Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL34328001M
Compliance #: HL34328002C

Date Concluded: May 20, 2022

Name, Address, and County of Licensee Investigated:
1-0 Granny's Helpful Hands
705 East Lake Street
Minneapolis, MN 55417
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Michele R. Larson
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 facility neglected to provide supervision and monitoring for the resident. The resident ingested an unknown amount of his prescribed medication after he broke into a locked medication closet and cart and stole his medications while an unlicensed personnel (ULP) slept on the facility's living room sofa. The resident was later found by staff having difficulty walking and slurring his speech. The resident was evaluated at a local hospital.

Investigative Findings and Conclusion:
Neglect was substantiated. The facility was responsible for the maltreatment. The resident's records indicated the resident was supposed to receive monitoring and supervision 24 hours per day, yet the facility allowed staff to sleep on the job, which left the resident unmonitored for hours at a time. During the time the resident went unsupervised, he used a butter knife and broke into the facility's medication closet and medication cart, ingesting an unknown number of medications, causing him to be admitted to the hospital. The facility never retrained staff after any of the resident's incidents.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included a review of the resident's medical record and onsite visit. The facility's incident reports, policies, and procedures were reviewed. The facility's video footage was reviewed.

The resident's diagnoses included, but were not limited to, unspecified psychosis, alcohol abuse, and cocaine abuse. The resident was alert and oriented and walked independently. The resident's medication assessment indicated the resident required management of his medications and had a history of misusing medications and drug diversion.

The resident's service plan indicated the resident required assistance with medication management, meals, housekeeping, laundry, personal cares, behaviors, scheduling and attending appointments, and protection from potential health and safety risks due to his mental health diagnoses. The resident had a history of elopement to obtain alcohol and drugs.

The resident's behavioral plan indicated the resident required staff monitoring and supervision 24 hours per day, and increased monitoring during times when he experienced behavioral issues. The behavioral plan failed to define how 24 hour supervision and monitoring were to be conducted.

The resident's incident report indicated one morning, the facility program manager observed the resident had glossy eyes, slurred speech, and difficulty standing and walking. During a search of the resident's room, staff discovered a Ziploc bag containing 55 pills prescribed to the resident. Inside the medication cart, the program manager noticed four of the resident's bubble pack medication cards were missing. The medication cards contained 140 pills. Staff sent the resident to the hospital for evaluation. The facility reviewed video security footage.

The facility's video footage showed at 4:40 a.m., the resident walked into the dining room and covered a camera with a wet paper towel while a ULP slept. At 6:05 a.m., the resident attempted to break into a medication closet using a butter knife he obtained from the kitchen. At 6:21 a.m., the resident tampered with the locked medication cart. At 7:19 a.m., the ULP woke up and administered the resident's 8:00 a.m. medications. At 9:11 a.m., the resident opened the medication cart with a butter knife and stole one of his medication cards while the ULP was outside of the building.

The resident's record indicated the Ziploc bag contained 55 of the resident's medications: (17) anticonvulsants, (24) antiseizure, (7) antipsychotic pills (2) antidepressant pills, and (5) antispasmodic pills. The resident's four bubble pack medication cards were missing 140 of his morning and nighttime medications: (14) antipsychotics pills, (35) antiseizure pills, (28) anticonvulsants, (56) antispasmodics, and (7) antidepressants. The resident's record indicated between the pills retrieved from the Ziploc bag and the missing pills from the medication bubble cards, 85 pills were unaccounted for.

During an interview, the resident stated he was hospitalized many times due to stealing his medications.

During an interview, the resident's mental health case manager stated the resident had a history of stealing medications, stating, "he was good at it."

During an interview with a ULP staff, the ULP stated the facility had 48-hour weekend shifts that started Friday at 11:00 p.m. and ended Sunday night at 11:00 p.m. The ULP stated one staff worked the 48-hour shift and slept during the night on the sofa.

During an interview, the program director stated the resident required 1:1 staff supervision due to his history of stealing his medications, inflicting self-harm, and using street drugs and alcohol when he eloped from the facility. The program manager stated the resident stole his medications around five times while staff slept. The program manager stated the facility did not retrain staff after the incidents but did install a deadbolt lock on the medication closet, stating "that was pretty much it."

During an interview, the registered nurse (RN) stated the resident was sent to the hospital every time he stole and ingested his medications. The RN stated the resident was supervised by one staff person who also supervised another resident. The RN stated the resident stole his medications at random times. The RN stated the facility installed a deadbolt lock on the medication closet after the resident's first incident, stating she wanted to make sure the resident did not steal his medications again.

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: Yes. The resident's mental health case manager was interviewed.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility installed a dead-bolt lock on the medication closet door to prevent the resident from breaking into the closet. The staff were instructed to always keep the keys to the medication cart and closet with them.

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.

The responsible party will be notified of their right to appeal the maltreatment finding.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34328	A. BUILDING: _____ B. WING _____	C 02/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
1-0 GRANNY'S HELPFUL HANDS LLC	5915 CHICAGO AVENUE MINNEAPOLIS, MN 55417

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL34328002C/#HL34328001M On February 24, 2022, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were three clients receiving services under the provider's Assisted Living license. The following immediate correction order is issued. Correction orders with a period to correct that are not immediate may be issued at a later date during the investigation. The following immediate correction order is issued for #HL34328002C/#HL34328001M, tag identification 2070.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 620 SS=D	144G.42 Subd. 6 Compliance with requirements for reporting ma	0 620		

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0 620	Continued From page 1 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 a resident's stealing and ingesting medications to the Minnesota Adult Abuse Reporting Center (MAARC) within 24 hours for one of one resident (R1) with record reviewed. While staff slept, R1 ingested an unknown number of his medications that he stole from the medication cart and closet. The resident required hospitalization. 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). Findings Include: R1's medical record was reviewed. R1 admitted to the licensee on August 11, 2021. R1's diagnoses included unspecified psychosis, alcohol abuse, cocaine abuse. R1 walked independently.	0 620		

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0 620	Continued From page 2 R1's service plan dated August 11, 2021, indicated R1 required assistance with medication management, meals, housekeeping, laundry, personal cares, behaviors, scheduling and attending appointments, and protection from potential health and safety risks due to his mental health diagnoses. R1 had a history of elopement to obtain alcohol and drugs. R1's behavioral plan dated August 11, 2021, indicated R1 required staff monitoring and supervision 24 hours per day during awake and asleep hours, and increased monitoring during behaviors. R1's medication assessment dated August 11, 2021, indicated R1 received medication management services. R1's medications were to be administered by staff. R1 had a history of misusing medications and drug diversion. R1's medication assessment indicated his medications were stored in a locked closet inside his room only staff had access to. R1's incident report dated November 9, 2021, indicated on November 8, 2021, at 8:15 a.m., program manager (PM)-D observed R1 had slurred speech, glossy eyes, and had difficulty standing and walking. Unlicensed personnel (ULP)-G searched R1's room and discovered a Ziploc bag containing 55 pills prescribed to R1. Inside the medication cart, PM-D noticed four of R1's bubble pack medication cards were missing. The medication cards contained 140 pills. R1 admitted at a hospital. The licensee reviewed video footage. The licensee video footage indicated on November 8, 2021, at 4:40 p.m., R1 walked into the dining room and covered a camera with a	0 620		

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0 620	Continued From page 3 wet paper towel while ULP-H slept on the sofa. At 6:05 a.m., R1 attempted to break into a medication closet using a butter knife. At 6:21 a.m., R1 tampered with the locked medication cart. At 7:19 a.m., ULP-H woke up and administered R1's 8:00 a.m. medications. At 9:11 a.m., R1 opened the medication cart with a butter knife and stole one of his medication cards while ULP-H was outside of the building. R1's record indicated the Ziploc bag contained 55 of R1's medications: (17) anticonvulsant, (24) antiseizure, (7) antipsychotic pills (2) antidepressant pills, and (5) antispasmodic pills. R1's four bubble pack medication cards were missing 140 of his morning and nighttime medications: (14) antipsychotics pills, (35) antiseizure pills, (28) anticonvulsants, (56) antispasmodics, and (7) antidepressants. R1's record indicated between the pills retrieved from the Ziploc bag and the missing pills from the medication bubble cards, 85 pills were unaccounted for. On November 9, 2021, at 8:30 a.m., R1 was discharged back to the licensee. The licensee installed a deadbolt lock on the medication closet after R1 returned from the hospital. The incident report indicated R1's care team would be notified within 24 hours upon knowledge of the incident. On November 10, 2021, at 8:56 a.m., the licensee filed an online .MAARC report, two days after the incident. On November 10, 2021, at 9:00 a.m., R1's care team were notified. On February 24, 2022, at 12:40 p.m., R1 stated	0 620		

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0 620	Continued From page 4 she was hospitalized many times due to stealing her medications. The licensee policy titled Vulnerable Adult Maltreatment-Prevention and Reporting, updated August 1, 2021, indicated staff were trained on identifying and reporting suspected maltreatment of vulnerable adults. MAARC reports must be made no later than 24 hours after the maltreatment was first suspected. TIME PERIOD TO CORRECT: Seven (7) days.	0 620		
0 630 SS=D	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 interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP), was developed to include 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; the person's risk for self-abuse, and statements	0 630		

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0 630	Continued From page 5 of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults for one of one resident (R1) with record reviewed. In addition, the licensee failed to update R1's IAPP after R1 ingested an unknown amount of his medications after he broke into the facility's medication cart and closet. R1 required hospitalization. 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's medical record was reviewed. R1 admitted to the licensee on August 11, 2021. R1's diagnoses included to unspecified psychosis, alcohol abuse, and cocaine abuse. R1 walked independently. R1's service plan dated August 11, 2021, indicated R1 required assistance with medication management, meals, housekeeping, laundry, personal cares, behaviors, scheduling and attending appointments, and protection from potential health and safety risks due to his mental health diagnoses. R1 had a history of elopement to obtain alcohol and drugs. R1's behavioral plan dated August 11, 2021, indicated R1 required staff monitoring and supervision 24 hours per day during awake and asleep hours, and increased monitoring during	0 630		

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0 630	Continued From page 6 behaviors. R1's IAPP dated August 11, 2021, indicated R1 frequently sought alcohol, prescribed and illegal drugs. Staff were to redirect, support, and encourage R1 to attend alcoholics anonymous (AA) meetings. R1 exhibited self-injurious behavior such as swallowed foreign objects, intentionally running away from the facility, exhibited verbal aggression towards others, destroyed property, exhibited suicidal gestures, and talk, and exhibited impaired judgement and actions when using alcohol. Staff were to follow R1's behavioral plan. R1's IAPP lacked indication of R1's susceptibility to being abused by other vulnerable adults, their risk of abusing other vulnerable adults. On April 22, 2022, at 11:30 a.m., registered nurse (RN)-E stated IAPPs were updated whenever there were changes in a resident's behaviors. The licensee policy titled Vulnerable Adult Maltreatment-Prevention & Reporting, updated August 1, 2021, indicated the licensee developed IAPPs to identify vulnerability risks and developed measures to minimize maltreatment based on identified information. TIME PERIOD TO CORRECT: Seven (7) days. Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP), was developed to include an individualized review or assessment of the	0 630		

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0 630	Continued From page 7 person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; the person's risk for self-abuse, and statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults for one of one resident (R1) with record reviewed. In addition, the licensee failed to update R1's IAPP after R1 ingested an unknown amount of his medications after he broke into the facility's medication cart and closet. R1 required hospitalization. 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's medical record was reviewed. R1 admitted to the licensee on August 11, 2021. R1's diagnoses included unspecified psychosis, alcohol abuse, and cocaine abuse.R1 walked independently. R1's service plan dated August 11, 2021, indicated R1 required assistance with medication management, meals, housekeeping, laundry, personal cares, behaviors, scheduling and attending appointments, and protection from potential health and safety risks due to his mental health diagnoses. R1 had a history of elopement to obtain alcohol and drugs. R1's behavioral plan dated August 11, 2021,	0 630		

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0 630	Continued From page 8 indicated R1 required staff monitoring and supervision 24 hours per day during awake and asleep hours, and increased monitoring during behaviors. R1's IAPP dated August 11, 2021, indicated R1 frequently sought alcohol, prescribed and illegal drugs. Staff were to redirect, support, and encourage R1 to attend alcoholics anonymous (AA) meetings. R1 exhibited self-injurious behavior such as swallowed foreign objects, intentionally running away from the licensee, exhibited verbal aggression towards others, destroyed property, exhibited suicidal gestures, and talk, and exhibited impaired judgement and actions when using alcohol. Staff were to follow R1's behavioral plan. R1's IAPP lacked indication R1 was assessed for her susceptibility to abuse other vulnerable adults. R1's incident report dated November 9, 2021, indicated on November 8, 2021, at 8:15 a.m., program manager (PM)-D observed R1 had slurred speech, glossy eyes, and had difficulty standing and walking. ULP-G searched R1's room and discovered a Ziploc bag containing 55 pills prescribed to R1. Inside the medication cart, PM-D noticed four of R1's bubble pack medication cards were missing. The medication cards contained 140 pills. R1 admitted at a hospital. The licensee reviewed video footage. Review of the licensee's video footage dated November 8, 2021, at 4:40 a.m., showed R1 covered the dining room camera with a wet paper towel while ULP-H slept on the sofa. At 6:05 a.m., R1 attempted to break into a medication closet using a butter knife. At 6:21 a.m., R1 tampered	0 630		

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0 630	Continued From page 9 with the locked medication cart. At 7:19 a.m., ULP-H woke up and administered R1's 8:00 a.m. medications. At 9:11 a.m. R1 opened the medication cart with a butter knife and stole one of his medication cards while ULP-H was outside of the building. R1's record indicated the Ziploc bag contained 55 of R1's medications: (17) anticonvulsants, (24) antiseizure, (7) antipsychotic pills (2) antidepressant pills, and (5) antispasmodic pills. R1's four bubble pack medication cards were missing 140 of his morning and nighttime medications: (14) antipsychotics pills, (35) antiseizure pills, (28) anticonvulsants, (56) antispasmodics, and (7) antidepressants. R1's record indicated between the pills retrieved from the Ziploc bag and the missing pills from the medication bubble cards, 85 pills were unaccounted for. R1's IAPP lacked evidence it was updated after R1 ingested and stole her medications. On February 24, 2022, at 12:40 p.m., R1 stated she was hospitalized many times due to stealing her medications. On April 22, 2022, at 11:30 a.m., registered nurse (RN)-E stated IAPPs were updated whenever there were changes in a resident's behaviors. The licensee policy titled Vulnerable Adult Maltreatment-Prevention & Reporting, updated August 1, 2021, indicated the licensee developed IAPPs to identify vulnerability risks and developed measures to minimize maltreatment based on identified information.	0 630		

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1-0 GRANNY'S HELPFUL HANDS LLC	5915 CHICAGO AVENUE MINNEAPOLIS, MN 55417

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0 630	Continued From page 10 TIME PERIOD TO CORRECT: Seven (7) days.	0 630		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct	01500		

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01500	Continued From page 11 support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received at least eight hours of annul training for each 12 months of employment for five of six employees [registered nurse (RN)-E, program manager (PM)-D, unlicensed personnel (ULP)-B, ULP-G , ULP-H] with training records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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	01500		

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01500	Continued From page 12 of the residents). Findings Include: RN-E RN-E was hired in May, 2018. RN-E's employee record lacked evidence of up-to-date annual training to include: *Reporting of maltreatment of vulnerable adults under section 626.557 *Review of the assisted living (AL) bill of rights (BOR) *Review of infection control techniques *Effective approaches to use to problem solve when working with a resident's challenging behaviors *Review of the facility's policies and procedures *Principles of person-centered planning and service delivery PM-D PM-D was hired on September 3, 2019. PM-D's employee record lacked evidence of up-to-date annual training to include: *Reporting of maltreatment of vulnerable adults under section 626.557 *Review of the assisted living (AL) bill of rights (BOR) *Review of infection control techniques *Effective approaches to use to problem solve when working with a resident's challenging behaviors *Review of the facility's policies and procedures *Principles of person-centered planning and service delivery	01500		

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01500	Continued From page 13 ULP-B ULP-B was hired on February 10, 2020. ULP-B's employee record lacked evidence of up-to-date annual training to include: *Reporting of maltreatment of vulnerable adults under section 626.557 *Review of the assisted living (AL) bill of rights (BOR) *Review of infection control techniques *Effective approaches to use to problem solve when working with a resident's challenging behaviors *Review of the facility's policies and procedures *Principles of person-centered planning and service delivery ULP-G ULP-G was hired on September 18, 2019. ULP-G's employee record lacked evidence of up-to-date annual training to include: *Reporting of maltreatment of vulnerable adults under section 626.557 *Review of the assisted living (AL) bill of rights (BOR) *Review of infection control techniques *Effective approaches to use to problem solve when working with a resident's challenging behaviors *Review of the facility's policies and procedures *Principles of person-centered planning and service delivery ULP-H ULP-H was hired on September 29, 2021. ULP-H's training record indicated on March 30,	01500		

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01500	Continued From page 14 2020, ULP-H completed training on reporting of maltreatment of vulnerable adults under section 626.557. ULP-H's employee record lacked evidence of an annual up-to-date vulnerable adult training. On April 20, 2022, at 1:50 p.m., executive director (ED)-C stated she would provide employee's up-to-date-training. On April 21, 2022, at 10:40 a.m., a policy on staff training was requested but not provided. On April 22, 2022, at 11:30 a.m., RN-E stated she was in charge of staff training. TIME PERIOD TO CORRECT: Twenty-one (21) days.	01500		
01640 SS=G	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan.	01640		

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01640	Continued From page 15 (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a resident's service plan included all the services to be provided as indicated in their record for one of one resident (R1) with record 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: R1's medical record was reviewed. R1 admitted to the licensee on August 11, 2021. R1's diagnoses included, but were not limited to unspecified psychosis, alcohol abuse, cocaine abuse, and transsexualism. R1 walked independently. R1's service plan dated August 11, 2021, indicated R1 received assistance with medication management, meals, housekeeping, laundry, behaviors, personal cares, vision and hearing, scheduling, and attending appointments. R1's	01640		

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01640	Continued From page 16 service plan indicated R1 was not allowed to be alone in the community due to mental health symptoms and cognitive ability. R1's service plan indicated R1 had a history of elopement to obtain alcohol and drugs. Staff were to follow R1's behavioral plan. R1's individual abuse prevention plan (IAPP) dated August 11, 2021, indicated R1 received one to two staff ratio and did not have alone time in the facility or community. Staff were to follow R1's behavioral plan R1's behavioral plan dated August 11, 2021, indicated R1 required staff monitoring and supervision 24 hours per day during awake and asleep hours, and increased monitoring during behaviors. R1's service plan lacked a service to provide 24/7 supervision and monitoring, along with frequency and instruction on how to perform the service of supervision and monitoring. R1's initial registered nurse (RN) assessment dated August 11, 2021, indicated R1 had a history of attempted suicide, self-injurious behavior, and drug overdoses. R1's incident reports dated August 14, 2021, through January 24, 2022, indicated R1 had the following incidents: *On August 14, 2021, at 11:00 a.m.: R1 left the facility, drank alcohol, and smoked marijuana with an unlicensed personnel (ULP). *On September 2, 2021, at 1:00 p.m.: R1 stole six bubble packs of his medication cards from medication cabinet. R1 was transferred to local	01640		

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01640	Continued From page 17 hospital for evaluation. *On September 8, 2021. (Unknown time): R1 broke into medication cart and stole one of his medication cards. *On September 17, 2021 (Unknown time): R1 cut the screen on his window and left the facility. During a search of R1's room, staff found two weeks of bubble pack medication cards in R1's room. R1 returned to the facility and was transferred to a local hospital for evaluation. *On November 8, 2021, at 8:15 a.m.: R1 broke into medication cart and stole a weeks' worth of his medications. Program manager (PM)-D observed R1 had slurred speech, glossy eyes, difficulty walking, and standing upright. R1 was brought to a local hospital and admitted for observation. *On January 23, 2022, at 12:00 p.m.: R1 went missing from the facility. *On January 24, 2022, at 11:40 a.m., R1 was located at an emergency department after he checked himself in due to experiencing shortness of breath. R1 was transferred from the emergency department to the hospital psychiatric ward for further evaluation. R1's record lacked documentation R1 received the 24/7 supervision and monitoring as indicated in their record. On April 22, 2022, at 11:30 a.m., RN-E stated R1 used to require 1:1 supervision but stated that changed to 1:2 staff to resident ratio, stating, "we just needed to make sure he always had a staff supervising R1." RN-E sated staff checked on R1	01640		

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01640	Continued From page 18 hourly, stating "my understandng was he needed to be watched at all times." The licensee policy titled, Service Plan, dated August 1, 2021, indicated service plans were the written plan between a resident or resident's designated representative and the licensee about the services provided to the resident. The service plan would include: (a) description of services provided based on the most recent assessement and resident preferences; (b) fees for services provided; (c) frequency of each service to be provided based on the most recent assessment and resident preferences; (d) identification of staff or categories of staff who would be providing services; (e) schedule and method for the next planned assessment or monitoring; (f) schedule and method for the next planned monitoring of staff who provided the services; (g) contingency plan that included: (i) actions the licensee would take if scheduled services could not be provided; (ii) information regarding how the resident would contact the licensee; (iii) names and contact information the resident wished to have notified in an emergency; (iv) identification and contact information of who the resident authorized to sign in the event of an emergency; TIME PERIOD TO CORRECT; Seven (7) days.	01640		
02070 SS=I	144G.81 Subd. 4 Awake staff requirement An assisted living facility with dementia care providing services in a secured dementia care unit must have an awake person who is physically present in the secured dementia care unit 24 hours per day, seven days per week, who is responsible for responding to the requests of	02070		

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02070	Continued From page 19 residents for assistance with health and safety needs, and who meets the requirements of section 144G.41, subdivision 1, clause (12). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure they had an awake staff person 24 hours per day seven days per week, who was responsible for responding to the requests of residents for assistance with health and safety needs. This affected all three residents. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings Include: On February 24, 2022, at 10:00 a.m., the state surveyor entered the facility. On February 24, 2022, at 10:30 a.m., unlicensed personnel (ULP)-B stated the facility had the following shifts: 7:00 a.m. to 3:00 p.m., 3:00 p.m. to 11:00 p.m., and 11:00 p.m. to 7:00 a.m. ULP-B stated, "we also have a 48 hour weekend shift that starts Friday night 11:00 p.m., and ends on Sunday night 11:00 p.m." ULP-B stated one staff person worked the 48 hour weekend shift. ULP-B stated the ULP who worked the 48 hour shift slept during the night on the living room sofa. The surveyor asked ULP-B how could the residents	02070		

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02070	Continued From page 20 be watched if staff were sleeping. ULP-B stated, "I'm a light sleeper" and would hear R1 wake up to go outside. ULP-B stated the facility was short staffed since the beginning of the pandemic. ULP-B stated the facility had a lot of turnover in the past few months. On February 24, 2022, at 11:03 a.m., executive director (ED)-C stated, "staffing is horrible." ED-C stated sometimes two staff are scheduled during the weekend, but it does not always work out. ED-C stated the other weekend shift was from 7:00 a.m. until 11:00 p.m. ED-C stated, but that was the shift that they do not always have covered. On February 24, 2022, at 11:10 a.m., the Minnesota Department of Health (MDH) issued an immediate correction order to the licensee due to licensee for failing to have awake staff 24 hours per day, seven days per week. TIME PERIOD TO CORRECT: IMMEDIATE Based on interview and record review, the licensee failed to ensure they had an awake staff person 24 hours per day seven days per week, who was responsible for responding to the requests of residents for assistance with health and safety needs. This affected all three residents. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems	02070		

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02070	Continued From page 21 are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings Include: On February 24, 2022, at 1:25 p.m., a written plan of correction (POC), was handed to the state surveyor. ED-C stated an updated staffing schedule showing additional staff and shifts would be emailed to the state investigator by the end of February 24, 2022. The licensee POC indicated the licensee would ensure 24-hour awake overnight staff would be provided seven days per week, starting February 22, 2022. On February 24, 2022, at 1:25 p.m., the immediacy of the correction order was lifted, the order remains issued at level I scope/serverity level for long-term development of the staffing plan to ensure awake staff. On February 24, 2022, at 5:22 p.m., ED-C emailed the updated POC staffing schedule to the state surveyor. The licensee policy titled, Staffing and Scheduling, dated August 1, 2021, indicated The clinical nurse supervisor would develop and implement a written staffing plan that provided an adequate number of qualified direct care staff to meet the resident's needs 24-hours per day, seven days per week. TIME PERIOD OF CORRECTION: 21 days	02070		

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02360	Continued From page 22	02360		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: Based on interviews, and document review, the facility failed to ensure one resident reviewed (R1) was free from maltreatment. R1 was neglected. Findings include: On May 20, 2022, the Minnesota Department of Health (MDH) issued a determination that neglect and abuse occurred, and that the facility was responsible for the maltreatment, in connection with incident which occurred at the facility. MDH concluded there was a preponderance of evidence that maltreatment occurred.	02360		
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 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	03000		

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03000	Continued From page 23 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 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 a resident's	03000		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
03000	Continued From page 24 stealing and ingesting medications to the Minnesota Adult Abuse Reporting Center (MAARC) within 24 hours for one of one resident (R1) with record reviewed. While staff slept, R1 ingested an unknown number of his medications that he stole from the medication cart and closet. The resident required hospitalization. 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). Findings Include: R1's medical record was reviewed. R1 admitted to the licensee on August 11, 2021. R1's diagnoses included unspecified psychosis, alcohol abuse, cocaine abuse. R1 walked independently. R1's service plan dated August 11, 2021, indicated R1 required assistance with medication management, meals, housekeeping, laundry, personal cares, behaviors, scheduling and attending appointments, and protection from potential health and safety risks due to his mental health diagnoses. R1 had a history of elopement to obtain alcohol and drugs. R1's behavioral plan dated August 11, 2021, indicated R1 required staff monitoring and supervision 24 hours per day during awake and asleep hours, and increased monitoring during behaviors.	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34328	A. BUILDING: _____ B. WING _____	C 02/24/2022

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03000	Continued From page 25 R1's medication assessment dated August 11, 2021, indicated R1 received medication management services. R1's medications were to be administered by staff. R1 had a history of misusing medications and drug diversion. R1's medication assessment indicated his medications were stored in a locked closet inside his room only staff had access to. R1's incident report dated November 9, 2021, indicated on November 8, 2021, at 8:15 a.m., program manager (PM)-D observed R1 had slurred speech, glossy eyes, and had difficulty standing and walking. Unlicensed personnel (ULP)-G searched R1's room and discovered a Ziploc bag containing 55 pills prescribed to R1. Inside the medication cart, PM-D noticed four of R1's bubble pack medication cards were missing. The medication cards contained 140 pills. R1 admitted at a hospital. The licensee reviewed video footage. The licensee video footage indicated on November 8, 2021, at 4:40 p.m., R1 walked into the dining room and covered a camera with a wet paper towel while ULP-H slept on the sofa. At 6:05 a.m., R1 attempted to break into a medication closet using a butter knife. At 6:21 a.m., R1 tampered with the locked medication cart. At 7:19 a.m., ULP-H woke up and administered R1's 8:00 a.m. medications. At 9:11 a.m., R1 opened the medication cart with a butter knife and stole one of his medication cards while ULP-H was outside of the building. R1's record indicated the Ziploc bag contained 55 of R1's medications: (17) anticonvulsant, (24) antiseizure, (7) antipsychotic pills (2) antidepressant pills, and (5) antispasmodic pills. R1's four bubble pack medication cards were	03000		

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03000	Continued From page 26 missing 140 of his morning and nighttime medications: (14) antipsychotics pills, (35) antiseizure pills, (28) anticonvulsants, (56) antispasmodics, and (7) antidepressants. R1's record indicated between the pills retrieved from the Ziploc bag and the missing pills from the medication bubble cards, 85 pills were unaccounted for. On November 9, 2021, at 8:30 a.m., R1 was discharged back to the licensee. The licensee installed a deadbolt lock on the medication closet after R1 returned from the hospital. The incident report indicated R1's care team would be notified within 24 hours upon knowledge of the incident. On November 10, 2021, at 8:56 a.m., the licensee filed an online .MAARC report, two days after the incident. On November 10, 2021, at 9:00 a.m., R1's care team were notified. On February 24, 2022, at 12:40 p.m., R1 stated she was hospitalized many times due to stealing her medications. The licensee policy titled Vulnerable Adult Maltreatment-Prevention and Reporting, updated August 1, 2021, indicated staff were trained on identifying and reporting suspected maltreatment of vulnerable adults. MAARC reports must be made no later than 24 hours after the maltreatment was first suspected. TIME PERIOD TO CORRECT: Seven (7) days.	03000		