Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL324194804M
Compliance #: HL324198139C

Date Concluded: December 29, 2023

Name, Address, and County of Licensee Investigated:
Gable Pines at Vadnais Heights
1260 East County Road East
Vadnais Heights, MN 55110
Ramsey County

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

Evaluator's Name: Brooke Anderson, RN
Special Investigator

Finding: Not Substantiated

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 alleged perpetrator (AP), an unlicensed facility staff, abused a resident when he roughly handled the resident during cares. In addition, the resident was neglected after being found on the ground and the facility failed to assess the resident for injuries.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. While the alleged perpetrator's (AP) actions were disrespectful and unprofessional, the actions of the AP did not meet the definition of abuse. The Minnesota Department of Health also determined neglect was not substantiated. Although the resident fell which resulted in bruising, the resident's plan of care was followed at the time of the incident. When the resident was found on the floor, facility staff immediately assessed the resident, and the resident returned to her baseline health condition.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident's medical record, video footage, personnel files, and facility policies and procedures. Also, the investigator toured the facility and observed interactions between staff and residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's disease, cervicobrachial syndrome (pain and stiffness of the cervical spine with symptoms in the shoulder and upper extremity), and diabetes. The resident's service plan included assistance with medication administration and assistance with bathing, grooming, dressing, mobility, and toileting. The resident's assessment indicated the resident was orientated to person and required direction and reminders from staff.

ABUSE

Facility management was informed of a concern regarding the AP's care of the resident. Video footage of the AP's interactions with the resident was provided to management staff.

Video footage reviewed identified the AP acting in a quick and aggressive manner when assisting the resident on multiple occasions. The AP did not explain or inform the resident of his actions prior to assisting the resident and ignored the resident's complaints of pain.

Upon management's investigation into the concern and review of video footage, the AP was immediately terminated.

During an interview, the AP denied abusing the resident.

During an interview, a family member stated she monitored the resident's room on the camera and saw the two incidents involving the AP. The family member reported the incidents to facility management. Facility management told the family they terminated the AP and reported the incident to law enforcement.

During an interview, facility management confirmed the AP was immediately terminated following their review of the video footage. Facility management indicated they also re-educated all staff on appropriate care and treatment of residents.

NEGLECT

The resident's medical record identified the resident fell and staff assisted the resident back to bed.

Video footage of the fall identified the resident was at the end of her bed and fell to the floor. Three facility staff entered the room and walked over to the resident. Two of the facility staff assisted the resident to a seated position. The two staff members used a transfer belt and assisted the resident off the floor, while the third staff member positioned the wheelchair behind the resident. Staff asked the resident if she was okay, and the resident stated she hit her

head. One of the staff members checked the resident's head for injury and assisted the resident back into bed.

Review of the resident's medical record indicated nursing staff assessed the resident after the fall and instructed staff to monitor for further injury.

Multiple staff members interviewed were unable to recall the incident.

During an interview, a family member stated facility staff responded to the resident quickly after the resident fell.

In conclusion, the Minnesota Department of Health determined abuse and neglect were not substantiated.

"Not Substantiated" means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: No, due to cognitive impairment.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility terminated the AP after the incident and provided education to facility staff.

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32419	A. BUILDING: _____ B. WING _____	C 10/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GABLE PINES AT VADNAIS HEIGHTS	1260 EAST COUNTY ROAD EAST VADNAIS HEIGHTS, MN 55110

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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: #HL324198139C/#HL324194804M #HL324193515C/#HL324197184M On October 30, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 59 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL324198139C/#HL324194804M, #HL324193515C/#HL324197184M, tag identification 0620, 0630, 0730, 1620, 2310, and 2350.	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.	
0 620 SS=D	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma	0 620		

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0 620	Continued From page 1 (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.	0 620		

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0 620	Continued From page 2 (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment for one of two residents (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted to the licensee on September	0 620		

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0 620	Continued From page 3 28, 2021, with diagnoses which included Alzheimer's disease, cervicobrachial syndrome, and type 2 diabetes mellitus. R1's service plan dated November 27, 2022, indicated R1 received assistance with dressing, grooming, transfers, and behavioral management. R1's nursing assessment dated November 27, 2022, indicated R1 had moderately severe cognitive decline. R1's individual abuse prevention plan (IAPP) dated November 1, 2022, indicated any concerns of physical abuse should be reported immediately to appropriate parties. A review of a police report dated January 13, 2023, indicated on November 5, 2022, ULP-D and ULP-E were putting R1 to bed. ULP-D pulled R1's feet out from under R1 and over ULP-E's head. R1 was put into bed and ULP-D and ULP-E laughed. A review of a police report dated January 13, 2023, indicated on November 6, 2022, ULP-D pushed R1 in a wheelchair through a doorway and R1's arm got caught. ULP-D did not check R1's arm. While changing R1 into her pajama's ULP-D pushed R1's neck down to get the pajamas over R1's head. R1 was yelling out in pain saying ULP-D was hurting R1. A review of the police report dated January 13, 2023, indicated on November 8, 2022, the licensee was notified of the incidents, and ULP-D was terminated. Unlicensed personnel (ULP)-D's employee	0 620		

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0 620	Continued From page 4 records indicated ULP-D received abuse prevention and vulnerable adult training. ULP-E's employee records indicated ULP-E received abuse prevention and vulnerable adult training. During an interview with the director of health services (DHS)-A on October 30, 2023, at 12:00 p.m., DHS-A stated she was under the impression a MAARC report was filed. RN-A stated nothing further was done after the abuse was reported other than terminating ULP-D. During an interview with executive director (ED)-B on October 30, 2023, at 12:30 p.m., ED-B stated she thought the incident was called into MAARC. ED-B stated if abuse is suspected an internal investigation would be completed immediately and depending on the nature of the complaint, a MAARC report is completed. The licensee's policy Vulnerable Adult dated August 1, 2021, indicated mandated reporters are required to report any actual or suspected maltreatment including abuse immediately or no longer than 24 hours after the incident. No further information provided. Time period for correction: Seven (7) days	0 620		
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	0 630		

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0 630	Continued From page 5 person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure development of an individual abuse prevention plan (IAPP) with the required content for three of three residents (R1, R2, R3) with records reviewed. 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 client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1's diagnoses included, Alzheimer's disease, cervicobrachial syndrome (pain and stiffness of the cervical spine with symptoms in the shoulder girdle and upper extremity), and Type 2 diabetes mellitus. R1's service plan dated August 17, 2022, indicated R1 received services which included medication administration and assistance with	0 630		

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0 630	Continued From page 6 bathing, grooming, dressing, and mobility. R1's Vulnerability Assessment/Abuse Prevention Plan dated July 6, 2022, identified areas of vulnerability with interventions in the following areas: orientation to person, place, and time; able to manage finances; able to ambulate safety with or without a device; chronic condition; risk for falls; aggression towards others; and wandering. R1's Vulnerability Assessment/Abuse Prevention Plan dated July 6, 2022, lacked interventions for the vulnerabilities listed above. R1's incident report dated November 6, 2022, indicated R1 fell. R1's incident report dated December 8, 2022, indicated R1 was "smacking" a resident lying in bed. R1's incident report dated January 9, 2023, indicated R1 fell. R1's incident report dated January 12, 2023, indicated R1 was found on the ground. R1's incident report dated March 6, 2023, indicated R1 was holding a resident's hand "really" tight while swearing. R1's incident report dated March 13, 2023, indicated R1 was found sitting on R1's floor sleeping. R1's incident report dated March 27, 2023, indicated R1 was found on the floor. On November 1, 2023, at 11:48 a.m., in an email correspondence with the director of health	0 630		

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0 630	Continued From page 7 services (DHS)-A, DHS-A indicated no updated assessment had been completed for R1 and the incidents were not added or updated on R1's IAPP and no interventions were implemented. R2 R2's diagnoses included, dementia and atrial fibrillation. R2's service plan dated April 11, 2023, indicated R2 received services which included medication administration, assistance with bathing, grooming, dressing, and behavior management. R2's Vulnerability Assessment/Abuse Prevention Plan dated March 27, 2023, indicated R2 was a high fall/bruise risk. R2's Vulnerability Assessment/Abuse Prevention Plan lacked interventions. R2's Vulnerability Assessment/Abuse Prevention Plan dated April 11, 2023, indicated R2 was able to ambulate safely with/without device and R2 is a high fall and/or bruising risk. Intervention included "staff to report any falls to nurse promptly, staff to use care with transfers and personal cares, [add resident specific interventions]" R2's incident report dated May 23, 2023, indicated R2 was found sitting on the floor with R2's walker in front of him. R2's incident report dated June 1, 2023, indicated R2 was found on the floor in his apartment. R2's incident report dated June 3, 2023, indicated R2 was found on the ground holding onto his wheelchair. R2's incident report dated June 7, 2023, indicated	0 630		

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0 630	Continued From page 8 R2 was found sitting in the floor in the hallway. R2's incident report dated June 9, 2023, indicated R2 reported he fell during the night, resulting in a laceration to the right side of R2's head. R2's medical record lacked an updated Vulnerability Assessment/Abuse Prevention Plan with new interventions to address the multiple falls. R3 R3's diagnoses included Type 2 diabetes mellitus, acute subdural hematoma, and vascular dementia. R3's service plan dated October 4, 2023, indicated R3 received services which included medication administration, bathing, dressing, grooming, and mobility. R3's Vulnerability Assessment/Abuse Prevention Plan dated October 4, 2023, indicated R3 was not able to ambulate safely with/without device. Intervention included staff to encourage R3 to "use ambulation devices while ambulating, assistance with ambulation, staff to keep area free of clutter/hazards, [specify resident mode of ambulation], [add resident specific interventions]." R3's Vulnerability Assessment/Abuse Prevention Plan indicated R3 is a high fall and/or bruising risk. Intervention included "staff to report any falls to nurse promptly, staff to use care with transfers and personal cares, [add resident specific interventions]" R3's incident report dated August 29, 2023, indicated R3 was found on the floor by his bedside.	0 630		

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0 630	Continued From page 9 R3's incident report dated September 4, 2023, indicated video footage showed R3 fell backwards and hit his head on the door frame. R3's incident report dated September 11, 2023, indicated R3 was found on the floor. R3's incident report dated October 10, 2023, indicated R3 was found on the floor in R3's room. R3's incident report dated October 11, 2023, indicated video footage showed R3 fell onto his right side in his bedroom. R2's medical record lacked an updated Vulnerability Assessment/Abuse Prevention Plan with new interventions. During an email correspondence on November 2, 2023, at 9:47 a.m., DHS-A indicated during the licensee's IAPPs were inadequate based on the facility's survey last October. The licensee assessments were restructured to include the IAPP into the assessment. The licensee's 2.44 Vulnerable Adult Maltreatment- Prevention and Reporting policy dated August 1, 2021, noted the licensee develops individualized vulnerable adult abuse prevention plans to identify vulnerability risks and develop measures to minimize maltreatment based on identified information. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		

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0 730	Continued From page 10	0 730		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32419	A. BUILDING: _____ B. WING _____	C 10/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GABLE PINES AT VADNAIS HEIGHTS	1260 EAST COUNTY ROAD EAST VADNAIS HEIGHTS, MN 55110

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0 730	Continued From page 11 and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure the resident record contained a discharge summary for one of three residents (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally) Findings include: R1's medical record indicated R1 was discharged from the licensee on June 14, 2023. R1's record lacked a discharge summary. During an email correspondence on November 8, 2023, at 1:33 p.m., director of health services (DHS)-A verified R1's record lacked a discharge summary. The licensee's Resident Record- Information and Content policy, dated August 1, 2020, indicated a	0 730		

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0 730	Continued From page 12 discharge summary would be completed and kept in the resident record. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview, and record review the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment	01620		

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01620	Continued From page 13 using the uniform assessment tool on day 90 and a change of condition assessment for two of three residents (R1, R2) as required, with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1's record lacked evidence an RN completed an assessment every 90 days as required. R1's diagnoses included Alzheimer's disease, cervicobrachial syndrome (pain and stiffness of the cervical spine with symptoms in the shoulder girdle and upper extremity), and Type 2 diabetes mellitus. R1's service plan dated August 17, 2022, indicated R1 received services which included medication administration and assistance with bathing, grooming, dressing, and mobility. R1's record included a Health and Service Evaluation (HSE) dated November 27, 2022. No further assessments were included in the client record. R1's record lacked 90-day assessments for: -March 31, 2023; and June 29, 2023.	01620		

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01620	Continued From page 14 On November 2, 2023, at 10:50 a.m. in an email correspondence, the director of health services (DHS)-A, DHS-A indicated the HSE assessments were reformatted, some of the assessments weren't auto populated quarterly and were not caught manually. DHS-A confirmed there were no additional assessments completed for R1. R2 R2's record lacked evidence an RN had completed an assessment for a change in condition after falls occurred. R2's diagnoses included, dementia and atrial fibrillation. R2's service plan dated April 11, 2023, indicated R2 received services which included medication administration, assistance with bathing, grooming, dressing, and behavior management. Fall 1: An incident report dated May 23, 2023, at 4:45 p.m., indicated R2 was found by staff in the common area on his buttocks with his walker in front of him. Range of motion intact. Complaints of low back pain, Staff assisted R2 to a standing position. R2's progress notes dated May 23, 2023, at 5:56 p.m., indicated R2 was found in the community room sitting on his buttocks. Range of motion completed; vital signs obtained. Complaints of pain in low back that was chronic. Wife notified. R2's progress notes dated May 26, 2023, at 7:05 p.m., indicated R2's family member brought R2 to see primary provider due to R2's complaints of pain. Family member thought R2 fell during the	01620		

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01620	Continued From page 15 night. Fall 2: R2's progress note dated May 30, 2023, at 8:42 a.m., indicated night staff reported R2 fell the night prior. R2 had complaints of body pain all over specifically in both hips. R2 was unable to bear weight. R2 was sent to the emergency room for evaluation. Fall 3: An incident report dated June 1, 2023, at 3:00 a.m., indicated R1 was found on the floor in the living room. R1 was sitting in the recliner, and he slid and sat on the floor. No apparent injury noted upon assessment. Denied pain or discomfort. Range of motion completed and neuro within baseline. Vital signs normal. Family member updated. R2's progress notes dated June 1, 2023, at 6:05 a.m., indicated R2 was found on the floor in the living room at 3:00 a.m., R2 was sitting in the recliner, and he slid and sat on the floor. No apparent injury noted upon assessment, denied pain or discomfort, ROM active in all extremities and neuro within baseline. Fall 4: An incident report dated June 3, 2034, at 9:15 p.m., indicated R2 called for help and staff found him with his wheelchair lying on his backside holding the wheelchair. Bruise noted on R2's elbow. Nurse assessed, obtained vitals, and cleansed wound. R2's progress note dated June 3, 2023, at 9:57 p.m., indicated R2 called for help and staff found him on the floor in the hallway. R2 had fallen backwards with wheelchair. Bruise noted on left	01620		

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01620	Continued From page 16 elbow, assisted him off the floor with 3 assists, range of motion completed, spouse notified. R2's medical record lacked documentation on follow up on the skin tear. Fall 5: Incident report dated June 7, 2023, at 8:45 a.m., indicated R2 was found sitting on the floor in the hallway. No new injuries noted. R2 had complaints of pain in right hip and tail bone. Incident report indicated "(related to previous falls)." R2's medical record lacked documentation of a previous incident with right hip and tail bone pain. R2's progress noted dated June 7, 2023, at 9:55 a.m., indicated R2 was found sitting on the floor in the hallway (closer to his apartment) No new injuries noted. "Complained of pain in the right hip and tail bone (related to previous falls)." Range of motions completed and within normal limits. Family notified. Fall 6: Incident report dated June 9, 2023, at 10:15 a.m., indicated R2 had a 1 ½ inch laceration on the right side of R2's head. R2 stated he fell during the night and hit his head but managed to get himself up. R2 was alert and orientated x2 with complaints of pain from the head wound 7 out of 10. R2 had continuous right hip pain "(related to previous fall)." Mild swelling and bruising noted on head wound. Family notified. R2's progress notes dated June 9, 2023, at 11:15 a.m., indicated staff alerted nursing to a laceration (1 1/2 inch) on the right side of R2's head. R2 reported that he fell during the night,	01620		

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01620	Continued From page 17 hitting his head but managed to get himself off the floor. R2 was alert and orientated x2. Complaint of pain from the head wound (7 out of 10) and continuous right hip pain (related to previous fall). Mild swelling and bruising was present with the head wound. Family notified. R2's medical record lacked follow up documentation regarding the fall. R2's medical record lacked an updated fall assessment and there was no evidence of new interventions implemented or evaluation of current interventions. During the entrance conference on October 30, 2023, at 9:15 a.m., director of health services (DHS)-A stated assessments are completed every 90 days, upon hospital return, or change in condition, and assessments are completed by DHS-A or the other two registered nurses. The licensee's 6.01 Assessments, Reviews and Monitoring Policy dated August 30, 2021, noted the initial nursing assessment or reassessment would include all of the elements of the uniform assessment tool as required. Resident reassessments and monitoring would be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessments and monitoring would be conducted as needed on changes in needs of the resident and cannot exceed 90 calendar days from the last assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		

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02310	Continued From page 18	02310		
02310 SS=H	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to a suitable and up-to-date plan, and subject to acceptable health care and medical, or nursing standards for three of three residents (R1, R2, R3) reviewed for falls. The licensee failed to ensure injuries were monitored and/or resolved and failed to develop and implement new interventions related to the root cause of the falls. 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: Facility documents indicated November 2022 the facility had 28 falls. Facility document indicated January 2023 the facility had 31 falls. Facility document indicated March 2023 the	02310		

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02310	Continued From page 19 facility had 32 falls. Facility document indicated April 2023 the facility had 22 falls. Facility document indicated May 2023 the facility had 38 falls. Facility document indicated June 2023 the facility had 31 falls. Facility document indicated August 2023 the facility had 42 falls. Facility document indicated September 2023 the facility had 19 falls. Facility document indicated October 2023 the facility had 23 falls. R1 R1's facility face sheet indicated R1 was admitted to the facility on September 28, 2021, with diagnoses which included Alzheimer's disease, cervicobrachial syndrome and Type 2 diabetes mellitus. R1's service plan dated November 27, 2022, indicated R1 received assistance with dressing, grooming, transfers and behavioral management. R1's assessment dated August 11, 2022, indicated R1 was a high potential for falls. Fall 1: An incident report dated November 6, 2022, at 7:15 a.m., indicated facility staff heard yelling down the hallway. R1 was found lying on her back outside the bathroom door covered in feces. R1 denied pain. The incident report lacked implementation of new fall prevention intervention(s). R1's progress notes dated November 6, 2022, at 8:57 a.m., indicated R1 was lifted with two staff. The licensee notified R1's daughter and primary	02310		

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02310	Continued From page 20 provider. The progress note indicated results for the urine culture were faxed to the primary provider. Fall 2: An incident report dated January 9, 2023, at 9:55 p.m., indicated R1 was seen on video walking along the edge of her bed talking to herself. R1 fell backwards. Staff assisted R1 back to the chair. The incident report lacked an assessment, vital signs, and pain assessment. R1'a medical record lacked a progress note for the incident and lacked follow up interventions for the head strike. Facility documents lacked education on falls for staff involved in incident. Fall 3: An incident report dated January 12, 2023, at 10:45 a.m., indicated R1 was found lying in the floor in front of the sofa. The incident report lacked content regarding any new fall prevention intervention(s) were provided. R1's progress notes dated January 12, 2023, at 5:14 p.m., indicated the R1 was assessed post fall. Range of motion intact. R1 denied pain and there was no injury noted and family was updated. R1's progress notes dated January 12, 2023, at 5:14 p.m., included late entry documentation signed by RN-P regarding R1's fall on 7/28/22, instructed facility staff to monitor R1 for changes or concerns after the fall and call back for questions or any changes. R1's progress notes dated January 20, 2023, at	02310		

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02310	Continued From page 21 5:54 p.m., indicated R1 had bruising on her back and right hip. R1 had a large bruise on her upper back also a large purple discolored area on right hip. Slight bruising on right outer forearm. R1 had a small skin tear on right outer forearm which was healing. R1 appeared baseline status and daughter was aware. R1'a progress notes dated January 23, 2023, at 12:12 p.m., indicated R1 was seen by the primary physician and orders for PT/OT evaluation and treatment ordered due to fall and weakness. Fall 4: An incident report dated March 16, 2023, at 4:45 p.m., indicated R1 was found on the floor in her closet sleeping with her wheelchair next to her. Nurse assessed, no injuries reported. The incident report lacked content regarding any new fall prevention intervention(s) were provided. R1's progress notes dated March 16, 2023, at 5:22 p.m., R1 was found on the floor sleeping in her closet with her wheelchair next to her. Nurse assessed. No injuries reported. Vital signs within normal limits. Fall 5: R1's progress note indicated staff called the nurse at 7:00 p.m. reporting R1 was on the floor in the dining room. R1 was lying on her right left side. R1 had a lump on top of her head. Three staff assisted R1 off the floor with a transfer belt. Daughter notified. Hospice updated. R1's medical record lacked an incident report. Fall 6: An incident report dated March 27, 2023, at 7:15 a.m., indicated R1 was found sitting on the floor	02310		

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02310	Continued From page 22 near her bed. Feces all over the carpet at 6:35 a.m. during morning rounds. No injuries noted, R1 denied pain. Staff assisted with two staff. Vital signs and range of motion at R1's baseline. The incident report lacked content regarding any new fall prevention intervention(s) were provided. R1's progress notes dated March 27, 2023, at 10:02 a.m., indicated R1 was found sitting on the floor near her bed. R1 had feces all over her and the carpet. No injuries noted, R1 denied pain. Two staff assisted R1 off the ground. R1's vital signs and range of motion at baseline. Hospice, daughter, and primary provider updated. R1's medical record lacked an updated assessments with interventions after R1's falls. R2 R2's diagnoses included, dementia and atrial fibrillation. R2's service plan dated April 11, 2023, indicated R2 received services which included medication administration, assistance with bathing, grooming, dressing and behavior management. R2's Vulnerability Assessment/Abuse Prevention Plan dated March 27, 2023, indicated R2 was a high fall/bruise risk. R2's Vulnerability Assessment/Abuse Prevention Plan lacked interventions. R2's Vulnerability Assessment/Abuse Prevention Plan dated April 11, 2023, indicated R2 was able to ambulate safely with/without device and R2 is a high fall and/or bruising risk. Intervention included "staff to report any falls to nurse promptly, staff to	02310		

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02310	Continued From page 23 use care with transfers and personal cares, [add resident specific interventions]" Fall 1: An incident report dated May 23, 2023, at 4:45 p.m., indicated R2 was found by staff in the common area on his buttocks with his walker in front of him. Range of motion intact. Complaints of low back pain, Staff assisted R2 to a standing position. The incident report lacked content regarding any new fall prevention intervention(s) were provided. R2's progress notes dated May 23, 2023, at 5:56 p.m., indicated R2 was found in the community room sitting on his buttocks. Range of motion completed; vital signs obtained. Complaints of pain in low back that was chronic. Wife notified. R2's progress notes dated May 26, 2023, at 7:05 p.m., indicated R2's family member brought R2 to see primary provider due to R2's complaints of pain. Family member thought R2 fell during the night. Fall 2: R2's progress note dated May 30, 2023, at 8:42 a.m., indicated night staff reported R2 fell the night prior. R2 had complaints of body pain all over specifically in both hips. R2 was unable to bear weight. R2 was sent to the emergency room for evaluation. R2's medical record lacked an incident report. Fall 3: An incident report dated June 1, 2023, at 3:00 a.m., indicated R1 was found on the floor in the living room. R1 was sitting in the recliner, and he slid and sat on the floor. No apparent injury noted	02310		

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GABLE PINES AT VADNAIS HEIGHTS	1260 EAST COUNTY ROAD EAST VADNAIS HEIGHTS, MN 55110

(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 24 upon assessment. Denied pain or discomfort. Range of motion completed and neuro within baseline. Vital signs normal. Family member updated. The incident report lacked content regarding any new fall prevention intervention(s) were provided. R2's progress notes dated June 1, 2023, at 6:05 a.m., indicated R2 was found on the floor in the living room at 3:00 a,m,, R2 was sitting in the recliner and he slid and sat on the floor. No apparent injury noted upon assessment, denied pain or discomfort, ROM active in all extremities and neuro within baseline. BP 123/70, T 97.4, P 70, R 16, Sat 98% RA. His wife was updated at 6:00 a.m. Fall 4: An incident report dated June 3, 2034, at 9:15 p.m., indicated R2 called for help and staff found him with his wheelchair lying on his backside holding the wheelchair. Bruise noted on R2's elbow. Nurse assessed, obtained vitals, and cleansed wound. The incident report lacked content regarding any new fall prevention intervention(s) were provided. R2's progress note dated June 3, 2023, at 9:57 p.m., indicated R2 called for help and staff found him on the floor in the hallway. R2 had fallen backwards with wheelchair. Bruise noted on left elbow, assisted him off the floor with 3 assists, range of motion completed, spouse notified. R2's medical record lacked documentation on follow up on the skin tear. Fall 5: Incident report dated June 7, 2023, at 8:45 a.m., indicated R2 was found sitting on the floor in the	02310		

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02310	Continued From page 25 hallway. No new injuries noted. R2 had complaints of pain in right hip and tail bone. Incident report indicated "(related to previous falls)." The incident report lacked content regarding any new fall prevention intervention(s) were provided. R2's medical record lacked documentation of a previous incident with right hip and tail bone pain. R2's progress noted dated June 7, 2023, at 9:55 a.m., indicated R2 was found sitting on the floor in the hallway (closer to his apartment) No new injuries noted. "Complained of pain in the right hip and tail bone (related to previous falls)." Range of motions completed and within normal limits. Family notified. Fall 6: Incident report dated June 9, 2023, at 10:15 a.m., indicated R2 had a 1 ½ inch laceration on the right side of R2's head. R2 stated he fell during the night and hit his head but managed to get himself up. R2 was alert and orientated x2 with complaints of pain from the head wound 7 out of 10. R2 had continuous right hip pain "(related to previous fall)." Mild swelling and bruising noted on head wound. Family notified. The incident report lacked content regarding any new fall prevention intervention(s) were provided. R2's progress notes dated June 9, 2023, at 11:15 a.m., indicated staff alerted nursing to a laceration (1 1/2 inch) on the right side of R2's head. R2 reported that he fell during the night, hitting his head but managed to get himself off the floor. R2 was alert and orientated x2. Complaint of pain from the head wound (7 out of 10) and continuous right hip pain (related to previous fall). Mild swelling and bruising was	02310		

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02310	Continued From page 26 present with the head wound. Family notified. R2's medical record lacked follow up documentation regarding the fall. R2's progress notes dated June 13, 2023, at 1:00 p.m., indicated R2's wife had concerns with the flooring in R2's room and his reoccurring falls. It was agreed upon R2 would move out to his new facility prior to the end of the lease. R2's medical record lacked an updated assessments with interventions after R2's falls. R3 R3's diagnoses included Type 2 diabetes mellitus, acute subdural hematoma, and vascular dementia. R3's service plan dated October 4, 2023, indicated R3 received services which included medication administration, bathing, dressing, grooming and mobility. R3's Vulnerability Assessment/Abuse Prevention Plan dated October 4, 2023, indicated R3 was not able to ambulate safely with/without device. Intervention included staff to encourage R3 to "use ambulation devices while ambulating, assistance with ambulation, staff to keep area free of clutter/hazards, [specify resident mode of ambulation], [add resident specific interventions]." R3's Vulnerability Assessment/Abuse Prevention Plan indicated R3 is a high fall and/or bruising risk. Intervention included "staff to report any falls to nurse promptly, staff to use care with transfers and personal cares, [add resident specific interventions]"	02310		

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02310	Continued From page 27 Fall 1: Incident report dated August 29, 2023, at 2:30 a.m., indicated R3 was found on the floor at his bedside. No injury or bruise noted. No complaints of pain or discomfort. Range of motion was active in all extremities and neuro within baseline. R3 was assisted back to bed and slept the rest of the morning. Family and provider updated. The incident report lacked content regarding any new fall prevention intervention(s) were provided. Fall 2: R3's progress notes dated September 2, 2023, at 9:42 a.m., indicated the licensee was shown a video of R2 sitting on the floor at bedside on September 1, 2023, at 7:00 a.m. The licensee was unaware of R3 being found on the floor. Range of motion completed and no signs of injury. Family notified. R3's medical record lacked an incident report. Fall 3: Incident report dated September 4, 2023, at 6:00 p.m., indicated R3's daughter emailed the licensee a video of R3 self-transferring from toilet and attempting to sit in wheelchair. R3 fell backwards and hit the back of his head on the door frame of the bathroom. R3 got himself back up onto the toilet. A staff member entered and assisted R3 back to the wheelchair. The licensee became aware of the fall on September 6, 2023. R3 was assessed, vitals were obtained, and no injuries noted on the back of R3's head. The incident report lacked content regarding any new fall prevention intervention(s) were provided. Fall 4: Incident report dated September 11, 2023, at 6:15 p.m., indicated R3 was found sitting on the floor	02310		

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02310	Continued From page 28 in the dinner area. No visible injuries, vital signs and range of motion within normal limits. Two staff assisted R3 off the ground with a transfer belt. Daughter and Hospice notified. The incident report lacked content regarding any new fall prevention intervention(s) were provided. R3's progress notes dated September 11, 2023, at 6:34 p.m., indicated R3 was found sitting on the floor in dinner area around 6;20 p.m. No injuries noted. Vital signs and range of motion are within normal limits. Two staff assisted R3 with transfer belt. Daughter notified; hospice updated. Fall 5: R3's progress notes dated September 26,2023, at 6:34 p.m., indicated R3 was found lying on his left side on the floor mat at 9:30 a.m. R3 denied pain. Vitals signs within normal limits. Hospice and daughter notified. R3's medical record lacked an incident report. Fall 6: Incident report dated October 10, 2023, at 3:00 p.m., indicated R3 was on the floor. R3 was kneeling on his knees leaning over the bed. R3 was helped assist of two with the transfer belt to the wheelchair. No apparent injuries, Vital signs, and range of motion within normal limits. Hospice, family, and bluestone updated. The incident report lacked content regarding any new fall prevention intervention(s) were provided. R3's progress notes dated October 10, 2023, at 3:37 p.m., indicated R3 was found on the floor at 3:00 p.m. on his knees lying over his bed. No apparent injuries. Hospice and family notified. Fall 7:	02310		

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02310	Continued From page 29 Incident report dated October 11, 2023, at 7:45 a.m., indicated R3's daughter called at 7:45 a.m. and stated that she watched on camera and R3 was on the floor. When the licensee went to R3's room R3 was found lying on his right side on the floor beside his bed. R3 was unable to state what happened. No injuries observed. Vital signs were within normal limits. Two staff assisted R3 off the ground. The incident report lacked content regarding any new fall prevention intervention(s) were provided. R3's progress notes dated October 11, 2023, at 9:27 a.m., indicated R3's daughter called 7:45 a.m. she watched on camera that R3 was on the floor, staff went to R3's room and found R3 lying on his right side on the floor beside his bed, resident unable to explain what happened, no injuries observed, vital signs are within normal limits. Staff helped R3 off the floor with two staff assistance, hospice and provider updated. During an interview dated October 30, 2023, at 12:00 p.m., director of health services (DHS)-A indicated if a resident falls a nurse is contacted to evaluate the resident. If a nurse is unavailable the staff are to call 911. If a resident has repeated falls, they have a few options like assistive devices, request for therapy, request for medications, and increased activities. DON-A stated there is a fall section in every assessment. We have options like proper footwear, need for physical therapy/occupational therapy or to keep items near residents. DON-A stated when the resident had dementia, we click that the disease process was the cause of the falls and no interventions are added. During an interview, dated October 30, 2023, at 12:59 p.m. executive director (ED)-B stated when	02310		

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02310	Continued From page 30 a fall occurs there is an incident report that is completed by the nursing team. Licensee staff are told to leave residents on the ground until nursing assesses. Then it depends on if the resident has an injury on if facility staff get them up or not. If residents have repeated falls, we talk about it at stand up and discuss with the therapy team. Nursing looks into the cause of the fall to hopefully decrease falls. During an email correspondence on November 3, 2023, at 10:52 a.m., DHS-A indicated when a fall occurred the expectation was to make contact with a member of the nursing staff and for nursing to provide assistance with assessment of the resident. If a nurse is not in the building or cannot be reached, the staff is to call the licensee cell phone. If a resident has a head strike or assumed head strike the direction is to call 911 or call 911 in the event a nurse cannot be reached after hours. The licensee's Role of Quality-of-Life Specialist, Medical Technician and Nurse in an Incident/Accident Policy dated November 1, 2017, indicated when and incident or accident occurs the licensee staff render immediate assistance, but do not move the resident until he/she has been examined for possible injuries, usually by a Licensed Nurse. Call 911 if uncertain or no Licensed Nurse is available. Provide emergency care/first aid as needed (if certified or qualified). Stay with the resident and call for assistance if needed and check the resident frequently (q15mins for 2hrs, q30mins for 4hrs, sooner if necessary, and then q2 hrs) for 24 hours after the incident or for another period as ordered by physician. If it is determined 911 is not to be called and if it is determined by nurse/supervisor it is safe to move the resident, assist the resident	02310		

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02310	Continued From page 31 to his/her bed. Documentation includes Incident Report, occurrence note and occurrence note follow up in the residents' medical record when appropriate until the condition of the resident is stable. The licensee's 1.12 Fall Risk and Prevention policy indicated after each fall, including near falls (e.g., resident is lowered to the floor by staff), an incident report is completed and forwarded to the RN. The RN is responsible for following up on all falls, including completing a fall risk assessment, and attempting to identify the causes of the fall and implement interventions to reduce the risk of future falls and injury. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		
02350 SS=G	144G.91 Subd. 7 Courteous treatment Residents have the right to be treated with courtesy and respect, and to have the resident's property treated with respect This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure residents were treated with courtesy and respect for one of one (R1) resident reviewed. 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	02350		

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02350	Continued From page 32 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 facility face sheet indicated R1 was admitted to the facility on September 28, 2021, with diagnoses which included Alzheimer's disease, cervicobrachial syndrome and Type 2 diabetes mellitus. R1's vulnerability assessment/Abuse Prevention Plan dated July 6, 2022, indicated R1 was orientated to person. During an interview October 30,2023 at 1:00 p.m., memory care director (MCD)-C stated R1's family had concerns and during a meeting MCD-C was shown video footage of staff handling R1. Video footage #1 from November 5, 2022, indicated R1 was in her room standing at her bedside facing the headboard. Unlicensed personnel (ULP)-D was in front of R1, and ULP-E was to R1's right. ULP-E had the wheelchair in front of her and ULP-D was transferring R1. ULP-D had his right hand on R1's right arm and his left hand on R1's lower right buttocks. ULP-E stated, "turn, oh she's got one shoe off and one shoe on." ULP-D assisted R1 to sit on the side of the bed. ULP-E is heard laughing and said, "oh sweet Jesus," then sets the wheelchair in front of a chair on the room. ULP-D stated, "scoot back, scoot back." ULP-E stated, "scoot back." Video footage #2 from November 5, 2022, R1 is grabbing the bottom of her nightgown and R1	02350		

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02350	Continued From page 33 stated, "then I can't work." ULP-D picks up the blanket and sets it back down and stated, "you don't work you are retired." R1 stated, "ok." R1 was leaning on the side of the bed and grabbing her gown. ULP-D bends down grabbed R1's legs causing R1 to fall back onto the bed. R1 gasped. ULP-D lifted R1's legs as high as ULP-E's shoulders and throws R1's legs onto the bed. R1 stated, "ah fuck, don't do one more thing like that or you are done. Do you understand me you little bastard?" as R1 was pointing at ULP-D. ULP-E covered R1 up with the blanket. A daily log dated November 6, 2022, indicated R1 was given a shower and the bathroom was cleansed. Video footage #1 from November 6, 2022, indicated R1 in a wheelchair, hair is visibly wet with only a brief on, and a blanket draped over R1's right arm. ULP-D was pushing R1 out of the bathroom in the wheelchair and hit R1's arm on the doorway. R1 stated, "I am so sick, ahhhhhh owwww, oh my God." R1 continued moaning. ULP-D stated, "you gotta move your feet." R1 stated, "how can I, I can't move a thing. Oh my God." R1 continued to moan. ULP-D walked into the bathroom to grab a pajama shirt. R1 grabbed the blanket and was trying to pull her right arm out from under the blanket. Video footage #2 from November 6, 2022, indicated R1 sitting in the wheelchair with just her brief on. R1 was picking at her brief and mubbling. ULP-D was straightening out the pajama top and then started to put it on R1. R1 stated, "owwww." Video footage #3 from November 6, 2022, indicated R1 sitting in the wheelchair with her	02350		

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02350	Continued From page 34 brief and pajama shirt on her left arm. ULP-D had his right finders on the back of R1's neck. ULP-D was done putting R1's right arm in the pajama's and R1 stated, "ohh my arm, my God my arm." R1 began to mumble and clenched her fingers as she mumbled. ULP-D was throwing R1's clothing in the laundry basket. Video footage #5 from November 6, 2022, indicated R1 sitting in a wheelchair with a pajama top on. A laundry basket full of clothes to the back right of her and ULP-D in the bathroom grabbing incontinent products and putting them outside the bathroom door. R1 stated, "what did you throw my thing to the side for?" R1 starts scooting the wheelchair forward. Video footage #6 from November 6, 2022, indicated R1 in the wheelchair, laundry basket to the back left of R1. ULP-D picking up items in the bathroom. R1 is reaching back to the back of her brief and stated, "what time do we get outta here by the way? What time do we get outta here?" ULP-D does not respond to R1. Video footage #7 from November 6, 2022, indicated R1 was in the wheelchair and was further in the room. R1 stated, "boy oh boy." ULP-D had a garbage bag in his left hand and was dragging the laundry basket with his right hand. ULP- opened the door and left the room. An incident report dated, January 9, 2023, indicated as seen on the video, R1 was walking along the edge of the bed talking to herself and she fell backwards. The incident report indicated staff came in and assisted R1 back to the chair. Video footage was from R1's room. Videos #1, #6, #8, #10, and #11 are from the bed view.	02350		

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02350	Continued From page 35 Videos #2. #3, #4, #5, #7, #9, #12, and #13 are from the entryway of the room. Video footage #1 dated January 9, 2023, indicated the lights are off R1 was standing at the end of the bed picking at the sheet and mumbling. R1 fell onto her right side and stated, "oh oh oh oh my God, oh my God." Video footage #2 dated January 9, 2023, indicated R1 laying on her right side. On the end of the right side of her bed. R1's back was up against the wall and R1 was moaning. ULP- F opened the door turns around and yells that R1 is on the floor. R1 stated, "oh my God, oh my God." Video footage #3 dated January 9, 2023, R1 was on the floor on her right side with her back against the wall. R1 stated, "where are you." ULP-E walked in and stated, "why are you on the floor? We just put you to bed." ULP-E was standing over R1. "You, OK?" ULP-G knocked, walked in and stated, "oh man". ULP-E stated, "alright, let's get her up and into bed" and ULP-G stated, "what happened" as they stand over R1 discussing where she had been. Video footage #4 dated January 9, 2023, ULP-E stated, "I know. When she said laying on the floor, I said we just put her to bed" And put her hands up in the air. "ULP-ULP-E reached for R1's left arm she said, "come on, sit up" and ULP-G reached in to help. R1 stated, "Oh, Oh, Oh." ULP-F entered the room. ULP-E told ULP-F to grab the belt as they discuss the fact that they had just put her to bed and had put her in the middle of the bed. Video footage #5 dated January 9, 2023, ULP-E and ULP-F wrapped the transfer belt around R1.	02350		

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02350	Continued From page 36 ULP-G stated, "why are you on the floor?" R1 stated, "oh my God." ULP-G stated, "What happened?" R1 mumbled about the bottom of the bed. ULP-G questioned about the bottom of the bed, but the conversation was not audible. Video footage #6 dated January 9, 2023, ULP-G stated, "Ok, you're going to standup, ok?" R1 was moaning. ULP-G stated, "One, TWO THREE" as ULP-E was lifting R1 by her armpits and/or with the belt and ULP-G was holding R1's left hand they assisted R1 up. R1 was moaning and said, "oh, oh oh". ULP-E pulled R1's wheelchair and they sit R1 in it. The transfer belt was up at the back of R1's neck when she sat in the wheelchair. ULP-E stated looking directly in R1's face, "we're gonna put you back in bed and you need to stay in bed. How did you get on the floor?" R1 stated, "I caught my pant, my sock" and ULP-E stated, "you don't have any socks on. All right, let's try this again". Video footage #7 dated January 9, 2023, ULP-E and ULP-G are lifting R1. The transfer belt is seen up by the back of R1's neck. ULP-F placed the wheelchair behind R1 and ULP-E and ULP-G set R1 down into the wheelchair. R1 was moaning as she sat down. ULP-E bends down in front of R1's face and stated, ", "we're gonna put you back in bed and you need to stay in bed. How did you get on the floor?" R1 stated, "I caught my pant, my sock" and ULP-E stated, "you don't have any socks on. ULP-F is seen turning the light on in the room. ULP-E stated, "alright, let's try this again." ULP-F stated, "is she hurt?" and walked up to R1. ULP-E was in front of R1 and stated, "are you ok?" R1 stated, "no." ULP-E stated, "does something hurt?" R1 moaned, "ohhhh." ULP-F was seen pulling R1's hair back and touching her head. ULP-E stated, "did you hit	02350		

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	32419	A. BUILDING: _____ B. WING _____	C 10/30/2023

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02350	Continued From page 37 your head?" R1 stated, "yes." Video footage #8 dated January 9, 2023, R1 stated, "I hit my head." ULP-G stated, "where?" R1 stated, something not audible then, "my little toe. ULP-E, ULP-F and ULP-G laughed. ULP-E stated, "Can we hold your head up to check you out? You, ok?" ULP-F stated, "Any bruise?" As ULP-F was seen touching R1's head. ULP-E stated, "You gotta stay in bed, ok?" Video footage #9 dated January 9, 2023, ULP-F stated, "how did she get up?" ULP-E stated, "she got outta the bed." ULP-pushed R1 in the wheelchair to R1's bedside. R1 moaned. ULP-G stated, to R1, "we'll help you back to bed" as he lifted her left arm. R1 was moaning. ULP-E and ULP-F lifted R1 up and set her on side of bed. The transfer belt was seen at the back of R1's neck. ULP-G put his right hand on R1's upper back and with his left hand, tried to lift her legs. R1 was moaning. ULP-F lifted R1's legs. Video footage #10 dated January 9, 2023, ULP-G stated, to R1, "we'll help you back to bed" as he lifted her left arm. R1 was moaning. ULP-E and ULP-F lifted R1 up and set her on side of bed. The transfer belt was seen up by R1's neck and then it dropped down near her buttocks. ULP-F attempted to remove the transfer belt but ULP-G lifted R1's legs and placed her in bed. ULP-F stated, "how come she aint in bed sleeping?" ULP-E stated, "that is what I thought." ULP-F lifted R1's legs and set them on the bed. ULP-E stated, "now we gotta move you farther even." ULP-F covered R1 up with a blanket. R1 was mumbling about something she needs to do. ULP-E stated, "you have to stay in bed." Video footage #11 dated January 9, 2023, R1	02350		

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02350	Continued From page 38 was lying in bed and ULP-F was on the left side of the bed and ULP-G was on the right side of the bed, they were positioning R1. ULP-E was standing holding the blanket. There is not audible conversation. ULP-F positioned R1's pillow and R1 grabs her head and said, "owwww ohhh ohhhh." R1 continued to have her hand on her head. ULP-G pointed to the other side of the bed and stated, "that way a little more?" ULP-F grabbed the sheet and pulled R1 towards her as ULP-G pushed R1 towards ULP-F. R1 stated, "ohhh." ULP-E stated, "now isn't that too far over that way?" ULP-G stated, "that's good she is going to turn this way anyway. ULP-E state, "yeah you are probably right." R1 started to sit up and ULP-E covered her up with the blanket. Video footage #12 dated January 9, 2023, conversation is heard between staff. ULP-E stated, "stay in bed ok, that is what you can do to help." ULP-F moved the wheelchair out of reach to the front of R1's black chair and as the staff walk out the door, ULP-E stated, "oh my God please stay in bed." During an interview October 30, 2023, at 12:00 p.m., director of health services (DHS)-A stated she was aware of the incident in November 2022 with ULP-D and ULP-E. DHS-A stated ULP-D was terminated. DHS-A stated no further follow up was completed after the incident. No residents were interview, no internal investigation and no follow up assessment completed on R1. Review of unlicensed personnel (ULP)-D's employee file indicated ULP-D's hire date was January 13, 2019. ULP-D received abuse and neglect training on April 6,2020, preventing, recognizing, and reporting abuse training on February 24,2020, and protecting resident rights	02350		

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02350	Continued From page 39 in assisted living facilities on March 2,2020. In addition, the file included a separation notice dated November 8,2022 indicated ULP-D was separated from employment for physical abuse to a resident. Review of ULP-E's employee file indicated ULP-E's hire date was August 11, 2021. ULP-E received preventing, recognizing, and reporting abuse training on August 15, 2021, and protecting resident rights in assisted living facilities training on August 15, 2021. In addition, the file included a behavioral change notice dated November 5, 2022, indicated ULP-E was present when R1's lower body was tossed on the bed. The file included a separation notice dated July 17, 2023, indicated ULP-F was separated from employment for swearing at a co-worker and supervisor and for refusing, neglecting, or avoiding duties. Review of ULP-F's employee file indicated ULP-F's hire date was July 20, 2021. ULP-F received preventing, recognizing, and reporting abuse training on July 25, 2021, protecting resident rights in assisted living facilities training on July 25, 2021. Review of ULP-G's employee file indicated ULP-G was an agency employee. ULP-G received abuse, neglect and exploitation (child, domestic, elder) and human trafficking and patient's rights training on February 23, 2023. During an email correspondence on November 3, 2023, at 10:00 a.m., DHS-A indicated she could not recall if she was shown the video footage from the January 2023 fall with R1. DHS-A indicated she could not confirm if education was provided to licensee employees after the fall incident.	02350		

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02350	Continued From page 40 During an interview on November 1, 2023, at 9:00 a.m., R1's family member stated, there was a pattern of poor behaviors from staff. R1's family stated they moved R1 to a different facility. During an email correspondence on November 9, 2023, at 10:57 a.m., DHS-A indicated the licensee expected staff to treat residents with courtesy and respect. Licensee staff were educated on the bill of rights during orientation. A licensee's 2.44 Vulnerable Adult Maltreatment - Prevention & Reporting dated August 1, 2021, consistent with the Minnesota Vulnerable Adults Act and Assisted Living licensure regulations, The licensee prohibits the maltreatment of residents. The licensee's Minnesota Bill of Rights for Assisted Living Residents dated November 8, 2022, provided to staff during training and residents upon admission included residents have the right to be treated with courtesy and respect. No further information was provided. Time period for correction: Seven (7) days	02350		