Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL33169011M
Compliance #: HL33169010C

Date Concluded: August 31, 2022

Name, Address, and County of Licensee Investigated:
The Harbors Senior Living
5300 4th Street Northeast
Fridley, MN 55421
Anoka County

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

Evaluator's Name: Peggy Boeck, RN
Special Investigator

Finding: Substantiated, facility responsibility

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

Initial Investigation Allegation(s):
The facility neglected to follow a resident's service plan for skin care, resulting in the resident developing a pressure ulcer.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility did not have a system in place to ensure implementation of interventions recommended by a homecare agency for getting the resident out of bed, turning, and repositioning the resident who was bedbound. The resident developed pressure ulcers on her bottom, and both legs. The facility further neglected to regularly assess the pressure ulcers, provide treatment of the pressure ulcers, or document about the pressure ulcers. The resident went to the hospital after staff accidentally ripped off a toenail and the pressure ulcers and toe wound were treated.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the home care agency staff as well as family. The investigation included review of resident records, hospital records, home care agency records, incident reports, grievances, procedures and policies related to acceptance of residents, admissions, bathing assistance, nursing assessments, contents of the resident's record, nurse availability, service plans, updates to service plans, treatments, and maltreatment of vulnerable adults. Also, the investigator toured the facility and observed staff/resident interactions.

The resident lived in an assisted living facility and had diagnoses including leukemia, facture of right fibula, and repeated falls. The resident could not bear weight on her right leg. The resident's service plan included assistance with bed baths, escorts to meals, dressing, grooming, ambulation, transfers with a full mechanical lift, and toileting. The resident received physical therapy for strength training, range of motion, and transfer assistance.

About 10 days after admission a home health agency physical therapist completed a full body assessment of the resident prior to the start of therapy and noted the resident had no pressure ulcers or skin breakdown. Physical therapy assistants provided the resident with strength training, range of motion, and transfer assistance several times per week. The physical therapy assistants documented recommendations that facility staff assist the resident out of bed every day and for all meals to help build strength.

The facility did not add the recommended interventions in the resident's service plan. The resident remained bedbound.

The physical therapist returned to the facility to conduct a 30-day assessment and discovered the resident had pressure ulcers. The physical therapist notified the director of nursing and a nurse on the floor, providing education. The physical therapist returned a week later, assessed the resident, noted no one had addressed the resident's wounds, so he found a nurse and showed them the pressure ulcers.

The director of nursing assessed the resident's pressure ulcers the same day, and recommended barrier cream to the resident's bottom and three times per day cares but did not make changes to the resident's care plan.

A consulting nurse assessed the resident a week later and documented that the resident needed help with turning and repositioning. The facility did not make changes to the resident's service plan.

The home care agency physical therapist assessed the resident a week after the nurse's assessment and recommended turning and repositioning the resident every two hours while in bed and every 30 minutes while in wheelchair. Staff told the physical therapist they were

managing the resident's wounds. The facility did not make changes to the resident's service plan.

During an interview, the physical therapist stated he communicated recommendations for the resident to the director of nursing and nurses. The physical therapist stated the facility did not address the resident's wounds and he recommended skilled nursing from the home care agency because the facility did not provide appropriate wound care.

The facility had no documentation of skilled nursing visits to provide wound care.

During an interview, the former director of nursing (DON) stated the facility had undergone a change in electronic health record provider during the time the resident was at the facility. The DON stated the old system did not automatically prompt the nurse to update the service plan so new interventions were not added to the services for the resident. The DON stated the facility may or may not treat a pressure ulcer (or leave it to be managed by skilled nurses from a home health agency), depending on the severity of the wound, and did not recall what they had done for this resident. The DON stated he thought maybe skilled nursing from the home health agency managed the resident's pressure ulcers. The DON stated the staff did not document the resident services, so it could not be proven or disproven what treatment was provided to the resident's pressure ulcers.

During investigative interviews, several staff members stated the resident did not get out of bed, and they were not aware that she had pressure ulcers. One staff stated she recalled turning the resident but did not document when she did.

During an interview, a family member stated the physical therapist notified her of the resident's pressure ulcers on the resident's bottom and legs. The family member stated it took weeks before the facility acknowledged the pressure ulcers, which had gotten worse. The family member stated the staff let the resident lie in bed, never taking her to the bathroom and put incontinence briefs on instead. The family member stated the resident needed help from staff to turn over in bed, as she could not do it on her own, but would cooperate when staff helped. The family member stated the staff accidentally ripped off the resident's toenail and that was why the facility sent her to the hospital. The family member stated the hospital saw the wounds on the resident's bottom and on her calves, where her legs rested on the bed, and began to treat them.

During an interview, a management staff stated she did not know if the resident had pressure ulcers but expected the director of nursing to keep her up to date regarding resident issues. The management staff stated the resident was cooperative with services provided as she was motivated to return home. The management staff stated the facility should have had a treatment plan for the resident's wounds.

In conclusion, neglect was substantiated.

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

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

Vulnerable Adult interviewed: No, per family
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility hired a consulting agency to update all residents’ nursing assessments and service plans to ensure accuracy of needs and service provided and provide education/training to staff.

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33169	A. BUILDING: _____ B. WING _____	C 08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HARBORS SENIOR LIVING FRID	5300 4TH STREET NE FRIDLEY, MN 55421

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL33169010C/#HL33169011M On August 25, 2022, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 37 residents receiving services under the provider's Assisted Living with Dementia Care license. Correction orders with a period to correct that are not immediate may be issued at a later date during the investigation. The following immediate correction order is issued for #HL33169010C/#HL33169011M, tag identification 1290. The investigator communicated the immediate order with the Assisted Living Director on August 25, 2022.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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0 000	Continued From page 1 On August 31, 2022, a visit was conducted to verify removal of the immediate correction order issued to the provider on August 25, 2022, tag identification 1290. The immediacy could not be removed and remains an immediate order. The following correction orders that were not immediate are issued for #HL33169011M/#HL33169010C, tag identification 2320 and 2360.	0 000		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the licensee failed to complete a background study for four of four staff (unlicensed personnel (ULP)-A, director of nursing (DON)-C, licensed practical nurse (LPN)-D, and ULP-E) reviewed for background studies. All four provided independent direct services to residents.	01290		

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01290	Continued From page 2 The licensee was notified of the immediate correction order on August 25, 2022. On August 31, 2022, the investigator conducted a licensing order follow-up on the immediate correction order issued to the provider on August 25, 2022. The immediacy could not be removed. The licensee failed to complete background studies for four additional staff (ULP-K, ULP-L, ULP-M, and ULP-N) reviewed for background studies, who provided direct care services to residents per the facilty schedule dated August 31, 2022. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: ULP-A's personnel file indicted the licensee hired ULP-A on April 29, 2021, to provide direct care services to residents. DON-C's personnel file indicated the licensee hired DON-C on August 8, 2022, to provide nursing services to residents. LPN-D's personnel file indicated the licensee hired LPN-D on June 28, 2022, to provide direct care services to residents. ULP-E's personnel file indicated the licensee	01290		

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01290	Continued From page 3 hired ULP-E on April 8, 2022, to provide direct care services to residents. ULP-K and ULP-L were not listed on the licensee's employee roster dated August 25, 2022. ULP-M was listed on the licensee's employee roster with a hire date of May 9, 2022, to provide medications and direct care services to residents. ULP-N was listed on the licensee's employee roster with a hire dated of February 15, 2022, to provide direct car services to residents. A search of the Minnesota Department of Human Services background study web site (https://netstudy2.dhs.state.mn.us/Live/Employees/SearchRoster) conducted on August 31, 2022, at 9:01 a.m. indicated the employee roster affiliation for the licensee (HFID #33169) did not include ULP-K, ULP-L, ULP-M, or ULP-N. A search of the Minnesota Department of Human Services background study web site (https://netstudy2.dhs.state.mn.us/Live/Employees/SearchRoster) conducted on August 24, 2022, at 12:52 p.m. indicated the employee roster affiliation for the licensee (HFID #33169) did not include DON-C or ULP-E, indicated ULP-A's background study was "in process" and indicated LPN-D's background study was "in process" . A search of the Minnesota Department of Human Services background study web site (https://netstudy2.dhs.state.mn.us/Live/Employees/SearchRoster) conducted on August 26, 2022, at 10:44 a.m. indicated ULP-A was affiliated with licensee's previous comprehensive license (HFID #33942) and indicated a background study was	01290		

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01290	Continued From page 4 initiated for current licensee HFID #33169 with "supervision required". A search of the Minnesota Department of Human Services background study web site (https://netstudy2.dhs.state.mn.us/Live/Employees/SearchRoster) conducted on August 26, 2022, at 10:48 a.m.indicated DON-C was affiliated with another of the licensee's facilities (HFID #32649) and had no current background study initiated for the current license (HFID #33169). A search of the Minnesota Department of Human Services background study web site (https://netstudy2.dhs.state.mn.us/Live/Employees/SearchRoster) conducted on August 26, 2022, at 11:04 a.m. indicated LPN-D affiliated with licensee (HFID #33169) with "supervision required". A search of the Minnesota Department of Human Services background study web site (https://netstudy2.dhs.state.mn.us/Live/Employees/SearchRoster) conducted on August 26, 2022, at 11:19 a.m. indicated ULP-E separated from licensee's previous comprehensive license (HFID #33942) which indicated "supervision required" and had no current background study initiated for the current license (HFID #33169). During observation on August 25, 2022, from 9:30 a.m. to 4:15 p.m., the investigator observed ULP-A, DON-C, LPN-D, and ULP-E interacting and providing services to residents. During an interview on August 25, 2022, at 2:54 p.m. licensed assisting living director (LALD)-B stated the previous comprehensive license held by the licensee (HFID #33942) was no longer in use, and LALD-B did not know she needed to	01290		

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01290	Continued From page 5 complete background studies for all employees working at the current facility (HFID #33169). LALD-B acknowledged many of the employees would need to get fingerprinted, as she hired them during the COVID-19 exception timeframe. LALD-B acknowledged the statute and the facility policy required direct supervision of staff without background study clearance. The facility Background Studies policy dated August 1, 2021, indicated no employee may provide direct services and have independent direct contact with any residents until acceptable result of the backgrounds study have been received. The policy further indicated employees shall not be permitted to interact or provide services to tenants or clients of the licensee except under the direct supervision (eyesight) of another qualified staff person. TIME PERIOD FOR CORRECTION: Immediate.	01290		
02320 SS=G	144G.91 Subd. 4 Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to provide and document appropriate care and services, for one of one resident (R1) reviewed for pressure ulcers. Physical therapy recommendations for bed	02320		

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02320	Continued From page 6 mobility were not implemented into the service plan, and when a nurse (former director of nursing (DON)-G) discovered a pressure ulcer on R1's buttock 36 days after R1's admission, R1's medical record lacked any documentation of ongoing skin assessments, treatment of wounds, interventions, healing, or lack of healing for 8 more days after discovery of the wound. On day 8 another nurse (registered nurse consultant (RNC)-J assessed R1 but provided no documentation of the buttock wound. Neither nurse updated R1's service plan to include interventions. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings include: R1 admitted to the facility on January 17, 2022, due to a fractured bone in her right leg and inability to bear weight on her right leg. R1's discharge orders from previous placement dated January 14, 2022, indicated R1 was to wear a CAM boot (controlled ankle movement boot used for walking to protect injury) when up, but not while in bed. R1 received physical therapy and occupation therapy home care services from an outside agency beginning on January 26, 2022. R1's home care visit note dated February 2, 2022, indicated physical therapy assisted R1 with bed mobility, strength, range of motion, and	02320		

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02320	Continued From page 7 transfers. The note directed staff to get R1 out of bed and sitting in either a recliner or wheelchair daily to gain strength. R1's service plan did not include this recommended change in service. R1's home care visit note dated February 3, 2022, indicated occupational therapy assisted R1 with strength training, and discussed with R1 getting up in the wheelchair daily. The note indicated R1 agreed to incorporate getting up into the wheelchair into her daily routine. R1's service plan did not include this recommended change in service. R1's home care visit note dated February 3, 2022, indicated occupational therapy recommended R1 be up for meals in her wheelchair. R1's service plan did not include this recommended change in service. R1's progress note dated February 22, 2022, indicated the nurse (DON-G) discovered a stage one deep tissue injury (a persistent deep red, purple, or maroon area of intact skin, non-intact skin, or blood-filled blister caused by damage to the underlying soft tissue) on both sides of R1's buttock and coccyx area with excoriation (raw, irritated skin) "due to prolonged exposure to stool and urine". The note recommended zinc-based barrier cream and three times daily cares. The note indicated the facility would ask for the doctor to add skilled nursing to the current home care visits or send R1 to the emergency department for a catheter to decrease skin exposure to urine. R1's service plan did not include the recommended change in services. R1's service plan did not include the recommended treatment or interventions. R1's physician's assistant visit summary dated	02320		

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02320	Continued From page 8 February 23, 2022, indicated R1 had a pressure ulcer starting on her buttocks and an abrasion on her left lower arm. The physician's assistant note indicated R1 would benefit from a skilled nursing assessment and treatment to assist with wound care management, decreasing risk for infection. R1's record lacked any documentation of whether the skilled nursing assessment or treatment occurred. R1's medical record contained no nursing or unlicensed staff progress notes between February 22, 2022, and March 18, 2022, when R1 discharged to the hospital. R1's "2022 Reset Assessment" dated March 2, 2022, completed by RNC-J, indicated R1 required assistance with turning and repositioning and used a bed rail to aid in positioning. The assessment indicated redness on R1's coccyx (not open), indicated the facility ordered barrier cream, and R1 "needs repositioning". The assessment indicated bruising and a skin tear on R1's left forearm, with dressing "completed by nursing". The assessment indicated R1 had an open area on the back of R1's right leg due to chronic edema, with "daily dressing changes completed by nursing". The assessment indicated home care and the facility nurse were "managing the wounds". R1's service plan did not include the recommended treatments or change in services. R1's home care visit note dated March 10, 2022, indicated physical therapy provided R1 with range of motion, strength training, and transfer assistance. The note indicated staff should "reposition [R1] every two hours while in bed and every 30 minutes when in wheelchair". R1's service plan did not include the recommended change in services.	02320		

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02320	Continued From page 9 R1's individual abuse prevention plan dated March 15, 2022, indicated R1 had skin breakdown on the coccyx and the facility ordered barrier cream (the plan did not indicate who applied the cream or when it was applied). The prevention plan indicated R1 required barrier cream, repositioning, adequate hygiene, and toileting. The prevention plan indicated R1 had an open area of skin on the back of her right leg, which required daily dressing changes, and indicated the nurse would monitor (the plan did not indicate frequency of "monitoring"). R1's service plan did not include the recommended change in treatment or services. R1's progress note dated March 18, 2022, indicated the facility sent R1 to the hospital to evaluate and treat R1's torn toenail on her left third toe. (R1 did not return to the facility). R1's hospital physician's progress note dated March 18, 2022, indicated R1 had a secondary infection to her leg wounds with elevated white blood count, requiring "better wound care and antibiotics". The physician admitted R1 to the hospital, where she remained for a week. R1's service plan dated March 23, 2022, (no previous versions available), indicated R1 received the following services from the licensee: bed bath with physical assist of two staff on p.m. shift (Mondays, Wednesdays, and Fridays); dining escorts daily at 8:00 am. and 5:00 p.m.; dressing assistance daily at 8:00 a.m. and 8:00 p.m.; set up for grooming and oral cares daily; ambulation assistance of two staff during a.m., p.m., and overnights; transfer assistance with two staff using a hoyer (full mechanical lift) as needed; transfer assistance with two staff using a	02320		

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	33169	A. BUILDING: _____ B. WING _____	C 08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HARBORS SENIOR LIVING FRID	5300 4TH STREET NE FRIDLEY, MN 55421

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02320	Continued From page 10 hoyer during a.m., p.m., and overnights; safety checks (at 12:00 a.m., 1:00 a.m., 3:00 a.m., 7:00 a.m., 9:00 a.m., 11:00 a.m., 4:00 p.m., 7:00 p.m., 10:00 p.m., and overnight.); and toileting with two staff using a hoyer during a.m., p.m., and overnights. During an interview on August 25, 2022, at 2:54 p.m. licensed assisted living director (LALD)-B stated she expected the director of nursing to keep LALD-B up to date on resident issues but did not know if R1 had pressure ulcers or if skilled nursing from the home care agency was involved with R1's care. LALD-B stated she expected the nurse to conduct an assessment if a resident had a skin issue and modify the resident's service plan. LALD-B stated if R1 had pressure ulcers there should be a treatment plan for the wounds. LALD-B stated the physical therapist from home care talked to staff about repositioning R1, but it did not happen, so the director of nursing got involved. LALD-B stated the facility changed electronic health record provider and some records from the old system may not be retrievable. LALD-B stated the facility hired a consultation company to review and update resident nursing assessments because they were out of compliance. LALD-B stated the consulting nurse sent her an e-mail with recommendations of services to be updated but did not get into R1's service plan. During an interview on August 29, 2022, at 8:23 a.m. former director of nursing (DON)-G stated the facility changed electronic health record in March 2022, and he did not recall where or if he wrote notes on R1's pressure ulcers/wounds. DON-G stated the facility had very little documentation in the electronic health record because staff did not document. DON-G stated	02320		

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02320	Continued From page 11 he recalled the home care agency was completely in charge of R1's wounds. DON-G stated he did not recall seeing progress notes from the home care agency on R1's wounds. During an interview on August 29, 2022, at 1:00 p.m. family member (FM)-H stated the physical therapist notified her of R1's wounds on her bottom and legs. FM-H stated the staff were supposed to turn R1 in bed but did not think staff ever did. FM-H stated R1 had a skin tear on her arm, but staff did not bandage it, and R1 waited until a nurse from home health came to bandage the wound. FM-H stated the staff did not move R1 out of bed and R1 developed sores on the backs of her legs where they rested on the bed. During an interview on August 30, 2022, at 9:00 a.m. physical therapist (PT)-I stated he completed a skin check on R1 at the start of home healthcare services on January 26, 2022. PT-I stated R1 had no areas of skin breakdown at the time. PT-I stated he completed a 30-day reassessment of R1 on February 22, 2022, and discovered wounds on R1's buttocks and right calf. PT-I stated he notified the director of nursing and family. PT-I stated he assessed R1 one week later and the facility had not addressed (treated) the wounds, so he brought a facility nurse (unknown name) into R1's room to show her the wounds. PT-I stated he assessed R1 two weeks (around March 8, 2022) after first discovering R1's wounds and due to lack of appropriate wound treatment, obtained a doctor's order for skilled nursing from the home care agency to provide wound care. PT-I stated he also recommended the staff get R1 up to her wheelchair every day, turn/reposition R1, and prop R1 with pillows to prevent pressure ulcers. PT-I stated the staff were not doing those	02320		

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02320	Continued From page 12 recommended interventions. (R1's record did not contain evidence of skilled nursing care of R1's wounds) During an interview on August 30, 2022, at 9:30 a.m., registered nurse consultant (RNC)-J stated the facility hired her company to complete nursing assessments for all the residents at the facility as they were not up to date with required 90-day assessments. RNC-J stated her role was to complete a face-to-face assessment of each resident talk with staff, talk with the resident, and ensure the services for the resident were still appropriate. RNC-J stated when she identified a new service need, she notified the facility executive director (LALD-B) and director of nursing, who would update the resident's service plan. The licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) document dated July 29, 2022, indicated the licensee services available included basic wound care, complex wound care, mechanical lift with assistance of two staff for transfers, and bed mobility. [Bed mobility is defined as: activities designed to adjust the body position of a recumbent patient to prevent the development of joint contractures or skin breakdown.] The investigator requested but did not receive from the facility copies of R1's medication administration records (MARs) for February/March 2022, R1's treatment administration records (TARs) for January/February/March 2022, any of R1's progress notes dated February 23, 2022, through March 18, 2022, written by nurses or unlicensed staff members, or documentation of R1's services completed.	02320		

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02320	Continued From page 13 The Acceptance of Residents policy dated August 1, 2021, indicated the facility would only accept a resident if the facility had staff sufficient in qualifications, competency, and numbers to adequately provide the services agreed to in the resident's contract and are within the scope of facility disclosed services. The Assessments, Reviews, and Monitoring policy dated August 1, 2021, indicated 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 assessment. The Bathing Assistance policy dated August 1, 2021, indicated staff were to notify the registered nurse of any new bruises, open sores, or skin irritations. The Resident Record policy dated August 1, 2021, indicated the resident's record must include documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the health care professional. The policy further indicated the record must include documentation that services have been provided as identified in the service plan. The Service Plan policy dated August 1, 2021, indicated service plans shall be revised if needed, based on the resident assessments and monitoring. The policy indicated all services indicated in the service plan shall be provided to the resident, and staff providing services shall be informed of the current written service plan. A review of the Mayo Clinic Pressure Ulcers web	02320		

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02320	Continued From page 14 page (Bedsores (pressure ulcers) - Diagnosis and treatment - Mayo Clinic https://www.mayoclinic.org/diseases-conditions/bed-sores/diagnosis-treatment/drc-20355899#:~:text=Care%20for%20pressure%20ulcers%20depends%20on%20how%20deep,the%20dressing%20is%20changed.%20Putting%20on%20a%20bandage) indicated treatment included reducing pressure on the affected skin, caring for wounds, controlling pain, preventing infection, and maintaining good nutrition. The resource indicated the first step in treatment is reducing pressure by turning and changing position often. TIME PERIOD FOR CORRECTION: Seven (7) DAYS	02320		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: Based on interviews, and document review, the facility failed to ensure one of one residents (R1) was free from maltreatment. R1 was neglected. Findings include: On August 25, 2022, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	

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02360	Continued From page 15 evidence that maltreatment occurred.	02360		