Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL339755501M
Compliance #: HL339757721C

Date Concluded: November 14, 2024

Name, Address, and County of Licensee Investigated:
Maple Woods Assisted Living
33310 State Highway 6
Deer River, MN 56636
Itasca County

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

Evaluator's Name: Barbara Axness, RN
Special Investigator

Finding: Inconclusive

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

Initial Investigation Allegation(s):
The facility neglected the resident when they failed to provide wound care in accordance with physician orders. The facility discontinued the resident's wound care services after the resident returned from the hospital with new orders, stating they were not able to provide the wound care due to staffing. The resident later admitted to the hospital with cellulitis.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. Although wound care was not consistently documented as provided in accordance with physician's orders, there was not a preponderance of evidence the actions, or inactions, of facility staff led to the resident being hospitalized with cellulitis. The facility discontinued wound care provided by unlicensed staff; however, continued providing wound care by a licensed nurse. Hospital records related to the hospitalization were not able to be obtained.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement, the case worker, hospital staff, and the resident's primary care provider. The investigation included review of the resident records, hospital records, facility incident reports, staff schedules, law enforcement report, and related facility policies and procedures. Also, the investigator observed the resident's wounds and wound care provided by the facility.

The resident resided in an assisted living facility. The resident's diagnoses included paraplegia and type two diabetes. The resident's service plan included assistance with wound care two times per day. The resident's assessment indicated the resident had two stage 3 (extending into the fatty tissue) pressure ulcers and a stage 4 (extending into the muscles, tendons, and ligaments) pressure ulcer to his buttocks. The resident was paralyzed from the chest down and required two people and a mechanical hoyer lift for all transfers. The resident was cognitively intact, managed his medications and directed his care. The resident had a history of pressure ulcers and skin breakdown to his coccyx and buttocks.

The resident's record indicated wound care to his three wounds was to be completed twice per day. Unlicensed personnel (ULP) initially performed the wound care, however facility management decided to not allow ULP to complete wound care as a delegated task and changed its policy to only allow licensed nurses to complete wound cares. As a result, wound care documentation was removed from the resident's service recap summary. Licensed nurses began documenting sporadically in progress notes when wound care was completed. In the two weeks leading up to his hospitalization, documentation of wound cares being completed was inconsistent. Six days lacked documentation of wound cares being completed. The resident's progress notes indicated staff observed swelling to the resident's groin area and his legs were firm with increased redness. Staff called 911 and the resident was admitted to the hospital and diagnosed with cellulitis. The resident spent six days in the hospital and was treated with IV antibiotics.

Hospital records related to the resident's hospitalization for cellulitis were requested, but only partial records were provided. Documentation related to the resident's reason for admission or condition of the wounds were not provided by the hospital. The facility was also unable to obtain documentation related to the resident's hospital admission.

During an interview, a facility nurse stated due to staffing constraints, the decision was made to not allow ULP to complete wound care and the nurses took over the task. The nurse stated she or one of the other nurses did his twice daily dressing changes but the service had been removed from his medical record so they documented in a progress note when it was completed. The nurse stated the resident's wound care was always completed.

During an interview the registered nurse (RN) stated when she began serving as the interim supervisor, she didn't feel the ULP were completing the dressing changes appropriately, so they transitioned the task to be completed by the licensed nurse only. The RN stated to her

knowledge, all wound cares were completed as ordered and none were missed. The RN stated she wasn’t as familiar with the facility’s electronic medical record and was not sure why some documentation was missing.

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

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

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

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

Action taken by facility:
No action taken.

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

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

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

You may also call 651-201-4200 to receive a copy via mail or email

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33975	A. BUILDING: _____ B. WING _____	C 10/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE WOODS ASSISTED LIVING	33310 STATE HIGHWAY 6 DEER RIVER, MN 56636

(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 ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. On October 7, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 20 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL339755501M/#HL339757721C, tag identification 0430, 0450, 0470, 1070, 1940, 1960.	0 000		
0 430 SS=F	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services	0 430		

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0 430	Continued From page 1 the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide notice of changes made to its Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) to one of one residents (R1) reviewed with wound care. The licensee informed the resident they would no longer offer complex wound care as a delegated service and ended those services without notice. This had the potential to affect all residents receiving wound care services from the facility. 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: R1 admitted to the facility on September 23,	0 430		

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0 430	Continued From page 2 2021, with various wounds present at admission. R1's diagnoses included paraplegia and type two diabetes. R1's service plan dated May 11, 2024, indicated unlicensed staff completed wound care two times per day and the nurse would supervise the wound once per week. R1's record contained a UDALSA dated January 25, 2024, which indicated the facility could provide basic and complex wound care. The UDALSA was signed by the resident on March 22, 2024. R1's most recent assessment dated October 3, 2024, indicated the resident had two stage 3 pressure ulcers and a stage 4 pressure ulcer to his buttocks. The resident was paralyzed from the nipples down and required two people with a mechanical hoyer lift for all transfers. The resident was noted to be cognitively intact and managed his own medications and directed his own care. The resident had a history of pressure ulcers and skin breakdown to his coccyx and buttocks since at least July 2022. R1's progress notes contained the following entries: -August 21, 2024, clinical nurse supervisor (CNS)-B wrote, "Writer visually assessed bilateral wounds to buttocks. The wounds have macerated skin in the wounds beds. Currently the unlicensed caregivers are completing the wounds care twice a day. The wounds Care includes wet to dry dressing and packing the wounds. Observation of the wounds via images in June of 2024 until today the wounds are worsening. Emailed and called clinic for PCP [primary care provider] to get new	0 430		

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0 430	Continued From page 3 orders for home care or TCU [transitional care unit] or SNF [skilled nursing facility] placement. Updated LALD. [licensed assisted living director]." Later that day, CNS-B wrote, "Writer spoke with resident due to complex wound care being completed by unlicensed caregivers. He was upset and stated that the aides are doing their best. Writer stated that is true but they are not trained in complex wound care and they are not capable of completing the wound care or monitoring the wounds for worsening conditions or signs of complications. He did state he wants to stay here. Writer explained that he may need to go for a short time until the wounds are more stable and do not require dressing changes twice a day. Writer called clinic and left a second message for the NP [nurse practitioner] regarding orders for a higher level of care due to wounds. The writer called the resident's mother and informed her of the situation. She was not aware the wounds were deep and needing to be packed, she is aware of the seriousness of the situation. Writer emailed the county worker to have her assist with placement if needed." -August 22, 2024, the resident was sent to the emergency room to evaluate his wounds. The resident returned later that day with instructions from the ER to "continue cares for these. I do not believe they actually look acutely infected at this time. Follow up with your wound care provider or return to here if they worse. Until you are able to follow-up with her continue wet to dry dressings twice daily" CNS-B documented, "Resident was made very clear prior to leaving the staff here could not continue to care for the wounds. He had stated he has wound care appointment Friday (tomorrow). Once he arrived he stated he does not have a wound care doctor appointment for infusions (cancer treatment). HE is aware staff here will not	0 430		

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0 430	Continued From page 4 continue to care for the wounds due to the complex nature of the wounds. Resident is aware this is self neglect due to knowing the staff can not care for the wounds...The LALD [licensed assisted living director] will follow up and discuss with the provider tomorrow the plan of care. Removed wound care from services for aides BID [twice a day] and nursing weekly to assess." On October 7, 2024, at 11:10 a.m., LALD-A stated CNS-B had told her the resident's wounds were too complex for them to manage at the facility and they needed to look for different placement for the resident. LALD-A stated CNS-B had made various recommendations of services to remove from the UDALSA including sliding scale insulin and complex wound care. LALD-A stated they had not yet updated the UDALSA or provide notice of changes to the residents but confirmed they had stopped providing twice daily wound care from ULP from R1's service plan. LALD-A confirmed a 60 day notice was not given to R1 before they changed services. On October 7, 2024, at 11:35 a.m., CNS-B stated she began working as the interim CNS mid-August and she had concerns with the unlicensed staff's ability to complete the twice daily dressing changes they had been doing for a while. CNS-B stated given the wounds needed packing and were stage 3 and 4, she was not comfortable with the ULP continuing to do the wound care so she changed it to only nurses completing the wound care. CNS-B stated the facility didn't have the staffing or management to oversee complex wound cares and they were not able to find any home health agencies that could come in to provide wound care as they also did not have staff available. CNS-B stated she had recommended the facility remove several things	0 430		

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0 430	Continued From page 5 from their UDALSA due to their staffing situation including IM injections and complex wound care. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 430		
0 450 SS=D	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall: (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide services in a person-centered manner for one of one residents (R1). The licensee moved the resident to its secured memory care unit, despite the resident not having a dementia-related diagnosis and being cognitively intact. 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	0 450		

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0 450	Continued From page 6 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included paraplegia and type two diabetes. R1's most recent assessment dated October 3, 2024, indicated the resident had two stage 3 pressure ulcers and a stage 4 pressure ulcer to his buttocks. The resident was paralyzed from the nipples down and required two people with a mechanical hoyer lift for all transfers. The resident was noted to be cognitively intact and managed his own medications and directed his own care. The resident had a history of pressure ulcers and skin breakdown to his coccyx and buttocks since at least July 2022. On October 7, 2024, at 10:00 a.m., the investigator visited R1 in his room on the secured memory care unit. A basket of unsecured medications were in the corner of the resident's room. R1 stated he sometimes gets frustrated living on the secured memory care unit side because residents will often wander in his room and pull his blankets or bother him. R1 stated he locks his door when he's out of the room but if he is in his room, he can't stop residents from wandering in. R1 stated he understood he had to live on this side due to staffing as he required two people for transfers and he couldn't get an assist of two on the assisted living side because they only had one person over there and the memory care person wouldn't be able to leave the unit	0 450		

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0 450	Continued From page 7 unsecured to go over and help provide transfer assistance. On October 7, 2024, at licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated the resident had been on the secured memory care unit for about a year, year and a half. LALD-A confirmed the resident was cognitively intact and did not have any diagnoses that would require he live on a secured unit. LALD/LPN-A stated the resident had moved to the secured side as he needed two people for transfers and there would always be two staff available on the secured side. On October 7, 2024, at 11:35 a.m., clinical nurse supervisor (CNS)-B stated she began consulting at the facility mid-August and from what she understood, R1 was on the memory care side due to staffing. CNS-B stated she thought the placement was highly innapropriate for the resident but the resident was afraid to move back to the assisted living side due to staffing availability. CNS-B confirmed the resident managed his own medications and while the door would be locked if he wasn't in the room, it was possible a resident could wander into the room while he was in it and get into his medications. A policy on person centered care was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 450		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements	0 470		

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0 470	Continued From page 8 (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the facility had sufficient staffing 24/7 to meet the scheduled and reasonably foreseeable unscheduled needs, as required by the resident's assessments and service plans, for one of one resident (R1) who required a mechanical lift. This had the potential to affect all residents receiving services at the facility.	0 470		

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0 470	Continued From page 9 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 7, 2024, at 10:00 a.m., the investigator visited R1 in his room on the secured memory care unit. R1 stated he sometimes gets frustrated living on the secured memory care unit side because residents will often wander in his room and pull his blankets or bother him. R1 stated he locks his door when he's out of the room but if he is in his room, he can't stop residents from wandering in. R1 stated he understood he had to live on this side due to staffing as he required two people for transfers and he couldn't get an assist of two on the assisted living side because they only had one person over there and the memory care person wouldn't be able to leave the unit unsecured to go over and help provide transfer assistance. On October 7, 2024, at licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated the resident had been on the secured memory care unit for about a year, year and a half. LALD-A confirmed the resident was cognitively intact and did not have any diagnoses that would require he live on a secured unit. LALD/LPN-A stated the resident had moved to the secured side as he needed two people for transfers and there would always be two staff available on the secured side.	0 470		

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0 470	Continued From page 10 The licensee's resident roster as of October 7, 2024, indicated the census was 20 out of a capacity of 25. The assisted living side had 11 residents and the secured memory care unit had nine residents. The licensee's summary of daily service minutes on October 7, 2024, indicated the facility had an average of 8,240 scheduled service minutes per day or approximately 137 service hours per day. The summary did not include unscheduled needs. The licensee's posted daily staffing schedule on October 7, 2024, at 9:35 a.m. was not filled in and was blank. A binder with a copy of the employee schedule near the white board for staffing indicated the following: -September 23, one ULP on the day shift, one ULP working a double shift (day and evening shift), one ULP working 7:00 a.m. to 7:00 p.m., one ULP on evening, one ULP from 7:00 p.m. to 7:00 a.m. and one ULP on overnight for a total of three ULP on days, three ULP on evenings, and two ULP overnight for a total of 72 hours. -September 24, two ULP on the day shift, one ULP working a double shift, one ULP on evening, one ULP overnight, and one ULP from 11:00 p.m. to 6:00 a.m. for a total of three ULP on days, two ULP on evenings, and two ULP overnight for a total of 55 hours. -September 25, one ULP from 6:00 a.m. to 2:00 p.m., one ULP from 7:00 a.m. to 11:00 p.m., one ULP from 7:00 a.m. to 7:00 p.m., one ULP from 11:00 a.m. to 11:00 p.m., two ULP on evening, and two ULP overnight for a total of four ULP on days, four ULP on evenings, and two ULP on overnights for a total of 80 hours.	0 470		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE WOODS ASSISTED LIVING	33310 STATE HIGHWAY 6 DEER RIVER, MN 56636

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0 470	Continued From page 11 -September 26, one ULP on days, two ULP from 7:00 a.m. to 7:00 p.m., one ULP on evenings, one ULP 7:00 p.m. to 11:00 p.m., and two ULP on nights for a total of three ULP on days, 2 ULP on evenings, and two ULP overnight for a total of 68 hours. -September 27, one ULP working a double shift (day and evening shift), two ULP on overnights, one ULP from 7:00 a.m. to 7:00 p.m., one ULP from 9:00 a.m. to noon, one ULP from 11:00 a.m. to 11:00 p.m., one ULP on evenings, and one ULP 3:30 p.m. to 9:00 p.m. for a total of 73.5 hours. -September 28, one ULP on days, one ULP working a double shift (day and evening shift), one ULP working 7:00 p.m. to 7:00 a.m., one ULP on evenings, one ULP on overnights, one ULP from 7:00 a.m. to 7:00 p.m., one ULP from 11:00 a.m. to noon, one ULP from 2:00 p.m. to 7:30 p.m., one ULP from 8:00 a.m. to noon, and one ULP from 4:30 p.m. to 8:00 p.m., for a total of 70 hours. -September 29, one ULP on days, one ULP working a double shift (day and evening shift), one ULP from 7:00 a.m. to 7:00 p.m., one ULP from 7:00 p.m. to 7:00 a.m., one ULP on overnight, and one ULP on evenings for a total of 64 hours. -September 30, one ULP on days, one ULP from 7:00 a.m. to 7:00 p.m., one ULP from 7:00 p.m. to 7:00 a.m., one ULP from 5:00 p.m. to 11:00 p.m., one ULP on overnight, and one ULP from 11:00 p.m. to 7:00 a.m. for a total of 58 hours. -October 1, two ULP on days, two ULP on evening, two ULP on overnights, one ULP from 11:00 a.m. to 11:00 p.m., and one ULP from 10:00 a.m. to 2:30 p.m. for a total of 64.5 hours. -October 2, two ULP on days, two ULP on evenings, two ULP on overnights, one ULP from 7:00 a.m. to 11:00 p.m., and one ULP from 7:00	0 470		

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0 470	Continued From page 12 p.m. to 8:00 p.m. for a total of 65 hours. -October 3, one ULP on days, one ULP on evenings, one ULP on overnights, one ULP from 9:00 p.m. to 7:00 a.m., one ULP from 7:00 a.m. to 7:00 p.m., one ULP from 7:00 a.m. to 9:00 p.m., and one ULP from 7:00 p.m. to 11:00 p.m. for a total of 60 hours. -October 4, one ULP working a double shift (day and evening shift), two ULP working from 7:00 a.m. to 7:00 p.m., two ULP on overnights, and one ULP from 9:00 a.m. to 7:00 p.m. for a total of 70 hours. -October 5, one ULP on the days, one ULP working a double shift (day and evening shift), two ULP working from 7:00 a.m. to 7:00 p.m., one ULP on evenings, and three ULP on overnights for a total of 80 hours. -October 6, one ULP on the days, one ULP working a double shift (day and evening shift), two ULP working from 7:00 a.m. to 7:00 p.m., one ULP on evenings, and three ULP on overnights for a total of 80 hours. The licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) dated January 25, 2024, noted the number of unlicensed direct care staff typically scheduled was two, and transfers with assist of two staff was available. A licensed nurse in addition to a RN who was required to be accessible to the staff 24/7 was noted to be either in the building, an attached building, or within the campus and available to respond to resident requests 24/7 was available. On October 7, 2024, at 11:35 a.m., CNS-B stated she was working as a contracted, interim CNS and began working at the facility mid-August. CNS-B stated she has voiced concerns about staffing to leadership and ownership of the facility	0 470		

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0 470	Continued From page 13 about needing more staff. CNS-B stated the facility currently only had three permanent ULP and the others were contracted from staffing agencies. CNS-B stated management has a scheduling meeting but she is not involved or invited to the meeting. CNS-B stated she's been telling management since day one that the facility needs better staffing but she has not been given the opportunity to work at scheduling. CNS-B stated the schedule she has on her desk is not accurate and she is not able to see the online schedule. CNS-B stated she is aware the CNS is responsible for overseeing staffing but she has not been able to do so as leadership will not allow her to. On October 15, 2024, at 12:50 p.m. CNS-B stated the ULP are also responsible for preparing breakfast and on weekends, there is no kitchen staff so staff are also responsible for all three meals and housekeeping, as well as laundry. The licensee's Direct-Care Staffing Plan dated May 1, 2024, indicated when residents required a two person assist, there would be a minimum of two staff available at all times. The adequate number of staff was determined by the level of care needed by each resident. Adequate staffing was identified as three ULP on day shift, three ULP on evening shift and two ULP overnight. The desired staffing model was identified as four ULP on the day shift, four ULP on the evening shift, and three ULP on the overnight shift. Minnesota Administrative Rule 4659.0180, Subpart 5 dated August 11, 2021, indicated "A minimum of two direct-care staff must be scheduled and available to assist at all times whenever a resident requires the assistance of two direct-care staff for scheduled reasonably	0 470		

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0 470	Continued From page 14 foreseeable and unscheduled needs, as reflected in the resident's assessments and service plan." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
01070 SS=D	144G.52 Subd. 10 Right to return If a resident is absent from a facility for any reason, including an emergency relocation, the facility shall not refuse to allow a resident to return if a termination of housing has not been effectuated. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to allow the return of one of one resident (R1) after they were sent to the emergency room. Hospital records indicated the licensee would not accept R1 back after being medically cleared to return. The licensee failed to offer any option for R1 to return as a housing-only resident with the necessary services provided by another agency. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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:	01070		

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01070	Continued From page 15 R1 admitted to the facility on September 23, 2021, with various wounds present at admission. R1's diagnoses included paraplegia and type two diabetes. R1's service plan dated May 11, 2024, indicated unlicensed staff completed wound care two times per day and the nurse would supervise the wound once per week. R1's record contained a Uniform Disclosure of Assisted Living Services (UDALSA) dated January 25, 2024, which indicated the facility could provide basic and complex wound care. The UDALSA was signed by the resident on March 22, 2024. R1's most recent assessment dated October 3, 2024, indicated the resident had two stage 3 pressure ulcers and a stage 4 pressure ulcer to his buttocks. The resident was paralyzed from the nipples down and required two people with a mechanical hoyer lift for all transfers. The resident was noted to be cognitively intact and managed his own medications and directed his own care. The resident had a history of pressure ulcers and skin breakdown to his coccyx and buttocks since at least July 2022. R1's progress notes contained the following entries: -August 21, 2024, clinical nurse supervisor (CNS)-B wrote, "Writer visually assessed bilateral wounds to buttocks. The wounds have macerated skin in the wounds beds. Currently the unlicensed caregivers are completing the wounds care twice a day. The wounds Care includes wet to dry dressing and packing the wounds. Observation of the wounds via images in June of 2024 until today	01070		

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01070	Continued From page 16 the wounds are worsening. Emailed and called clinic for PCP [primary care provider] to get new orders for home care or TCU [transitional care unit] or SNF [skilled nursing facility] placement. Updated LALD. [licensed assisted living director]." Later that day, CNS-B wrote, "Writer spoke with resident due to complex wound care being completed by unlicensed caregivers. He was upset and stated that the aides are doing their best. Writer stated that is true but they are not trained in complex wound care and they are not capable of completing the wound care or monitoring the wounds for worsening conditions or signs of complications. He did state he wants to stay here. Writer explained that he may need to go for a short time until the wounds are more stable and do not require dressing changes twice a day. Writer called clinic and left a second message for the NP [nurse practitioner] regarding orders for a higher level of care due to wounds. The writer called the resident's mother and informed her of the situation. She was not aware the wounds were deep and needing to be packed, she is aware of the seriousness of the situation. Writer emailed the county worker to have her assist with placement if needed." -August 22, 2024, the resident was sent to the emergency room to evaluate his wounds. The resident returned later that day with instructions from the ER to "continue cares for these. I do not believe they actually look acutely infected at this time. Follow up with your wound care provider or return to here if they worse. Until you are able to follow-up with her continue wet to dry dressings twice daily" CNS-B documented, "Resident was made very clear prior to leaving the staff here could not continue to care for the wounds. He had stated he has wound care appointment Friday (tomorrow). Once he arrived he stated he does not have a wound	01070		

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01070	Continued From page 17 care doctor appointment for infusions (cancer treatment). HE is aware staff here will not continue to care for the wounds due to the complex nature of the wounds. Resident is aware this is self neglect due to knowing the staff can not care for the wounds...The LALD [licensed assisted living director] will follow up and discuss with the provider tomorrow the plan of care. Removed wound care from services for aides BID [twice a day] and nursing weekly to assess." -August 30, 2024, the resident admitted to the hospital with cellulitis. -September 5, 2024, CNS-B documented she spoke with the resident's primary care provider, a case manager, and a hospitalist regarding the resident's return to the facility and reported, "The staff at the Assisted living are not able to perform the wound care twice a day and it is not a safe discharge plan." Later that day, the facility documented it had a pre termination meeting to discuss the resident's complex wound cares and that they were unable to accommodate it due to his increased needs. A 30 day discharge notice was issued. The resident returned to the facility later that day. Shortly after returning to the facility, CNS-B documented they obtained an order for a direct admission to the hospital and to send the resident back to the emergency room. As the resident was being loaded into the ambulance to return to the hospital, the hospitalist called and stated they would not do an admission to the hospital as there was no reason to admit him. CNS-B told the hospitalist the resident had already left and "she stated he will be sent away and not admitted. Writer stated, " It is an unsafe discharge plan and we are not able to provide his level of care he needs at this time due to the twice a day wound care." The resident was brought back to the facility. -September 18, 2024, a care conference was	01070		

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01070	Continued From page 18 held with the resident, his mother, his sister, the county case manager, a community advocate, the licensed assisted living director, CNS-B, and another facility nurse. The community advocate requested the 30 day notice be removed due to failure to follow state regulations and requested a 60 day notice be given to resident regarding changes to services offered at the facility. The note indicated the resident and his family were agreeable for the resident to move to a skilled nursing facility no sooner than September 25, 2024. -September 20, 2024, the resident was admitted to the hospital due to abdominal pain. -September 30, 2024, CNS-B wrote they reported to the hospital they can't provide his level of care with wound care twice a day and "informed her again we can not take him back we can not provide his level of care. He has spent 2 weeks in the hospital since beginning of Sept." -October 2, 2024, licensed assisted living director (LALD)-A wrote she called the hospital discharge planner and "left a message on her line that we cannot provide resident's level of care." Later that day, CNS-B wrote, "[discharge planner] from [hospital] called the police to inform the facility he has a right to come back to the facility due to his 30 day notice not being expired. 30 day notice will expire on 10/05/2024. Ombudsman contacted he would like the resident to come back until resident can be relocated to a SNF or other ALF. [Hospital discharge planner] reported resident has wound care once a day now. Resident is set to leave Duluth tomorrow at 1030am. Orders and update will be sent via fax tomorrow morning. Hospital records indicated the resident was admitted on September 20, 2024, and discharged back to the facility on October 3, 2024. The resident was admitted for an abdominal wall	01070		

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01070	Continued From page 19 hematoma and approved to discharge back to the facility on September 23, 2024. Notes entered by the hospital discharge planner on September 23, 2024, indicated clinical nurse supervisor (CNS)-B told hospital staff they were unable to manage the resident's wounds at this time as they were having the on-call nurse come in twice daily to do the resident's dressing changes. CNS-B told hospital staff they felt the resident needed a higher level of care. On September 24, 2024, hospital discharge planners visited with CNS-B again who stated the barrier to the resident returning to the facility was his twice a day dressing change as they do not have skilled staff in the facility outside of Monday through Thursday day shift. Hospital discharge planners followed up with the facility on September 26, 2024, to discuss the resident returning to the facility and "it is reported that the barrier to the patient's return is twice a day dressing changes as the ALF does not have skilled nursing Friday, Saturday, or Sunday, however patient indicates ALF non-licensed staff were completing the wound care prior to hospitalization for the past two years." The resident's provider at the hospital wrote, "Patient reports if he were to change facilities he would be away from his dying mother and his son who does not have a driver's license, away from his support system. Ideally he would like to stay in the facility he is already in." On September 30, 2024, hospital discharge planners documented they received a call from CNS-B to see if they had any luck finding long term care placement for the resident as the facility was unable to do the twice daily dressing changes. Hospital discharge planners contacted some skilled nursing facilities to inquire about placement. On October 1, 2024, a hospital discharge planner spoke with CNS-B and she	01070		

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01070	Continued From page 20 indicated they were unable to accommodate the resident's now once daily dressing changes due to no nurse on site Friday, Saturday, Sunday. Hospital discharge planners coordinated for the emergency room in Deer River to complete the resident's dressing changes when the facility was not able to do so. However, the hospital discharge planner was unable to arrange transportation to the emergency room on Sundays. The resident told hospital staff he would skip his Sunday dressing change if he had to in order to return to the facility. On October 2, 2024, hospital discharge planners contacted law enforcement as the facility was not allowing for the resident to return to the facility. The resident discharged back to the facility on October 3, 2024. A police report dated October 2, 2024, indicated police responded to the facility at 2:17 p.m. for a civil matter after the hospital called to request assistance with allowing the resident to return to the facility. The police report indicated, "After conversation with Maplewood staff and leadership a new plan for [R1] is in the works and he will be allowed to return to Maplewood tomorrow with services." On October 7, 2024, at 11:10 a.m., LALD-A stated CNS-B had told her the resident's wounds were too complex for them to manage at the facility and they needed to look for different placement for the resident. LALD-A stated she felt they had been managing the wounds well prior to this and nothing had changed with the wound care orders when it was determined the resident could not come back. LALD-A stated she was confused with CNS-B's approach and that while she understood the rationale behind it, there are appropriate steps the facility had to take and	01070		

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01070	Continued From page 21 they couldn't just not take him back. LALD-A stated as far as his wound care went, they had been monitoring them, reporting what needed to be reported, and she felt things were going fine with the wound care and they had a good handle on it. On October 7, 2024, at 11:35 a.m., CNS-B stated she began working as the interim CNS mid-August and she had concerns with the unlicensed staff's ability to complete the twice daily dressing changes they had been doing for a while. CNS-B stated given the wounds needed packing and were stage 3 and 4, she was not comfortable with the ULP continuing to do the wound care so she changed it to only nurses completing the wound care. CNS-B stated the facility didn't have the staffing or management to oversee complex wound cares and they were not able to find any home health agencies that could come in to provide wound care as they also did not have staff available. CNS-B stated the resident needed a higher level of care than what the facility could provide and they did not feel the hospital was doing enough to find other placement for the resident. On October 10, 2024, discharge planner (DP)-E stated the facility tried extremely hard to not take the resident back and they had to reach out to community advocates and law enforcement as the facility was refusing to allow him to return. DP-E stated the facility kept saying they couldn't meet his needs, however his twice daily dressing changes had been completed for at least a year or two and nothing had changed in the dressings or level of care. DP-E stated she told the facility they would have to prove there is a legitimate reason they can't meet his needs and it can't be that you can't find staff as you have an obligation	01070		

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01070	Continued From page 22 to the resident to provide the agreed upon cares. A policy on the right to return was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01070		
01940 SS=G	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33975	A. BUILDING: _____ B. WING _____	C 10/07/2024

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01940	Continued From page 23 possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop, implement, and maintain a current individualized treatment management plan to include all required content to identify, administer, and document treatment as prescribed for one of one resident (R1) who received wound care. 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: R1 admitted to the facility on September 23, 2021, with various wounds present at admission. R1's diagnoses included paraplegia and type two diabetes. R1's record contained a UDALSA dated January 25, 2024, which indicated the facility could provide basic and complex wound care. The UDALSA was signed by the resident on March 22, 2024. R1's service plan dated May 11, 2024, indicated unlicensed staff completed wound care two times	01940		

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01940	Continued From page 24 per day and the nurse would supervise the wound once per week. R1's assessment dated October 3, 2024, indicated the resident had two stage 3 pressure ulcers and a stage 4 pressure ulcer to his buttocks. The resident was paralyzed from the chest down and required two people with a mechanical hoyer lift for all transfers. The resident was noted to be cognitively intact and managed his own medications and directed his own care. The resident had a history of pressure ulcers and skin breakdown to his coccyx and buttocks since at least July 2022. R1's record lacked a treatment management plan and failed to identify a statement of the type of wound care services that will be provided; documentation of specific resident instructions relating to the treatment; identification of treatment or tasks delegated to unlicensed personnel; procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; any resident-specific requirements relating to documentation of treatment received, verification that all treatment was administered as prescribed, and monitoring of treatment to prevent possible complications or adverse reactions. R1's August 2024 Service Recap Summary included AM and PM wound care, however it was not consistently documented and was discontinued on August 22, 2024. Wound care was not documented on August 17, August 18 in the morning and was not documented on August 18 and August 21 for the evening.	01940		

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01940	Continued From page 25 R1's progress notes lacked documentation of wound care being completed on the following dates: -August 13 -August 17 -August 18 -August 21 -August 23 -August 25 -August 26 R1's progress notes contained the following entries: -August 21, 2024, clinical nurse supervisor (CNS)-B wrote, "Writer visually assessed bilateral wounds to buttocks. The wounds have macerated skin in the wounds beds. Currently the unlicensed caregivers are completing the wounds care twice a day. The wounds Care includes wet to dry dressing and packing the wounds. Observation of the wounds via images in June of 2024 until today the wounds are worsening. Emailed and called clinic for PCP [primary care provider] to get new orders for home care or TCU [transitional care unit] or SNF [skilled nursing facility] placement. Updated LALD. [licensed assisted living director]." Later that day, CNS-B wrote, "Writer spoke with resident due to complex wound care being completed by unlicensed caregivers. He was upset and stated that the aides are doing their best. Writer stated that is true but they are not trained in complex wound care and they are not capable of completing the wound care or monitoring the wounds for worsening conditions or signs of complications. He did state he wants to stay here. Writer explained that he may need to go for a short time until the wounds are more stable and do not require dressing changes twice a day. Writer called clinic and left a second message for the NP [nurse practitioner] regarding	01940		

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01940	Continued From page 26 orders for a higher level of care due to wounds. The writer called the resident's mother and informed her of the situation. She was not aware the wounds were deep and needing to be packed, she is aware of the seriousness of the situation. Writer emailed the county worker to have her assist with placement if needed." -August 22, 2024, the resident was sent to the emergency room to evaluate his wounds. The resident returned later that day with instructions from the ER to "continue cares for these. I do not believe they actually look acutely infected at this time. Follow up with your wound care provider or return to here if they worse. Until you are able to follow-up with her continue wet to dry dressings twice daily" CNS-B documented, "Resident was made very clear prior to leaving the staff here could not continue to care for the wounds. He had stated he has wound care appointment Friday (tomorrow). Once he arrived he stated he does not have a wound care doctor appointment for infusions (cancer treatment). HE is aware staff here will not continue to care for the wounds due to the complex nature of the wounds. Resident is aware this is self neglect due to knowing the staff can not care for the wounds...The LALD [licensed assisted living director] will follow up and discuss with the provider tomorrow the plan of care. Removed wound care from services for aides BID [twice a day] and nursing weekly to assess." -August 30, 2024, the resident admitted to the hospital with cellulitis. R1 was hospitalized August 30 through September 5 to treat a cellulitis infection. R1's September 2024 Service Recap Summary included wound care at 11:00 a.m. and 6:00 p.m. beginning on September 13, 2024, however	01940		

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01940	Continued From page 27 documentation on wound care stopped on September 21, 2024. The wound care service from September 1 through September 12 was blacked out. R1's progress notes lacked documentation of wound care being completed on the following dates: -September 6 wound care was not done as the resident left early and came back late from an appointment -September 7 -September 8 -September 12 -September 13 -September 14 -September 15 Hospital records indicated the resident was admitted on September 20, 2024. Notes entered by the hospital discharge planner on September 23, 2024, indicated clinical nurse supervisor (CNS)-B told hospital staff they were unable to manage the resident's wounds at this time as they were having the on-call nurse come in twice daily to do the resident's dressing changes. CNS-B told hospital staff they felt the resident needed a higher level of care. On September 24, 2024, hospital discharge planners visited with CNS-B again who stated the barrier to the resident returning to the facility was his twice a day dressing change as they do not have skilled staff in the facility outside of Monday through Thursday day shift. R1 discharged from the hospital back to the facility on October 3, 2024 with once daily dressing changes. R1's October 2024 Service Recap Summary	01940		

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01940	Continued From page 28 lacked wound care services. On October 7, 2024, at 1:30 p.m., the investigator observed clinical nurse supervisor (CNS)-B perform a dressing change to R1's wounds. On October 7, 2024, at 11:35 a.m., CNS-B stated she began working as the interim CNS mid-August and she had concerns with the unlicensed staff's ability to complete the twice daily dressing changes they had been doing for a while. CNS-B stated given the wounds needed packing and were stage 3 and 4, she was not comfortable with the ULP continuing to do the wound care so she changed it to only nurses completing the wound care. CNS-B stated the facility didn't have the staffing or management to oversee complex wound cares. On October 15 2024, at 12:50 p.m., clinical nurse supervisor (CNS)-B confirmed a treatment plan was not developed for R1's wounds but was not sure why one was not created. CNS-B confirmed administration of wound care was not documented each time it was completed. A policy on treatment management plans was requested, but not provided. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident	01960		

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01960	Continued From page 29 record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure treatments or therapies were administered as prescribed and if not administered, the reason why they were not provided was documented for one of one resident (R1) reviewed with wounds managed by the licensee. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 admitted to the facility on September 23, 2021, with various wounds present at admission. R1's diagnoses included paraplegia and type two diabetes. R1's service plan dated May 11, 2024, indicated unlicensed staff completed wound care two times	01960		

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01960	Continued From page 30 per day and the nurse would supervise the wound once per week. R1's most recent assessment dated October 3, 2024, indicated the resident had two stage 3 pressure ulcers and a stage 4 pressure ulcer to his buttocks. The resident was paralyzed from the nipples down and required two people with a mechanical hoyer lift for all transfers. The resident was noted to be cognitively intact and managed his own medications and directed his own care. The resident had a history of pressure ulcers and skin breakdown to his coccyx and buttocks since at least July 2022. R1's record lacked a treatment management plan. R1's August 2024 Service Recap Summary included AM and PM wound care, however it was not consistently documented and was discontinued on August 22, 2024. Would care was not documented on August 17, August 18 in the morning and was not documented on August 18 and August 21 for the evening. R1's September 2024 Service Recap Summary included wound care at 11:00 a.m. and 6:00 p.m. beginning on September 13, 2024, however documentation on wound care stopped on September 21, 2024. The wound care service from September 1 through September 12 was blacked out. R1's October 2024 Service Recap Summary lacked wound care services. R1's progress notes lacked documentation of wound care being completed on the following dates:	01960		

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01960	Continued From page 31 -September 15 -September 14 -September 13 -September 12 -September 8 -September 7 -September 6 wound care was not done as the resident left early and came back late from an appointment The resident was hospitalized August 30 through September 5 to treat a cellulitis infection. -August 26 -August 25 -August 23 -August 18 -August 17 -August 13 R1's progress notes contained the following entries: -August 21, 2024, clinical nurse supervisor (CNS)-B wrote, "Writer visually assessed bilateral wounds to buttocks. The wounds have macerated skin in the wounds beds. Currently the unlicensed caregivers are completing the wounds care twice a day. The wounds Care includes wet to dry dressing and packing the wounds. Observation of the wounds via images in June of 2024 until today the wounds are worsening. Emailed and called clinic for PCP [primary care provider] to get new orders for home care or TCU [transitional care unit] or SNF [skilled nursing facility] placement. Updated LALD. [licensed assisted living director]." Later that day, CNS-B wrote, "Writer spoke with resident due to complex wound care being completed by unlicensed caregivers. He was upset and stated that the aides are doing their best. Writer stated that is true but they are not	01960		

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01960	Continued From page 32 trained in complex wound care and they are not capable of completing the wound care or monitoring the wounds for worsening conditions or signs of complications. He did state he wants to stay here. Writer explained that he may need to go for a short time until the wounds are more stable and do not require dressing changes twice a day. Writer called clinic and left a second message for the NP [nurse practitioner] regarding orders for a higher level of care due to wounds. The writer called the resident's mother and informed her of the situation. She was not aware the wounds were deep and needing to be packed, she is aware of the seriousness of the situation. Writer emailed the county worker to have her assist with placement if needed." -August 22, 2024, the resident was sent to the emergency room to evaluate his wounds. The resident returned later that day with instructions from the ER to "continue cares for these. I do not believe they actually look acutely infected at this time. Follow up with your wound care provider or return to here if they worse. Until you are able to follow-up with her continue wet to dry dressings twice daily" CNS-B documented, "Resident was made very clear prior to leaving the staff here could not continue to care for the wounds. He had stated he has wound care appointment Friday (tomorrow). Once he arrived he stated he does not have a wound care doctor appointment for infusions (cancer treatment). HE is aware staff here will not continue to care for the wounds due to the complex nature of the wounds. Resident is aware this is self neglect due to knowing the staff can not care for the wounds...The LALD [licensed assisted living director] will follow up and discuss with the provider tomorrow the plan of care. Removed wound care from services for aides BID [twice a day] and nursing weekly to assess."	01960		

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01960	Continued From page 33 -August 30, 2024, the resident admitted to the hospital with cellulitis. On October 7, 2024, at 1:30 p.m., the investigator observed clinical nurse supervisor (CNS)-B perform a dressing change to R1's wounds. On October 7, 2024, at 11:35 a.m., CNS-B stated she began working as the interim CNS mid-August and she had concerns with the unlicensed staff's ability to complete the twice daily dressing changes they had been doing for a while. CNS-B stated given the wounds needed packing and were stage 3 and 4, she was not comfortable with the ULP continuing to do the wound care so she changed it to only nurses completing the wound care. CNS-B stated the facility didn't have the staffing or management to oversee complex wound cares. On October 15 2024, at 12:50 p.m., clinical nurse supervisor (CNS)-B confirmed documentation was not consistent for R1's wound care and it should have been documented each time it was completed. (CNS)-B also confirmed a treatment plan was not developed for R1 and was not sure why one was not created. A policy on documentation of treatments was requested, but not provided. No additional information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01960		