an

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02170	Continued From page 22 activity plan was required. On September 8, 2022 at 3:05 p.m., director of nursing (DON)-F stated her expectation would be for an activity evaluation and plan be completed and shared with the activities director. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02170		
02310 SS=I	144G.91 Subd. 4 Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure assisted living services were provided that were appropriate based on the resident's needs and according to an up-to-date service plan and subject to accepted health care standards for six of six residents (R1, R2, R3, R4, R5, R6) with records review. This had the potential to affect all 20 residents residing on 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 the potential to affect a large portion or all of the residents).	02310		

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The findings include:

R1

R1 resided in a memory care facility with current diagnoses including vascular dementia with behavioral disturbance, repeated falls, and seizure disorders. R1's service plan dated January 5, 2022, indicated R1 requested assistance with dressing, bathing, and grooming and was independent with ambulation. The service plan directed staff to complete hourly safety checks and monitor for agitation, anxiety, and behaviors. The service plan was updated on June 24, 2022, indicated R1 may hit out at staff or other residents. The interventions included: use a calm approach, walk away, remove other residents and administer as needed medications. The service plan did not include interventions to protect R1 from other aggressive residents.

R1's individual abuse prevention plan (IAPP) dated June 5, 2022, indicated R1 was at risk for physical, emotional, financial, and verbal abuse. The assessment indicated R1 would swear, hit, kick or punch. The interventions listed included to administer as needed medications and provided one to one redirection.

R1's progress and provider notes indicated the following:

- June 5, 2022, R7 assaulted R1. R1 was sent to the emergency department for a contusion to the left chest wall. The police were called and R7 was taken into police custody. R7 returned to the facility two days later.
-June 16, 2022, R1 punched another resident in the face; sent a message to the provider and

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requested an increase in Olanzapine (antipsychotic medication).
- June 22, 2022, The provider increased Olanzapine to 10 milligrams (mg).
-July 7, 2022, R1 assaulted three other residents last evening.
-July 9, 2022, R1 hit another resident with a coffee mug and the resident had to go to the emergency room (ER). The other resident punched him back.
-August 25, 2022, tried to hit another resident in the face.
-August 26, 2022, provider started R1 on Sertraline (antidepressant)
-August 26, 2022, staff heard a loud commotion and saw R5 on top or R1. R1 had R5 by the beard and R1 was bleeding from his face. R1 was sent to the ER and returned with diagnoses of facial contusion and abrasions.
-August 29, 2022, bruising to R1's eyes on the inner corner, dark purple in color .5 x .5 centimeter (cm) and a scab on the bridge of the nose. No intracranial injury noted after testing.

R1's IAPP dated August 29, 2022, indicated R1 was at risk for physical, emotional, financial, and verbal abuse, but did not include interventions to prevent these vulnerabilities or minimize the risk of abuse. The assessment indicated R1 was cognitively impaired and would swing at others, kick, punch, and hit people. Interventions listed were to administer as-needed medication for behaviors and redirect the resident to another area. The assessment indicated R1 had areas of vulnerability, but no displayed no signs of abuse or neglect. The IAPP did not include review or interventions to protect R1 from abuse or protect others from abuse by R1.

During an observation on September 7, 12:45

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p.m., R1 was sleeping and light purple bruising was observed around both of R1's eyes.

R2

R2 resided in a memory care facility with current diagnoses including schizoaffective disorder, dementia with Lewy bodies, and post-traumatic stress disorder (PTSD). R2's service plan dated February 28, 2022, indicated R2 required assistance with dressing, grooming, bathing, medications, and was independent with ambulation and transfers. The service plan also indicated R2 had severe confusion, required safety checks every shift and had a history of wandering into other resident rooms.

R2's vulnerability assessment dated January 12, 2021, indicated R2 was disoriented to time, place and situation and was not able to give accurate information consistently. The assessment indicated R2 was unable to report abuse or neglect and R2 had areas of potential vulnerability but displayed no signs of abuse or neglect. The assessment also indicated R2 may pose a risk to others but did not include R2's susceptability to abuse or neglect.

R2's progress notes indicated:

-July 7, 2022, at 7:30 p.m., R2 came out of the bathroom and R1 hit R2 on the head.
-July 9, 2022, at 8:00 p.m., R2 was sent to the ER due to a severe head wound by another resident with a coffee cup. R2 punched R1. R2's head wound was closed with tissue glue.
-July 28, 2022, at 10:34 p.m., another resident shoved a sandwich forcefully in R2's face, there was redness to the right side of R2's face and five scratches on the end of his nose.

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-August 7, 2022, late entry written for August 31, 2022, indicated facility staff conducted a skin assessment and noted a 13cm x 1 cm scratch on R2's back that was painful to touch. It was unknown how R2 received this scratch. The scratch later that day was measure as 3 cm x 1 cm.

R2's IAPP was not updated following the above incidents which were identified in R2's progress notes and the IAPP did not include review or interventions to protect R2 from abuse or protect others from abuse by R2.

R3

R3 resided in a memory care unit with current diagnoses including dementia with behavioral disturbance, stroke, and delirium. R3' s' service plan dated June 29, 2022, indicated R3 required assistance with toileting, dressing, medications, safety checks twice a shift, had a history of wandering and hitting out when frustrated and during refusals of toileting. Staff was directed to use caution and walk away, remove other residents and provide as- needed medications. The service plan also indicated R3 was independent with ambulation, transfers, and bed mobility.

R3's IAPP dated June 30, 2022, indicated R3 was at risk from abuse, but did not include interventions to prevent the abuse.

Incident reports:

-July 7, 2022 @ 10:00 p.m., R3 was found in another resident's room. The other resident stated R3 hit him, and they were wrestling around on the ground.

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R3's IAPP was not updated following the above incident which were identified in R3's progress notes and the IAPP did not include review or interventions to protect R3 from abuse or protect others from abuse by R3.

R3's discharge and deceased resident roster indicated R3 passed away on August 31, 2022.

R4

R4 resided in a memory care unit with current diagnoses including dementia, stroke, delusions, aphasia (loss of ability to understand or express speech) and impulse disorder. R4's service plan dated March 15, 2022, indicated R4 required assistance with medications, anxiety, and hourly safety checks. R4 was independent with transfers, bed mobility, behavior monitoring with behaviors including medication refusal.

R4's IAPP dated February 23, 2021, indicated R4 was disoriented, forgetful and unable to give accurate information. Staff were to perform 30 minute checks due to R4's elopement risk. The IAPP indicated the resident did not pose a physical violence risk to others.

Progress notes:

-June 14, 2022, at 2:43 p.m., another resident attempted to get into R4's room, R4 attempted to kick the other resident.
-June 16, 2022, at 5:00 p.m., a resident attempted to go into R4's room, R4 told the other resident to get out and the residents swung at each other but didn't make contact.
-July 5, 2022, at 6:59 p.m., staff found a 27

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cm x 5 cm scratch in the middle of R4's back during a skin assessment that occurred on the weekend when R3 and R4 were found in R4's room. R3 was on the floor and the tray table was broken. Staff separated the residents and a bruise was found on R3 over the weekend.

-July 22, 2022, at 2:23 a.m., R4 shoved another resident out of his room. The other resident was not injured and seemed not bothered by the confrontation.

-July 28, 2022, R4 was yelling at another resident for coming into his room. R4 told the other resident he was going to "kick his ass," and stated he would kick his ass so bad he would have to go to the hospital. Residents were separated.

-August 11, 2022, at 11: 38 p.m., R4 pushed another resident in the doorway of his room and then again threatened to beat the other resident up. Staff separated the residents.

R4's IAPP was not updated following the above incidents which were identified in R4's progress notes and the IAPP did not include review or interventions to protect R4 from abuse or protect others from abuse by R4.

R5

R5 resided in a memory care unit with current diagnoses including alcohol dependence, low back pain and moderate intellectual disabilities. R5's service plan dated February 21, 2022, indicated R5 received hourly checks, medications, and monitoring for agitation and wandering. R5 was independent with bed mobility, transfers, and ambulation.

R5's progress notes:

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-November 2021 to May of 2022, three vulnerable adult reports were completed related to resident-to-resident altercations with R5 as the aggressor.

-May 19, 2022, at 10:17 p.m., staff saw R5 slap the back of his roommate's wheelchair while their roommate was in the chair. After an hour, staff heard a resident yelling and saw R5 push another resident out of his room.

-June 1, 2022, at 6:22 p.m., R5 pushed another resident extremely hard and forceful.

-June 12, 2022, at 3: 30 p.m., Staff heard another resident yelling in agony and saw R5 attempting to slam/squish another resident into the wall with his room door.

-July 23, 2022, at 7:26 p.m., staff saw R5 in his room charging towards his roommate with aggression and rose his arm over another resident in a wheelchair about to swing down. Staff blocked him from hitting the other resident. The other resident had fear in his eye and R5 stated that the other resident kept changing the channel.

-July 28, 2022, at 8:45 p.m., staff heard screaming and found another resident standing outside of R5's room. The staff noticed redness by the resident's eye and R5 admitted he punched the other resident in the eye.

-August 9, 2022, at 4:57 p.m., R5 was punched by another resident with no injury.

-August 26, 2022, at 8:00 p.m., staff heard commotion and R5 was on top of R1 with his fist raised. R1 had a hold of R5's beard. Staff separated the residents and R5 stated "looks like the mother fucker wants to go again." R1 had bruising under his eyes and was taken to the ER.

-August 30, 2022, staff requested R5's provider for a medication review due to an increase in behaviors.

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R5's IAPP dated August 29, 2022, indicated the R5 was at risk for abusing others but did not include interventions to protect R5 from abuse or protect others from abuse by R5.

On September 8, 2022 at 1:38 p.m., R5 stated R1 grabbed his beard and was pulling on it so R5 punched him in the eye. R5 stated there were not any staff around. R5 stated the licensee is short staffed.

R6

R6 resided in the memory care unit with current diagnoses including dementia with behavioral disturbance, aphasia,and hemiplegia. R6's service plan dated February 8, 2022, indicated R6 required hourly safety checks related to falls, smoking escorts, medication management, transfers, and ambulation. The service plan also included for staff to monitor for behaviors.

R6's Progress notes:

- August 7, 2022 at 6:02 p.m., R6 took a broom and dust pan and was pushing another resident with it to get the other resident out of the way. Facility staff reminded R6 he could not hit people.
- August 26, 2022, 10:30 a.m., Another resident hit R6 in the face and grabbed his arm. No bruising or pain.

R6's IAPP dated August 16, 2021, indicated R6 was not able to give reliable information due to dementia. The IAPP indicated there were identified areas of potential vulnerability, displayed no signs of abuse or neglect and the client may pose a risk to other vulnerable adults. The IAPP did not include his susceptibility of

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abuse by others. The IAPP was not reviewed or updated follwoing the August 26, 2022 incident.

On September 7, 2022, at 4: 30 p.m., unlicensed personnel (ULP)-B stated there were only two staff working on the locked memory care unit that evening until 11:00 p.m., and stated the common areas would be left unattended.

On September 7, 2022, at 5:07 p.m., registered nurse (RN)-C stated the licensee is taking residents they are not able to care for and the licensee is "biting off more than we can chew." RN-C stated the interventions to attempt to prevent resident to resident altercations are to watch the residents that wander. RN-C also stated after the altercation with R1 and R5, R5's smoking privileges were taken away and he was not allowed to attend activities due to the altercation.

On September 8, 2022, at 11:06 a.m., RN-D and RN-E stated they were behind on charting and the resident's individual abuse prevention plans (IAPP) were not up to date due to staffing concerns. RN-D and RN-E stated they were at a loss on what to do with the aggressive residents. RN-D and RN-E stated they tried moving a couple resident rooms, but that did not help. RN-D and RN-E stated staff did not have enough training to care for some of the residents.

On September 8, 2022, at 1:10 p.m., the director of nursing (DON)-F confirmed all resident to resident altercations should be reported and the IAPP should be updated after incidents and every 90 days. DON-F also stated interventions should be implemented to attempt to prevent resident to resident altercations. DON-F also confirmed resident to resident altercations were not tracked

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02310	Continued From page 32 and trended to assess when the altercations occurred. The licensee's 4.06 Staffing & Scheduling policy dated August 1, 2021, indicated the licensee will assure qualified employees will be scheduled to meet operations requirements and the needs of the residents. The policy directed the clinical nurse supervisor will develop and implement a written staffing plan that provides an adequate number of qualified direct-care staff to meet the resident's needs 24-hours a day, seven-days a week. The licensee's Individual Abuse Prevention Plan dated August 1, 2021, indicated the licensee will develop and implement an IAPP for each vulnerable adult. The IAPP will include 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 or other vulnerable adults. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: Based on observations, interviews, and document	02360	No Plan of Correction (PoC) required.	

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02360	Continued From page 33 review, the facility failed to ensure six of six residents reviewed (R1, R2, R3, R4, R5, R6) were free from maltreatment. R1, R2, R3, R4, R5, R6 were neglected. Findings include: The Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	02360	Please refer to the public maltreatment report (report sent separately) for details of this tag.	