Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL319875001M
Compliance #: HL319876663C

Date Concluded: November 19, 2024

Name, Address, and County of Licensee Investigated:
Northern Lakes Senior Living
8186 Excelsior Road
Baxter, MN 56425
Crow Wing County

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

Evaluator's Name: Barbara Axness, RN
Special Investigator

Finding: Substantiated, facility responsibility

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

Initial Investigation Allegation(s):
The facility neglected the resident when a urine sample was ordered but not followed up on by facility staff. After family noticed the issue, another sample was collected, and the resident was diagnosed with a urinary tract infection (UTI). The resident's provider failed to write orders for antibiotics and the facility failed to follow up on orders for treatment of the UTI.

The facility neglected the resident after her air conditioning unit quit working and facility staff failed to notice a change in condition with the resident and failed to repair the air conditioning unit after family notified the facility. The resident was later taken to the emergency room and diagnosed with dehydration and heat exhaustion.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to collect a urine sample and failed to follow-up with a physician after the resident was diagnosed with a urinary tract infection (UTI)

resulting in a delay in care. In addition, facility staff failed to ensure the resident's air conditioner was in proper working order and failed to assess and follow-up on the resident's change in condition. Days later, the resident was taken to the emergency room by family and diagnosed with heat exhaustion and dehydration.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's primary care provider and ophthalmologist. The investigation included review of the resident records, hospital records, lab results, clinic visit notes, staff schedules, and related facility policies and procedures. Also, the investigator observed the resident's room and air conditioning unit.

The resident resided in an assisted living facility. The resident's diagnoses included hypertension (high blood pressure), type two diabetes, and mild cognitive impairment. The resident's service plan included assistance with safety checks two times per day, assistance with dressing, bathing, reminders for meals, and medication administration. The resident's assessment indicated the resident was independent with transfers and mobility and relied on staff to administer medications.

UTI

The resident's medical record indicated family voiced concerns about the resident's increase in confusion. The registered nurse (RN) faxed the resident's provider and obtained an order for a urine analysis/urine culture (UA/UC). No follow-up was completed to ensure the sample was obtained and sent to the lab until one week later when the resident's family alerted staff that a urine sample was left in the resident's cabinet. A second urine sample had to be obtained and was brought to the lab eight days after the initial sample was ordered.

The results of the culture indicated the resident had a UTI. Facility staff failed to follow-up on the results of the culture and no contact was made with a medical provider to treat the UTI.

When the resident went to a scheduled ophthalmologist appointment two days later, the ophthalmologist noticed the resident was not being treated for the UTI and prescribed an antibiotic. Due to the untreated infection, the resident's upcoming surgery was cancelled.

The resident's record contained two orders for antibiotics. One order written by the resident's ophthalmologist for Bactrim (an antibiotic) twice a day for ten days. The other order was written twos day later by the resident's primary care provider (PCP). The PCP reviewed the resident's urine culture results and wrote, "Culture growing bacteria. Needs antibiotic (I do not see anything started in my absence?) Macrobid sent to [pharmacy]. Advise ALF [assisted living facility]."

During an interview, the resident's responsible party (RP) stated they had suspected the resident had a UTI and the resident was given a cup to collect a sample, which she did. The RP stated the resident placed the sample in a cabinet in her bathroom and no one at the facility

followed up on the sample and no one noticed one was never done. The RP stated another family member was visiting the resident several days later and found the urine sample in a cabinet and notified staff. The RP stated the facility collected a second urine sample and a few days later, a notice in the electronic medical record said she had a UTI. The RP assumed the facility was aware of the positive result and that treatment was being obtained but found out later that her provider was on vacation, and nobody was monitoring emails or tests so no follow up happened. The RP stated when he brought the resident to her eye appointment the doctor noticed she wasn't being treated for the UTI, cancelled their surgery, and prescribed an antibiotic to treat the UTI. The RP stated the UTI went on for at least three weeks before the resident got a prescription. The RP felt this could have been prevented had the facility monitored and when they gave someone a cup to take a sample they should figure out where it is.

During an interview, facility nursing staff stated the facility normally had a very good process for tracking and following up on lab orders but due to the holiday weekend, the provider being on vacation, and other staffing changes, the appropriate follow-up did not occur. The nurse stated the resident was given the collection cup and asked to notify staff when she had obtained a urine sample, but staff should have followed up to see if it was collected.

During an interview, the resident’s PCP stated she would not consider the time it took to treat the resident's UTI timely and would have expected the facility to collect the sample within 48 hours and follow-up if they saw the resident had a UTI but no treatment was prescribed.

AIR CONDITIONING

The resident’s medical record indicated that an RN assessed the resident around 1:30 p.m. on Saturday after the resident complained of not feeling well. The RN documented that the room was very hot, so she turned the air conditioner on. The resident declined to go to the emergency room and declined for her family to be updated. The RN encouraged the resident to drink more fluids and requested staff to check in with the resident a couple times and pass on the next shift to alert the nurse if there was any change with the resident.

No additional follow-up documentation was entered in the resident’s medical record until after the resident returned from an ER three days later with a diagnosis of heat exhaustion.

The resident’s hospital records indicated she was brought to the emergency room on Tuesday after family visited the resident over the weekend and noticed her room was extremely warm and the air conditioner unit was malfunctioning. The resident had a decreased appetite, fatigue, generalized weakness, and a headache. Lab work indicated the resident's blood had elevated creatinine [an indicator of kidney health] which was documented as likely a result of dehydration and heat exhaustion from extreme heat in the room at the facility. The resident was diagnosed with heat exhaustion and dehydration and given intravenous (IV) fluids.

During an interview, the resident's responsible party (RP) stated they spoke to management one week prior to the resident's emergency room visit and was told some of the air conditioners were approaching ten years old and it was time to get replaced. Facility staff assured him it would get replaced. The RP stated when he spoke with the resident on Thursday, she said she was sick to her stomach and didn't want him to stop by. The RP stated he was going to pick her up Friday to go to the cabin, but she complained of not feeling well again and didn't want to go. The RP stated his wife came to visit on Monday morning and the resident was very lethargic, had a flushed face and when his wife looked in the resident's refrigerator, four days of meals were sitting untouched in the fridge. She noticed the air conditioner was still not working and the room was warm so she took the resident to their house to take care of her and see if they could get her to eat. The RP stated when the resident wasn't feeling better by Tuesday, they brought her to the emergency room. The RP stated he would have normally gone to visit the resident on Thursday, but she had told him not to come in as she wasn't feeling well and didn't want to get him sick. The RP stated he should have gone in anyway, but he had sense of security from conversation with [management] that the air conditioner had been fixed so he hadn't thought of that being a potential issue as part of it [why she wasn't feeling well]. The RP stated if the resident was lethargic for five or six days, someone should be saying something to keep us in the loop.

During an interview, a facility nurse stated she spoke with the resident's family on Thursday about the resident not feeling well and she went to check on the resident and encouraged fluids and planned to follow up the next day. On Friday the resident reported she was feeling fine. The nurse stated staff reported on Friday night that the resident not feeling well but the resident declined for her family to be updated. The resident's air conditioner was noted to be blowing cool, not cold, air so she had staff unplug it and plug it back in and it was blowing cold air at that point. The nurse stated she was called again Saturday morning and told the resident's air conditioner was unplugged so she directed staff to plug it back in. The resident complained of not feeling well again. The nurse stated when she came in on Monday, she was told it wasn't functioning again and blowing cool air, so they replaced the air conditioning unit on Monday.

During an interview, the RN who assessed the resident that Saturday stated she was in the resident's room and the room "was hotter than a pistol, she had her air conditioner shut off and all the windows were wide open. We turned the air conditioner back on." The RN stated the air conditioner was putting out cool air but given how warm the room was, it would have taken a long time for the room to cool down. The RN stated it seemed like the heat had gotten to the resident and she looked kind of warm, but her vital signs were OK. The RN stated the resident declined any further medical attention and did not want her family notified. The RN stated she was not aware the resident's air conditioner had not been working properly and had she been aware there were concerns with it not working properly, it would have changed how she responded to the situation.

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

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

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
“Neglect” means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The resident’s air conditioner was replaced.

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
Crow Wing County Attorney
Baxter City Attorney
Baxter Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31987	A. BUILDING: _____ B. WING _____	C 09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN LAKES SENIOR LIVING	8186 EXCELSIOR ROAD BAXTER, MN 56425

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL319875001M/#HL319876663C On September 16, 2024, 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 64 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL319875001M/#HL319876663C, tag identification 2310, 2360.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.	
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services	02310		

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02310	Continued From page 1 (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 to provide care and services according to acceptable health care, medical, or nursing standards when facility staff failed to follow up to obtain a urine culture. The facility did not notice the initial urine sample was never taken or brought to the lab. Family notified the facility and another sample was taken eight days after it was ordered. The urine sample indicated the resident had a urinary tract infection (UTI), however the resident's provider was on vacation and did not review the results or prescribe antibiotics. The facility failed to follow up and obtain antibiotic orders. In addition, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards when facility staff failed to assess a change in condition for one of one resident (R1) when staff were made aware of the resident's air conditioner not working properly. The air conditioner was reset, but continued to not work properly. The resident's room was observed to be very warm and the resident showed signs of heat exhaustion, but the resident's family or provider were not updated. The resident was taken to the emergency room by family and diagnosed with heat exhaustion and dehydration. 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	02310		

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02310	Continued From page 2 serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included hypertension (high blood pressure), type two diabetes, and mild cognitive impairment. R1's service plan dated February 4, 2024, indicated the resident received twice daily safety checks, one at noon and another at 5 p.m., assistance with dressing, bathing, reminders for meals, and medication administration. R1's assessment dated May 30, 2024, indicated the resident was independent with transfers and mobility and relied on staff to administer medications. UTI The resident began showing signs and symptoms of a urinary tract infection (UTI) and an order was obtained on July 26, 2024, to obtain a urine culture for a urine analysis. The facility failed to follow up and ensure the sample was collected and taken to the lab. The resident collected a sample and placed it in her cabinet, which was not noticed until a family member found it a few days later and notified the facility. A second sample had to be obtained. The urine sample was not collected until eight days after the initial order. The resident's provider did not review the results or prescribe antibiotics to treat the UTI in a timely manner. The facility failed to follow up with the provider to obtain an order for antibiotics. The resident had a planned eye surgery, which was	02310		

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02310	Continued From page 3 canceled after the ophthalmologist realized the resident had a UTI that was not being treated. The ophthalmologist prescribed an antibiotic on July 8, 2024, and rescheduled the resident's surgery. The resident began the antibiotic on July 9, 2024, 13 days after an order was given to test for a UTI and symptoms were first observed. The resident's provider reviewed the lab results and prescribed an antibiotic on July 10, 2024. R1's progress notes included the following entries: -June 26, 2024, the resident's family voiced concerns about increasing confusion. The RN faxed the resident's provider and obtained an order for a urine analysis/urine culture (UA/UC). -July 4, 2024, the resident's urine was collected and brought to the lab at 9:00 a.m. -July 10, 2024, "resident is currently being treated for UTI [urinary tract infection], received additional order for antibiotic, called [pharmacy] with request to not fill and the antibiotic she is on currently is sensitive..." R1's record contained the results of a urine culture collected on July 3, 2024. The culture resulted on July 6, 2024, at 7: 33 a.m. and indicated the resident had a UTI. R1's record contained two orders for antibiotics. One order was written on July 8, 2024, by the resident's ophthalmologist for Bactrim twice a day for ten days. The other order was written by the resident's PCP. PCP-C reviewed the resident's culture results on July 10, 2024, and wrote, "Culture growing bacteria. Needs antibiotic (I do not see anything started in my absence?) Macrobid sent to [pharmacy]. Advise ALF [assisted living facility]."	02310		

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02310	Continued From page 4 On September 17, 2024, at 11:25 a.m., the resident's responsible party (RP)-B stated they had suspected the resident had a UTI and the resident was given a cup to collect a sample, which she did. RP-B stated the resident placed the sample in a cabinet in her bathroom and no one at the facility followed up to see if she collected a urine sample and no one noticed one was never done. RP-B stated another family member was visiting the resident a few days later and found the urine sample in a cabinet and notified the facility. RP-B stated the facility collected the second urine sample and a few days later, they saw a notice in her MyChart [electronic medical record] for the clinic that she had a UTI. RP-B stated he assumed the facility was also aware of the positive result and that treatment was being obtained but "evidently her provider was on vacation and nobody was monitoring emails of tests so none of that happened." RP-B stated when he brought the resident to her eye appointment the doctor noticed she wasn't being treated for the UTI and canceled their surgery and prescribed an antibiotic to treat the UTI. RP-B stated "the whole UTI thing went on for at least probably three weeks by the time we got her a prescription for it which could have been prevented had they monitored it and said hey, you gave someone a cup to take a sample, you should figure out that day where it is..." On September 18, 2024, at 11:15 a.m., registered nurse (RN)-I stated she was told there wasn't anything they could do if the provider didn't reply to them right away and they would have to keep trying to contact them. RN-I stated after the second urine sample was collected, they got the results a few days later which confirmed the resident had a UTI and the lab would have also	02310		

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02310	Continued From page 5 sent those results to the provider. RN-I stated she didn't see any orders for antibiotics come through for the resident and when she came back to work that Monday (July 8, 2024), the resident's son brought the resident back from an eye appointment with an antibiotic. On September 18, 2024, at 11:45 a.m., RN-J stated it would sometimes take a few days for providers to respond to lab results or other faxes from the facility and she would have to "just keep re-faxing it if I don't get a response." On September 18, 2024, at 1:30 p.m., clinical nurse supervisor (CNS)-A stated the facility normally had a very good process for tracking and following up on lab orders but due to the holiday weekend, the provider being on vacation, and other staffing changes, the appropriate follow up did not occur. CNS-A stated staff had given the resident the collection cup and asked she notify them when she had obtained a urine sample for the first collection attempt as she was independent with most activities of daily living but staff should have followed up to see if it was collected. CNS-A stated the primary care provider (PCP) was on vacation the week of July 1st and they do not know which providers will be filling in for them and it can change from day to day but the person filling in would be responsible for reviewing the PCP's orders and lab results. CNS-A stated she spoke with someone at the clinic after the incident occurred and she was told it appeared no one had read the lab result until the PCP did on July 10, 2024. CNS-A stated they would normally follow up with providers but there were times it was harder to get ahold of the provider and it could sometimes be a day or two before they would get a return call.	02310		

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02310	Continued From page 6 On September 20, 2024, at 1:35 p.m., the resident's primary care provider (PCP) stated the facility had contacted them on June 24, 2024, to obtain an order for a urine culture and the order was sent on June 25, 2025. The PCP stated she would not consider the time it took to treat the resident's UTI timely and she would have expected the facility collect the sample within 48 hours and follow up if they saw the resident had a UTI but did not get any treatment prescribed. AIR CONDITIONING The resident's air conditioner was noted to have issues on July 15, 2024. While the facility followed up and reset the air conditioning unit, the air conditioner continued to malfunction. The resident began to display signs of heat exhaustion including nausea/upset stomach and fatigue, on July 18, 2024, however the facility failed to notify the resident's provider. The resident's room was observed by staff to be very warm on July 20, 2024, and the resident was observed to look flushed. The RN assessing the resident was not aware of issues with the resident's air conditioner. The facility failed to notify the resident's provider. The resident was brought to the emergency room by family on July 23, 2024, and diagnosed with heat exhaustion and dehydration. R1's progress notes contained an entry dated July 20, 2024, indicating a RN assessed the resident around 1:30 p.m. after staff requested she come check on the resident. The note indicated the RN "arrived to resident's room. RA [unlicensed personnel] in room with her. RA reports resident complaining of not feeling well. Room is very hot, turned on air conditioner...Asked her if she felt she needed to go to the ED for evaluation, she stated no.	02310		

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02310	Continued From page 7 Encouraged resident to drink more fluids as her room was very hot, air conditioner turned on. Requested staff check in with her a couple of times and pass on to PM shift as well and if any changes to update nurse. Requested med tech to check her MAR [medication administration record] to see if she has an order for some antacid. Resident declined for family to be updated. Reminded her to use her call pendant if she started feeling worse to alert staff." No additional documentation was entered until July 30, 2024, after the resident returned to the facility from a "leave of absence and subsequent ER visit." The resident was noted to have a new diagnosis of heat exhaustion. R1's hospital records indicated she was brought to the emergency room on July 23, 2024, at 2:15 p.m. after family "visited over the weekend and noticed her room was extremely warm after the AC unit was malfunctioning...The patient has decreased appetite, belching, fatigue, and generalized weakness, headache. Noticed that she was sleeping during breakfast this morning..." Lab work was completed and the resident's blood had "elevated creatinine [an indicator of kidney health] likely secondary to dehydration prior heat exhaustion posterior to extreme heat in room at nursing home." The resident was diagnosed with heat exhaustion and dehydration and given IV fluids. Discharge instruction indicated "Your ED evaluation shows that your symptoms are likely heat exhaustion causing dehydration and kidney dysfunction. Make sure to recheck kidney function with primary care provider in one week..." A clinic visit note dated July 29, 2024, indicated the resident "was in the emergency department on July 23 after she was found in her apartment at Northern Lakes with a room temperature of 90	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 8 degrees due to air conditioning malfunction...It was felt that she was significantly dehydrated and her creatinine had significantly worsened from 0.82-1.26..." On September 17, 2024, at 11:25 a.m., the resident's responsible party (RP)-B stated they first noticed the air conditioning unit wasn't working when they brought her back on a Sunday evening and when he went in her apartment it was "like 83 degrees, it was just cooking" so he spent about an hour trying to get it to work but it kept blowing coolish air so he eventually used a fan to blow cool air from the hallway into the resident's room to get it to cool down. RP-B stated he spoke to CNS-A that Monday [July 15] and she had told him some of the air conditioners were approaching ten years old and it was time to get replaced and "she assured me it would get replaced...I thought ok that's fine as long as you replace it because it's supposed to be plenty hot that week." RP-B stated he spoke with the resident later that week on Thursday [July 18] and she said she was feeling sick to her stomach and she didn't want him to stop by and pick up what she had. RP-B stated he was going to pick her up Friday to go to the cabin but again she complained of not feeling well and didn't want to go. RP-B stated his wife came to visit on Monday morning [July 22] and the resident was very lethargic with a flushed face and laying on the couch and when she looked in the resident's refrigerator, four days worth of meals were sitting untouched in the fridge. RP-B stated she had noticed the air conditioner was still not working and the room was warm so she took the resident to their home to take care of her and see if they could get her to eat. RP-B stated when the resident wasn't feeling better by Tuesday, they brought her to the emergency room. RP-B stated	02310		

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	31987	A. BUILDING: _____ B. WING _____	C 09/16/2024

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02310	Continued From page 9 he would have normally gone to visit the resident on Thursday but she had told him not to come in as she wasn't feeling well and didn't want to get him sick. RP-B stated, "I shoulda gone in anyway, I had sense of security from conversation with [CNS-A] that the air conditioner had been fixed so I hadn't thought of that being a potential issue as part of it [why she wasn't feeling well]. It was farthest thing from my mind til my wife told me Monday morning it wasn't fixed...If she was lethargic for five, six days, someone should be saying somethings up with your family member or get us in the loop" On September 18, 2024, at 10:30 a.m., environmental services director (ESD)-H stated he was informed the air conditioning wasn't working so he went up to the resident's room and noted it was blowing cool, not cold, air so he reset the unit and it started blowing cold air again. ESD-H stated he went back two days later to check on it and it was still blowing cold air and "my assessment was it was working and just needed to be reset." ESD-H stated when he came back the following Monday, he got word it wasn't working again so he reset it again and it was blowing cold air. ESD-H stated the resident's family came back later that afternoon and complained of it being warm and so the decision was made to replace the unit. ESD-H stated around this time, the outdoor temperature was in the mid 80s and humid and while he didn't formally check the temperature in the resident's room, the thermostat was in the mid 70s. ESD-H stated the thermostat wasn't always accurate as it was not a digital thermostat though. ESD-H stated he is on call 24/7 and all staff have his phone number so if there are maintenance issues on evenings or weekends, staff could contact him and he would respond. ESD-H stated he did not	02310		

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02310	Continued From page 10 get any calls from staff about the resident's room being too warm or the air conditioner not working. ESD-H stated he's heard the resident would have a history of turning off her air conditioning unit and forgetting to turn it back on. On September 18, 2024, at 1:30 p.m., clinical nurse supervisor (CNS)-A stated she spoke with the resident's son on July 18, 2024, about the resident not feeling well and she went to check on the resident and encouraged fluids and would follow up the next day. On Friday, July 19th, the resident reported to her she was feeling fine. CNS-A stated she was called by staff on the evening of July 19, 2024, to report the resident not feeling well but the resident declined having her family updated. The resident's air conditioner was noted to be blowing cool, not cold, air so she had staff unplug it and plug it back in and it was blowing cold air at that point. CNS-A stated she was called again Saturday morning, July 20th, and told the resident's air conditioner was unplugged so she directed staff to plug it back in. The resident complained of not feeling well again. CNS-A stated when she came in on Monday, she was told it wasn't functioning again and blowing cool air so they replaced the air conditioning unit on Monday. On September 18, 2024, at 2:10 p.m., RN-J stated she was in the resident's room on July 20, 2024, and the room "was hotter than a pistol, she had her air conditioner shut off and all the windows were wide open. We turned the air conditioner back on." RN-J stated the air conditioner was putting out cool air but given how warm the room was, it would have taken a long time for the room to cool down. RN-J stated it seemed like the heat had gotten to the resident as she said she felt just kinda blah and looked	02310		

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02310	Continued From page 11 kind of warm but her vital signs were OK. RN-J stated the resident declined any further medical attention and did not want her family notified. RN-J stated she was not aware the resident's air conditioner had not been working properly and had she been aware there were concerns with it working properly, it would have changed how she responded to the situation. The licensee's Change in Client Condition Reporting By Unlicensed Staff policy dated December 1, 2023, indicated staff were trained and expected to observe, and report changes in client condition to the nurse in a timely manner. The nurse was expected to evaluate and investigate the reported change in condition based on best practice and professional nursing judgment. No further information was provided. 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: The facility failed to ensure one of one residents reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH)	02360	No plan of correction required for this tag.	

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02360	Continued From page 12 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		