Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL33613005M
Compliance #: HL33613006C

Date Concluded: February 11, 2022

Name, Address, and County of Licensee Investigated:
The Sanctuary at St. Cloud
2410 20th Avenue SE
St. Cloud, MN 56304
Sherburne County

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

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

Finding: Substantiated, facility responsibility

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

Allegation(s): it is alleged: The resident was neglected when the facility failed to ensure the resident was safe when smoking after the resident burned her chest when smoking.

Investigative Findings and Conclusion:
Neglect was substantiated. The facility was responsible for the maltreatment. Facility staff were aware the resident was unsafe during smoking which resulted in a burn to the resident's chest and multiple burn holes in the residents clothing. The facility did not implement interventions to prevent further burns and injury to the resident.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The residents medical record, employee records, incident reports, and facility policy and procedures were reviewed. In addition, observations were made of the facility environment, the resident's clothes, and the resident's room.

The resident's medical record indicated diagnoses including left sided hemiparesis (weakness), chronic pain, anxiety, and history of a stroke. The resident was wheelchair bound and received services including toileting, bathing, dressing, transferring, safety checks, and behavior management. The resident was a current smoker and chose to smoke in un-designated areas and had burns to her left side due to hot ash falling on her while smoking. The service plan indicated a licensed nurse should monitor the resident's left upper chest near the clavicle area at the burn site daily until healed.

The resident's vulnerability assessment indicated the resident was a smoker and was able to demonstrate lighting a cigarette and putting it out safely but would let hot ashes drop on her body causing some burns. The assessment did not include interventions regarding how to ensure the resident was safe while smoking to avoid burns.

The resident's progress note indicated the resident was a smoker with left sided weakness. The resident had a burn to her upper left chest clavicle area that measured approximately 3 centimeters (cm) in diameter.

Approximately a week later the resident's progress notes indicated the residents burn on the left chest/clavicle area measured 2 cm x 2cm. The licensed practical nurse (LPN) noticed many outer pieces of the residents clothing had burn holes. The note indicated nursing contacted the certified nurse practitioner (CNP) and Community access for disability inclusion (CADI) worker to see if obtaining a smoker's apron was an option. The following day it was documented an outside agency could obtain a smoking apron for the resident to wear.

Approximately three weeks after the incident the resident's progress notes indicated while the facility staff monitored the resident's chest area the resident stated she burned herself while smoking. Staff also observed a burn hole on the resident's scarf.

Approximately five weeks after the incident the resident's progress notes indicated the certified nurse practitioner (CNP) ordered a smoking apron to be worn when the resident smoked.

During an observation more than two months after the incident, the investigator observed the resident's smoking apron in the resident's room unopened. The investigator also observed multiple burn holes in the resident's pants and coat.

During interview, the resident stated she did not need staff supervision while smoking and denied having burn holes in her clothes. The resident stated she was not aware she had a smoking apron. The resident stated if she had a smoking apron, she would wear it when she smoked.

During an interview, the independent living services (ILS) worker stated most of the resident's clothes have burn holes in them from smoking.

During an interview, the ILS manager stated the facility staff never contacted her to order a smoking apron for the resident.

A follow up email from the ILS manager indicated the company does not have access to resident funds to purchase anything for the people they serve so the manager would not have been able to order the smoking apron for the resident.

During an interview an unlicensed staff stated staff can assist the resident in and out of the building but cannot be outside when the resident smokes. The staff member stated she observed burn holes on the resident's gloves. The staff stated she was not aware of any interventions or specific instructions for staff regarding the resident smoking.

During interview the licensed practical nurse stated he was aware of the burn holes on the resident's clothes and the previous director of health services completed a smoking assessment after the burn on the resident's chest and recommended a smoking vest.

During interview, the director of health services (DHS) stated she remembered discussions about a smoking apron and escorts for the resident when smoking but she was unsure if the facility staff implemented the interventions. DHS stated as soon as the facility knew the resident was unsafe to smoke interventions for the resident's safety should have been put into place. DHS did not know when the smoking apron was delivered to the facility.

During an interview, the previous Executive director (ED) stated there were a lot of concerns regarding the resident's ability to safely smoke. The resident had burns on her fingers and clothing and smoked in her apartment. The ED stated she wrote vulnerable adult reports for self-harm related to smoking. The ED stated facility staff never supervised the resident during smoking and the facility did not complete smoking evaluations.

During an interview, the Certified nurse practitioner stated the facility staff should have implemented the interventions [smoking apron] immediately to prevent further burns to the resident when smoking.

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:
(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

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

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: No
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
Staff re-education to encourage the resident to wear the smoking apron. The facility also completed a smoking and vulnerability assessment on the resident.

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,
or call 651-201-4890 to be provided a copy via mail or email. 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
Sherburne County Attorney
St. Cloud City Attorney
St. Cloud Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33613	A. BUILDING: _____ B. WING _____	C 12/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SANCTUARY AT ST CLOUD	2410 20TH AVENUE SE SAINT CLOUD, MN 56304

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0 000	Initial Comments Initial comments ******ATTENTION****** REVISED 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: HL33613001M/HL33613002C HL33613003M/HL33613004C HL33613005M/HL33613006C HL33613007M/HL33613008C HL33613009M/HL33613010C HL33613011M/HL33613012C On December 21, 2021 through December 22, 2021, the Minnesota Department of Health conducted complaint investigations at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 104 residents receiving services under the provider's Assisted Living with Dementia Care license. The following immediate orders were issued for HL33613005M/HL33613006C, tag identification 0630. The immediacy was removed on	0 000	Assisted Living Provider 144G. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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0 000	Continued From page 1 December 22, 2021. Non-compliance continues at a scope and severity of a D. The following correction orders which are not immediate are issued for the following: HL33613001M/HL33613002C, tag identification 0730, 1620. HL33613003M/HL33613004C, tag identification 0510, 1620 HL33613005M/HL33613006C, tag identification 0470, 0510, 2360 HL33613007M/HL33613008C, tag identification 0470, 0730 HL33613009M/HL33613010C, tag identification 0730, 0510 HL33613011M/HL33613012C, tag identification 0620 2360, 3000	0 000		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be:	0 470		

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0 470	Continued From page 2 (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the required staffing plan was developed, implemented, and evaluated for appropriateness of staffing levels as required, potentially affecting all of the current residents, staff and visitors. In addition, the licensee also failed to ensure call lights were answered timely for 3 of 4 residents (R1, R5, and R6) 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's staffing plan was requested on December 21, 2021. On December 22, 2021 at 12:05 p.m., registered nurse (RN)-F provided the licensee's staffing plan and verified the staffing plan was completed and signed on that date. RN-F stated there had been	0 470		

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0 470	Continued From page 3 discussions about staffing, however, there was no documentation of the development or implementation of the staffing plan. The licensee's Staffing Plan policy dated, August 1, 2021, indicated the director of health services (DHS) or designee, will develop, write, and implement a staffing plan. The staffing plan will provide qualified direct-care staff sufficient to meet the resident's needs 24 hours a day, seven days a week and will be adequate to address; each resident needs per the service plan and contract, residents acuity level, resident's schedule and unscheduled needs, and staff are trained and competent. Call light response time R1's face sheet indicated current diagnoses including dementia, anxiety, and depression. R1's service plan dated October 1, 2021, indicated the resident lived in memory care and required staff assistance with activities of daily living (ADLs) turning, repositioning and toileting every two hours, assistance with eating, medication administration, and safety checks every two hours. On December 28, 2021, R1's family member (FM)-M stated R1's call light usually took over 30 minutes to be answered. FM-M stated the morning R1 passed away a staff member was sleeping at the desk when she went out to look for someone to help R1. R1's discharge summary indicated R1 passed away on November 22, 2021. R1's call light report indicated the following:	0 470		

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0 470	Continued From page 4 * November 3, 2021 at 4:07 p.m. 41 minute wait time. * November 8, 20021, at 3:26 p.m. 26 minute wait time. * November 10, 2021 at 2:00 p.m. 50 minute wait time. * November 12, 2021 at 4:23 a.m. 34 minute wait time. * November 15, 2021 at 6:47 p.m. 49 minute wait time * November 16, 2021 at 4:31 p.m. 102 minute wait time. * November 20, 2021 at 10:33 a.m. 59 minutes wait time. * November 22, 2021 at 3:46 a.m. 81 minutes wait time. R5's diagnoses included left sided hemiparesis (weakness), chronic pain, anxiety and history of stroke. R5's service plan dated November 3, 2021, indicated R5 was wheelchair bound and received services including toileting, bathing, dressing, transferring, safety checks, and behavior management. On December 22, 2021, at 11: 15 a.m., unlicensed personnel (ULP)-P stated R5 had to wait a long time in the mornings for assistance. R5's call light report for December 2021, indicated the following: * December 22, 2021, at 8:37 a.m., 48 minute wait time * December 22, 2021, at 7:17 a.m., 72 minute wait time * December 22, 2021, at 5:19 a.m., 83 minute	0 470		

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0 470	Continued From page 5 wait time. * December 21, 2021, at 7:29 p.m., 37 minute wait time. * December 21, 2021, at 3:20 p.m., 42 minute wait time. * December 21, 2021, at 4:33 p.m., 51 minute wait time. * December 20, 2021, at 3:05 p.m., 41 minute wait time. * December 20, 2021, at 9:59 p.m., 27 minute wait time. * December 18, 2021, at 7:09 a.m., 73 minute wait time. * December 17, 2021, at 4:30 p.m., 22 minute wait time. * December 17, 2021, at 3:21 p.m., 33 minutes wait time. * December 17, 2021, at 11:43 a.m., 126 minute wait time. * December 17, 2021, 9:44 a.m., 60 minute wait time. * December 17, 2021, at 8:22 a.m., 38 minute wait time. *December 15, 2021, at 4:28 p.m., 32 minute wait time. * December 15, 2021, at 1:53 p.m., 35 minutes wait time. R6's diagnoses included post traumatic stress disorder, bipolar disorder, and poly neuropathy. R6 service plan dated December 23, 2021, indicated the resident received staff assistance with showers, dressing, grooming, medication management, and transfers. On December 21, 2021, at 12:40 p.m., R6 stated his call light had been on for over an hour and it usually takes 30 minutes for staff to respond. R6 stated most of the time the phones (how staff are	0 470		

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0 470	Continued From page 6 notified of call lights) are left on the medication carts and will ring for a long time before staff hears them. R6's Call light report for December 2021, indicated the following: * December 23, 2021, at 11:15 a.m., 29 minute wait time. * December 23, 2021, at 7:58 a.m., 30 minute wait time. * December 20, 2021, at 9:25 a.m., 39 minute wait time. * December 1, 2021, at 12:36 p.m., 190 minute wait time. On December 22, 2021 at 11:00 a.m., unlicensed personnel (ULP)-A, ULP-B and ULP-C stated there was not enough staff to complete cares or answer call lights in a timely manner and some residents would have to wait longer than 30 minutes for staff assistance. On December 22, 2021 at 12:17 p.m., RN-D stated at times services are not being provided timely and call lights can have a longer response time due to short staffing. On January 19, 2021 at 10:30 a.m., RN-E stated the licensee recently educated staff to ensure they had the needed equipment for their shift including their phones so staff can respond to call lights. The licensee's Pendant and Pull cord policy, dated February 3, 2020, indicated the pendant call system is to summon staff for health needs including concerns or emergencies. The policy also indicated call light response times will vary depending on the building layout size, staff availability, and the time of day.	0 470		

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0 470	Continued From page 7 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 470		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to establish and maintain an infection control program that complies with accepted health care, medical and nursing standards for infection control. The licensee failed to conduct COVID-19 screening for five of five resident (R2, R3, R5, R6, R8) reviewed. The licensee also failed to ensure personal protective equipment (PPE) was disposed of appropriately for one of one resident (R8) reviewed. This had the potential to affect all 104 residents, employees, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 510		

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0 510	Continued From page 8 safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: RESIDENT COVID-19 MONITORING AND SCREENING The Center's for Disease Control (CDC) Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 (COVID) Spread dated September 10, 2021, indicated facilities should actively monitor all residents upon admission and at least daily for fever and symptoms consistent with COVID-19, including an assessment of oxygen saturation via pulse oximeter. R2's face sheet indicated diagnoses including anxiety, depression, and post traumatic stress disorder. R2's current service plan dated December 23, 2021, indicated the resident required assistance with showers, safety checks, and COVID screening. The resident was independent with all other activities of daily living (ADLs). R2's Service Checkoff list for the month of December 2021, indicated COVID-19 screening was completed two times out of 22 days. R3's face sheet indicated current diagnoses including Alzheimer's, depression, and anxiety. R3's current service plan December 23, 2021,	0 510		

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0 510	Continued From page 9 included COVID-19 screening, exercise program, behavior monitoring, dressing, grooming, and bathing twice weekly. R3's service check-off list for the month of December indicated COVID-19 screening was completed four times out of 22 days. R5's record indicated diagnoses including left sided hemiparesis (weakness), chronic pain, anxiety, and history of stroke. R5's service plan dated November 3, 2021, indicated R5 was wheelchair bound and received services including toileting, bathing, dressing, transferring, safety checks, and behavior management. R5's November, 2021, Service check off list indicated COVID-19 screening was completed three times out of 30 days. R5's December, 2021 service check off list indicated COVID-19 screening was completed one time out of 12 days. R5 progress notes indicated R5 was admitted to the hospital on December 7, 2021, with a diagnosis of COVID-19 and returned to the facility nine days later. R6's face sheet indicated diagnoses including post traumatic stress disorder, bipolar disorder, and poly neuropathy. R6's service plan dated, December 23, 2021, indicated the resident required assistance with showers, dressing, grooming, medication management, COVID-19 screening, and assist of one for transfers.	0 510		

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0 510	Continued From page 10 R6's December, 2021, the residents service check off list indicated COVID-19 screening was completed three times out of 22 days. R8's face sheet indicated diagnoses including sleep apnea and anxiety. R8's service plan dated, January 27, 2021, indicated the resident required assistance with showers, medications administration, safety checks, and COVID-19 screening. R8's November, 2021, service received document indicated COVID-19 screening was completed three times out of 30 days. R8's December, 2021, service received document indicated from December 1, 2021 to December 15, 2021, COVID-19 screening was completed three times in 15 days. On December 22, 2022, at 2:00 p.m., registered nurse (RN)-F stated COVID-19 screening should be completed daily for all residents. The licensee's COVID-19 Emergency Preparedness Plan policy dated, December 9, 2021, indicated all residents were being monitored for COVID-19 and temperature and respiratory symptoms checked at least daily. Transmission Based Precautions The undated CDC guidance titled, Sequence for putting on Personal Protective Equipment (PPE) indicated all PPE should be removed before exiting the patient room except the respirator. On December 21, 2021, at 11:00 a.m., the	0 510		

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0 510	Continued From page 11 director of health services (DHS)-G stated R8 was positive for COVID-19 and was in isolation. R8's face sheet indicated diagnoses including sleep apnea and anxiety. R8's service plan dated, January 27, 2021, indicated R8 required assistance with showers, medications administration, safety checks, and COVID-19 screening. R8's progress notes dated, December 22, 2021, indicated R8 tested positive for COVID-19 on December 15, 2021. During an observation on December 21, 2021 at 3:40 p.m., R8's door had signage which identified what PPE staff should wear. The garbage can for disposable gowns was located outside of R8's room. A garbage was outside of the residents door and had a disposable gown hanging out of the top of the garbage can. On December 21, 2021, at 4:00 p.m., DHS-G stated the the garbage should not be outside of R8's room and stated it would be put into the residents room. The licensee's policy was request, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 510		
0 620 SS=G	144G.42 Subd. 6 Compliance with requirements for reporting ma	0 620		

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0 620	Continued From page 12 144G.42 Subd. 6. Compliance with requirements for reporting maltreatment of vulnerable adults; abuse prevention plan. (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. 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 and complete a thorough investigation for one of one resident (R4) with records 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 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: R4 resided in memory care with diagnoses which included Parkinson's disease, dementia, and pulmonary embolism. R4's service plan dated, July 30, 2021, indicated the resident received services including assistance with all activities of daily living (ADLs) including transfer assistance, escorts, and medication management. The facility staff were	0 620		

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0 620	Continued From page 13 directed to monitor the resident for behaviors including agitation, hallucinations, delusions, paranoia, and insomnia. The staff were to encourage the resident to participate, provide distractions, and provide reassurance. R4 liked to sort and fold clothes. R4's assessment completed May 28, 2021, indicated R4 ambulated with a walker and had dementia with anxiety and aggressive behaviors. Non-pharmacological interventions included allow R4 to vent her feelings, provide distractions, give personal attention, provide a calm approach, reassurance, encourage activity participation, and try to anticipate needs. R4's Vulnerability Assessment dated, May 28, 2021, indicated if R4 had anxiety or aggressive behaviors staff should provide a calm approach, reassurance, re-approach as needed, and to keep other residents away if the resident was hitting, kicking, spitting or yelling. R4 was at risk for abuse as she was not able to report abuse. R4's Vulnerability Assessment indicated staff were trained in vulnerable adult and maltreatment reporting and were to intervene immediately, and report suspected abuse. R4's progress notes dated November 11, 2021, at 9:06 p.m., indicated registered nurse (RN)-H received a call from R4's family member (FM)-O. FM-O stated she was watching the camera in the residents room, R4 was agitated, and the staff in the room with R4 were not helping the situation. RN-H went to R4's room in memory care and told the other staff to leave the residents room. The other staff left and RN-H assisted R4 with cares, administered her medication, and helped R4 to bed.	0 620		

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0 620	Continued From page 14 A video recording of R4's room dated November 11, 2021, was reviewed. The video lasted approximately 19 minutes and unlicensed personal (ULP)-I and ULP-J were in R4's room. The video starts with R4 sitting on the edge of her bed with her shirt off. The ULPs were attempting to assist R4 to get ready for bed. R4 lifted her legs off the bed in the direction of ULP-I and ULP-I yelled at R4, "keep your foot on the ground, keep your foot on the ground! You've got cameras in here and now we'll put you in jail for putting your hands on us! You want to go to jail? That's what I thought, keep your foot and hands to yourself." ULP-I stood on one side of R4, and ULP-J stood on the other side. Both ULPs were grabbing at R4's arms attempting to get her arms into the pajamas. R4 was not cooperative with the ULPs during this time and R4 kept grabbing both of the ULP's hands. ULP-I yelled at R4, "keep your hands to yourself this is not a joke or a game!" ULP-I took out her phone and repeatedly yelled, "I'm calling the police, I'm calling the police, I'm calling the police, you're going to jail tonight, you're going to jail tonight." ULP-I put the phone up to her ear and stated, "I got [R4] here, no, no, do you want me to take videos of what she is doing? Okay, I'll take the videos now." ULP-I then put the phone away. ULP-I continued to yell at R4 to let go of her hands and take her pills. R4 replied to ULP-I that she could not let go of her hands and the resident started yelling, "help, help." And then stated, "wait a minute, wait a minute," ULP-I yelled at R4 "No! you promised that 30 times, now I can't trust you, all you do is just play around your whole life, all you do is just play around!" ULP-I assisted R4 to stand while ULP-J pulled down R4's pants. While ULP-J was bent over assisting R4 the resident lifted her elbow and hit ULP-J's eye. ULP-I yelled at the resident, "Why would you just elbow her in her	0 620		

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0 620	Continued From page 15 eye, you're going to jail tonight, you're going to jail tonight because you elbowed her in her eye and now she is going to have a black eye, how wrong of you!" R4 stated wait a minute and ULP-I yelled, "No more wait a minute!" ULP-I continued to yell at R4 and increase the residents anxiety, and ULP-J asked R4 several times if she wanted to go to jail. Eventually RN-H entered R4's room and directed the staff to leave the residents room. RN-H continued to assist R4 with cares. An email dated November 12, 2021, indicated FM-O sent an email to the licensee which was forwarded to the regional executive director (ED)-L. The email included a copy of the video and FM-O indicated the staff interactions seemed to escalate R4's behavior and anxiety. On January 5, 2022, at 2:30 p.m., the residents family member (FM)-N stated a video was emailed to the licensee regarding the verbal abuse of R4. FM-N stated staff scolded R4 for not staying in bed and yelled at the resident they were going to call the police and put R4 in jail. FM-N stated the facility was called and asked the nurse to intervene during the interaction. The FM-N stated the staff were being rough and repeatedly grabbed R4's hands during this incident. On January 22, 2022, at 12:00 p.m., RN-H said she received a call from FM-O on November 11, 2021, at around 8:00 p.m. FM-O told RN-H staff were being rude to R4 and were not making R4's behavior any better. RN-H stated FM-O told her staff told R4 they were going to call the police. RN-H stated she called the executive director (ED) to inform her of the incident.	0 620		

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0 620	Continued From page 16 On January 18, 2022, at 11:00 a.m., ED-L stated she and RN-E reviewed the video and determined it did not meet the definition of abuse and therefore not reported. ED-L stated ULP-I and ULP-J attempted to get R4 to calm down since she was very agitated and swinging out. ED-L stated it was a very inappropriate intervention, but not abuse. ED-L said there was a need for re-education with staff. ED-L stated there was no documentation of staff re-education and other staff or residents were not interviewed as part of the internal investigation. On January 19, 2022, at 10:30 a.m. the RN-E stated she and ED-L did not feel the incident was reportable at that time, however now stated the incident should have been reported. RN-E stated she had staff review three or four re-education materials, however, she could not locate those materials. RN-E stated she spoke to ULP-I and ULP-J about the incident but did not document the discussion. RN-E said this was a system process that needed improvement and said the licensee is doing re-education on vulnerable adult training. The licensee reported the incident to the Minnesota Adult Abuse Reporting Center (MAARC) on January 19, 2022. Approximately two months after the abuse allegation. The licensee's Vulnerable Adult Reporting and Investigation policy dated, December 2, 2020, indicated any staff person who witnesses or suspects any form of client maltreatment must report the incident immediately. The director of health services (DHS) or ED are responsible for investigating reported incidents and will complete the vulnerable adult internal investigation of	0 620		

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0 620	Continued From page 17 suspected maltreatment from for any incident of suspected maltreatment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
0 630 SS=G	144G.42 Subd. 6 Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to identify a specific intervention for each known vulnerability and failed to update the individual abuse prevention plan (IAPP) after an incident indicated a new vulnerability and the risk of causing harm to self for one of one resident (R5) reviewed. This resulted in an immediate correction order on December 22, 2021, at approximately 12:50 p.m. The immediacy was removed on December 22, 2021, at approximately 1:50 p.m.. Noncompliance	0 630		

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0 630	Continued From page 18 remains at a scope and severity of a D. This practice resulted in a level three violation (a violation that harmed a client'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 clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R5's record indicated diagnoses including left sided hemiparesis (weakness), chronic pain, anxiety and history of stroke. R5's service plan dated November 3, 2021, indicated R5 was wheelchair bound and received services including toileting, bathing, dressing, transferring, safety checks, and behavior management. The service plan indicated a licensed nurse should monitor R5's left upper chest near clavicle area at burn site daily until healed. R5's 90-day assessment dated, October 14, 2021, indicated R5 was a smoker but did not include any other details. R5's Vulnerability assessment dated, December 16, 2021, indicated R5 was a smoker and was able to demonstrate lighting a cigarette and putting it out safely, but would let hot ashes drop on her body causing some burns. The assessment did not include interventions regarding smoking. R5's change of condition assessment dated December 16, 2021, indicated R5 was a current smoker and identified R5 chose to smoke in	0 630		

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0 630	Continued From page 19 un-designated areas and had burns to her left side due to hot ash falling on her while smoking. R5's cognitive ability assessment dated, December 16, 2021, indicated R5 had intact cognition. R5's progress note dated October 14, 2021, indicated R5 had a burn to her upper left chest clavicle area that measured approximately 3 centimeters (cm) diameter and had a bright pink outer rim with yellowing appearance. The same document indicated R5 was a smoker with left sided weakness related to a stroke and indicated R5 was unaware and did not know how it occurred. The same document indicated the current plan of care would be continued and the area was left open to air. R5's progress note dated, October 20, 2021, indicated the area R5's left chest clavicle area measured 2 cm x 2 cm and R5 denied pain. The same document indicated R5 had burn holes to many outer pieces of clothing and the staff would await response from the certified nurse practitioner (CNP) and Community access for disability inclusion (CADI) worker if obtaining a smokers apron was an option. R5's progress noted dated October 21, 2021, indicated an outside agency could obtain a smoking vest for R5 to wear and/or find alternatives to smoking if resident agrees. R5's progress note dated November 2, 2021, indicated R5 stated she burned herself, but the area to the left chest did not hurt. The progress note indicated a burn spot on R5's scarf. R5's progress notes dated November 16, 2021,	0 630		

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0 630	Continued From page 20 indicated orders from CNP that included wear smoking protective vest while smoking. R5 progress note, dated November 18, 2021, healed, and await delivery of smoking apron. R5's progress notes indicated R5 was admitted to the hospital with diagnoses of COVID-19 on December 6, 2021 and returned to the facility on December 15th, 2021. R5's progress note dated, December 15, 2021, indicated R5 was seen going outside to smoke with her oxygen on and R5 was reminded she had COVID and could not leave her apartment until the isolation period ended. R5's progress notes dated, December 18, 2021, indicated R5 was leaving her room to smoke during quarantine. R5 was reminded she should not leave her room during quarantine due to COVID symptoms. On December 21, 2021, at 1:14 p.m., the Director of Health Services (DHS) said R5 did have a burn from a cigarette and was aware of burn holes in her clothes. The DHS said the facility is non-smoking facility and they do not assist anyway with smoking. On December 22, 2021, at 10:30 a.m., the surveyor observed R5 outside leaning to the right side and had the cigarette in her mouth and used her right hand to attempt to light the cigarette. R5 attempted multiple times to the light the cigarette and was unsuccessful. R5 was assisted into the building by staff. On December 22, 2021, at 11:15 a.m., R5 said she did not need to be supervised while she	0 630		

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0 630	Continued From page 21 smoked. She also said she did not have burn holes in her clothes and was not aware she had a smoking apron, but said if she did she would wear it. On December 22, 2021, at 11:20 a.m., the surveyor observed a smoking apron on R5's counter that had not been taken out of the package. The surveyor also observed R5's pants and coat had multiple burn holes. On December 22, 2021, at 11:40 p.m. unlicensed personnel (ULP)-A, B and C said R5 did not need to be assisted when she smoked. ULP-A, B and C also said they were aware of the burn holes in R5's clothes but were not aware of a smoking apron. On December 22, 2021, at 12:10 p.m., the regional registered nurse (RN) indicated the licensee does not assist with smoking in anyway and smoking is not supposed to occur on the grounds since all the licensee's grounds should be smoke free. The regional RN was not aware of R5's burn holes in her clothing and also was not aware R5 had a smoking apron in her room. On December 22, 2021, at 12:17 p.m., registered nurse (RN)-A said she did not think R5 was safe to smoke and was aware of the burn holes in R5's clothes. RN-A stated, "that is why I don't think she is safe." RN-A also said R5 did not have a smoking apron but could benefit from one. On December 22, 2021, at 12:50 p.m. the administrator and regional RN were notified of the immediate correction order. On December 22, 2021, at approximately 1:50 p.m. the regional RN said she spoke to R5	0 630		

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0 630	Continued From page 22 regarding the use of the smoking apron and R5 agreed. The regional RN provided R5's service plan, which was was updated and signed. The regional RN also created a document for staff to sign which identified staff were aware R5 had a smoking apron, and that staff should assist R5 with the smoking apron before R5 goes outside. The surveyor requested an IAPP and smoking policy, but neither were provided by the licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 630		
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	0 730		

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0 730	Continued From page 23 assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure documentation of services had been provided as identified in the service plan for one of one resident (R2) with records reviewed. In addition, the facility failed to complete a discharge summary for one of one resident (R1, R4) with discharge record 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	0 730		

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0 730	Continued From page 24	0 730		

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:

R2's face sheet indicated diagnoses including anxiety, depression, and post traumatic stress disorder.

R2's service plan dated December 23, 2021, indicated the resident required assistance with showers three times a week, safety checks four times daily, COVID-19 screening, and behavior monitoring. R2 was independent with all other activities of daily living (ADLs).

R2's December, 2021, service check-off list indicated safety checks were to be completed at 3:00 a.m., There was no documentation the safety checks were completed from December 1, 2021 to December 21, 2021.

On December 21, 2021, R2 stated facility staff were supposed to check on her during the night to make sure she was breathing and if they didn't check on her it made her anxious. R2 stated in the last four months facility staff checked on her about three times.

Review of an email dated January 12, 2022, written by registered nurse (RN)-F indicated staff were having supervisors sign off on services which caused a delay in documentation of cares in the residents medical record. RN-F stated this was not their standard of practice and staff were expected to document on their own unless there was a problem with the charting system. RN-F

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0 730	Continued From page 25 stated the licensee was working on the issue. R1's face sheet indicated diagnoses including dementia, anxiety, and depression and R1 resided in memory care. R1's service plan dated October 1, 2021, indicated R1 required assistance with activities of daily living (ADLs) turning, repositioning and toileting every two hours, assistance with eating, medication administration and safety checks every two hours. R1's discharge summary dated, December 23, 2021, indicated R1 passed away on November 22, 2021. The discharge summary contained no further information. R4's diagnoses included Parkinson's disease, cognitive deficits, and pulmonary embolism. R4's service plan dated July 30, 2021, indicated the resident received services including all activities of daily living (ADLs) including transfer assistance, escorts, and medication management. R4's discharge summary dated, December 23, 2021, indicated the resident passed away on December 1, 2021. The discharge summary contained no further information. The licensee's policy was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 730		

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01620	Continued From page 26	01620		
01620 SS=D	144G.70 Subd. 2 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 observation, interview, and record review, the facility failed to ensure the registered nurse (RN) conducted ongoing client monitoring and reassessments, not to exceed 90 calendar days from the last assessment, for two of six residents (R3, R4) reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01620		

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01620	Continued From page 27 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: R3's diagnoses included dementia, chronic obstructive pulmonary disorder (COPD), depression, and neuropathy. R3's service plan dated December 23, 2021, indicated R3 received services including bathing, dressing, medication management, escorts to meals, and a safety check. On December 23, 2021, R3's most recent assessment was identified as being completed on August 13, 2021. R4's diagnoses included Parkinson's disease, cognitive deficits, and pulmonary embolism. R4's service plan dated July 30, 2021, indicated the R4 received services including all activities of daily living (ADLs) including transfer assistance, escorts, and medication management, On December 23, 2021, R4's most recent assessment was identified as being completed on May, 28, 2021. R4's discharge summary dated, December 23, 2021 indicated R4 passed away on December 1, 2021. On December 23, 2021, registered nurse (RN)-F	01620		

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01620	Continued From page 28 indicated in an email R3's last assessment was completed on August 13, 2021 and R4's last assessment was completed on May, 28, 2021, both were over the required 90 day requirement. The RN verified the assessments were not up to date and additional nurses would be assisting with updating resident assessments to ensure the assessments were up to date. The licensee's Assessment of Clients - Initial and Ongoing policy, dated August 1, 2021, indicated ongoing assessments will be based on residents need with the frequency of assessment no more than 14 days after initiation of care and thereafter not to exceed 90 days from the last assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.	01760		

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01760	Continued From page 29 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure medication was administered as prescribed for one of one resident (R6) with records reviewed. In addition, the licensee failed to ensure medication were administered as ordered; 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: R6's face sheet indicated diagnoses including chronic pain, arthritis, post traumatic stress disorder, bipolar disorder and poly neuropathy. R6's service plan dated December 23, 2021, indicated R6 received assistance with showers, dressing, grooming, medication management, and assistance of one for transfers. R6's change of condition assessment dated October 11, 2021, indicated R6 had complaints of low back pain, rated the pain 7/10, and medications helped decrease the pain. R6's progress notes dated December 1, 2021, indicated new medication orders for pain were written for hydromorphone 2 milligrams (mg) by mouth four times daily, every four hours while awake.	01760		

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01760	Continued From page 30 R6's progress notes dated, December 9, 2021, indicated R6 was out of hydromorphone. R6's December, 2021 medication administration record (MAR) indicated hydromorphone 2 mg tablet was scheduled four times daily, but was not documented as administered on the following days/ times: - December 9. 2021 at 4:00 p.m. - December 9, 2021 at 8:00 p.m. - December 10, 2021 at 8:00 a.m. - December 10, 2021 at 12:00 p.m. - December 17, 2021 at 4:00 p.m. December 2021, medication errors were reviewed and did not include any of the above medications or notification to the provider these medications were not administered as ordered. On December 21, 2021, at 12:40 p.m., R6 stated in the last few months the facility has run out of his pain medications at least three times when staff forgets to tell nursing to order it. R6 stated when he runs out of his pain medications it causes him pain. On December 22, 2021 at 12:17 p.m., registered nurse (RN)-D stated the licensee runs out of medications frequently because staff do not tell the nurses when medications are running low. On December 22, 2021, at 1:52 p.m., RN-F stated if medications were not administered as ordered or if facility staff did not order the medication a medication error report should be completed. A policy was requested, but not provided.	01760		

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01760	Continued From page 31 No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01760		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: Based on observations, interviews, and document review, the facility failed to ensure two of five residents (R4, R5) reviewed were free from maltreatment. R4 was abused and R5 was neglected. Findings include: On January 31, 2022, the Minnesota Department of Health (MDH) issued a determination that abuse and neglect occurred, and that the facility and individual staff were responsible for the maltreatment of R4, and the facillity was responsible for the maltreatment of R5, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	
03000 SS=D	626.557 Subd. 3 Timing of report (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	03000		

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03000	Continued From page 32 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. (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	03000		

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03000	Continued From page 33 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) an allegation of suspected abuse for one of one resident (R4) reviewed with an allegation of abuse. 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: R4's diagnoses included Parkinson's disease, cognitive deficits, and pulmonary embolism. R4's service plan dated July 30, 2021, indicated R4 received services including assistance with all activities of daily living (ADLs) including transfer assistance, escorts, medication management, and behavior monitoring for agitation, hallucinations, delusions, paranoia, and insomnia. If R4 had behaviors staff were directed to encourage participation, distraction, and provide reassurance. R4 also liked to sort and fold clothes.	03000		

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03000	Continued From page 34 R4's assessment completed May 28, 2021, indicated R4 ambulated with a walker and had dementia with anxiety and aggressive behaviors. Non-pharmacological interventions included allow R4 to vent her feelings, provide distractions, give personal attention, provide a calm approach, reassurance, encourage activity participation, and try to anticipate needs. R4's Vulnerability Assessment dated, May 28, 2021, indicated if R4 was not able to report abuse and had anxiety and/or had aggressive behaviors. Staff were directed to provide a calm approach, reassurance, re-approach as needed, and keep other residents away if hitting, kicking, spitting or yelling. The interventions indicated staff were trained in vulnerable adult and maltreatment reporting and staff were to intervene immediately, and report suspected abuse. R4's progress notes dated, November 11, 2021, at 9:06 p.m., indicated registered nurse (RN)-H received a call from R4's family member (FM)-O. FM-O saw via the camera in R4's room R4 was agitated, and the staff who were in the room with the resident were not helping. RN-H went to the residents room in memory care and told the other staff to leave the resident's room. The nurse assisted the resident to bed and provided cares and medication. R4's provider note dated, November 15, 2021, indicated the resident was unable to participate in visit due to advanced dementia. Video footage that was sent to the licensee dated November 12, 2021, identified ULP-I continuously yelling at R4 and arguing with the resident telling R4 ULP-I was going to call the police, the resident	03000		

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03000	Continued From page 35 was going to jail, and there was a video camera watching R4 so she was going to be in trouble. ULP-J was observed hanging onto R4's hand and observing the ongoing yelling and arguing between ULP-I and R4. ULP-J also told R4 she was going to call the police and asked R4 if she wanted to go to jail. During this time ULP-I and ULP-J were attempting to assist R4 to get dressed for bed. On January 19, 2022, at 10:30 a.m., RN-E stated she and the executive director (ED)-L did not feel the incident was reportable at that time. However, they now feel they should have reported the incident. The licensee reported the incident to the Minnesota Adult Abuse Reporting Center (MAARC) on January 19, 2022, approximately two months after they were made aware of the abuse allegation. The licensee's Vulnerable Adult Reporting and Investigation policy dated, December 2, 2020, indicated any staff person who witnesses or suspects any form of client maltreatment must report the incident immediately. The director of health services (DHS) or ED are responsible for investigating reported incidents and will complete the vulnerable adult internal investigation of suspected maltreatment from for any incident of suspected maltreatment. No Further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	03000		