

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL34426001M
Compliance #: HL34426002C

Date Concluded: July 12, 2022

Name, Address, and County of Facility

Investigated:

Elk Ridges Alzheimer's Specialty
1700 Beam Ave.
Maplewood, MN 55109
Ramsey County

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

Evaluator's Name: Lori Pokela, R.N.
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:

It is alleged neglect occurred when the facility failed to implement adequate interventions to protect two residents who were engaging in sexual activity.

Investigative Findings and Conclusion:

Neglect was substantiated. The facility was responsible for the neglect. Neither residents' individual abuse prevention plans (IAPP) were updated with adequate interventions after the continuation of sexual behaviors were documented and observed by family and facility staff. As a result, nonconsensual sexual contact continued to occur between the residents.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, family members and unlicensed staff. In addition, the investigator contacted law

enforcement. The investigation included review of medical records, incident reports, training records, relevant policies, and procedures.

The first resident (R1) had a history of dementia, depression, and anxiety. The resident's IAPP indicated the resident was not able to identify potentially dangerous situations, and had anxiousness, agitation, and decreased community orientation skills. The document indicated R1 did not appear to have any risk of maltreatment requiring interventions. This same document indicated staff would monitor and report signs and symptoms of maltreatment, as R1 was susceptible to abuse. This same document also indicated R1 would have tearful episodes and a desire to go home. R1's IAPP also indicated her husband was not able to visit due to being in another assisted living facility with a diagnosis of cancer.

The second resident (R2) had a history of dementia and was admitted to the facility after living independently at home. R2's IAPP indicated R2 had a cognitive decline, failure to thrive, and depression. This same document also indicated R2 did not have family or friends involved in his care and was at risk for abusing other residents.

R1 and R2 were found on two occasions (incident 1 and incident 2) in R2's room on R2's bed.

In the first incident, R1 was found, by a staff member, in R2's bed, with some of her clothing off. R2 was with her, and he was fully clothed. R1 and R2 were engaging in sexual activity. After being found, staff assisted R1 to get dressed and separated both residents by bringing them to the community area. R1's nurses' notes after the first incident, indicated R1 stated she was "ok" after the incident but had a nonsensical story when interviewed by a staff.

A facility incident report completed after the first incident, indicated after R1 and R2 were separated, staff relocated R2's room in a closer location to the nurse's station, and locked R1 and R2's room door while both were in community areas.

A police record of the first incident indicated R1 denied any physical harm or aggression occurred and had no recall of the incident thirty minutes after the incident had occurred.

R1's nurse's notes indicated R1's nurse practitioner (NP) reviewed R1's medications after the first incident and ordered a new medication to assist with R1's behaviors.

R2's medication administration record (MAR) during the month after the first incident indicated R2 refused over three-quarters of prescribed medications for agitation and sleep. R2's as needed medication was not documented as administered during this same time period.

R2's nurse's notes indicated that R2's NP was updated regarding the first incident. The NP gave orders to continue to monitor and redirect R2, to prevent him from touching female residents.

R2's nurse's notes indicated, on several occasions, staff had to redirect R2 from touching female residents, including separating R2 from R1 before the second incident occurred.

During the second incident, R1 was again found on R2's bed, this time she was fully dressed with R2's hand on top of her shirt, placed on her abdomen area. The residents were again separated.

R1's nurse's notes indicated R1 was found in R2's room with R2, for a second time. Both residents were fully clothed. After R1 and R2 were found, the residents were separated and the resident's family and guardian were updated regarding this additional incident.

After the second incident, an unlicensed direct care staff member wrote a note to management staff which indicated while R1 was observed to be upset; R1 stated she did not want R2 to touch her anymore but did not want to hurt his feelings.

During an interview, a staff member stated R2 would bring R1 into his room. The staff member stated that when R2 was asked regarding the incidences, R2 denied he had touched anyone and became very agitated, yelling at staff. This staff member stated she reported the incident to her supervisor the next day.

During an interview, another staff member stated she had observed R2 continuing to inappropriately touch R1 after both incidences. She stated R2 would lure R1 out of staff vision and touch her breasts and attempt to stick his hands down her pants.

During an interview, a facility management staff stated she felt R1 and R2 were not together as much because of R1's wandering, exit seeking, and anxiety all of which had become much worse. Management staff stated she understood R1's family wanted the residents separated. Management staff also stated R2 and his guardian had been actively looking for a more independent living situation.

During an interview, R1's family member stated staff had reported to her several of the same type of incidences between R1 and R2 since the initial incident. She stated R1 had cognitive issues and was not oriented to date and time, thus, she thought R1 could not consent to sexual activity with R2. The family member stated she called law enforcement after the first incident. She decided not to send R1 to the emergency department after the first incident because was reported by staff that there was no physical contact was made between the residents. The facility staff said they would be monitoring the situation between the residents. The family member stated there was a lack of follow-up after this, including no care conference offered.

During an interview, another family member of R1 stated while visiting after the first incident, R1 repeatedly stated that she (R1), was sorry for being a bad girl and that she (R1) would be a good girl if she could go home.

During an interview, R2's representative stated the facility had not made her aware that the incidents were continuing. R2's representative stated at the time of the first incident, there seemed to be a lack of follow-up.

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:

Resident 1: No. Family Member stated "no" as the resident had impaired cognition and might it be upsetting to R1.

Resident 2: No. Guardian stated "no" and feels it may exacerbate R2's behaviors.

Family/Responsible Party interviewed: Yes, for both Resident 1 and Resident 2.

Alleged Perpetrator interviewed: Yes.

Action taken by facility:

The facility completed facility incident reports for both incidences. The facility had interventions in place and notified both resident's providers for the first incident.

Action taken by the Minnesota Department of Health:

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

<https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html>, or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

cc: The Office of Ombudsman for Long-Term Care

The Office of Ombudsman for Mental Health and Developmental Disabilities
Ramsey County Attorney's Office
Maplewood City Attorney's Office
Maplewood Police Department
Maplewood Public Safety

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34426	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/13/2022
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NAME OF PROVIDER OR SUPPLIER ELK RIDGE ALZHEIMER'S SPECIAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1700 BEAM AVENUE MAPLEWOOD, MN 55109
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0 000	<p>Initial Comments</p> <p>Initial comments *****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, the Minnesota Department of Health issued a correction order(s) pursuant to a survey.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p>#HL34426002C/#HL34426001M, #HL34426004C/#HL34426003M, and #HL34426006C/#HL34426005M</p> <p>On April 13, 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 41 residents receiving services under the assisted living facility with dementia care license.</p> <p>The following correction orders are issued for #HL34426002C/#HL34426001M, #HL34426004C/#HL34426003M, and #HL34426006C/#HL34426005M, tag identification: 0630, 1620, 1640, and 1890.</p> <p>The following correction order is issued for</p>	0 000	<p>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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>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.</p>	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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0 000	Continued From page 1 HL34426001M, tag identification: 2360.	0 000		
0 630 SS=H	<p>144G.42 Subd. 6 (b) Compliance with requirements for reporting ma</p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individualized abuse prevention plan (IAPP) was updated for three of six residents (R1, R2, and R3) reviewed. After R1 and R2 engaged in sexual activity while in R2's room, the licensee failed to update either residents' IAPP to address that issue. As a result, R1 continued to experience non-consensual sexual contact. In addition, R3's family reported injuries of unknown origin on R3, and R3's IAPP was not updated to reflect this issue.</p> <p>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more</p>	0 630		

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0 630	<p>Continued From page 2</p> <p>than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).</p> <p>The findings include:</p> <p>R1 R1's medical record was reviewed. R1 was admitted to the licensee on September 24, 2021, with diagnoses of dementia, depression, and anxiety.</p> <p>R1's nursing assessment, dated September 24, 2021, indicated R1 ambulated independently and occasionally used a walker for assistance. This same document indicated R1 was an elopement risk and had a history of anxiety, tearful episodes, wandering, and wanting to go home. R1's husband resided in an assisted living and was unable to visit R1 due to a diagnosis of cancer.</p> <p>R1's IAPP, dated September 24, 2021, indicated R1 was not able to identify potentially dangerous situations, and had anxiousness, agitation, and wanting to go home along with decreased community orientation skills. The document indicated R1 did not appear to have any risk of maltreatment requiring interventions. This same document indicated staff would monitor for signs and symptoms of abuse/neglect and report promptly. R1 was susceptible to abuse from another individual, including other vulnerable adults.</p> <p>R1's nurse's notes, dated December 1, 2021, indicated R1 was found disrobed in R2's bed. The nurse's note indicated R1 stated she was "ok" and had a nonsensical story regarding the incident.</p>	0 630		

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0 630	<p>Continued From page 3</p> <p>R1's medication administration record (MAR) for the month of December 2021, indicated the following medications were ordered to be administered:</p> <ul style="list-style-type: none"> - Depakote 125 milligrams (mg), take two capsules by mouth (po) three times daily (TID) for agitation: eighty-nine doses out of ninety-three were administered, two times the medication was spit out and two times the medication was refused. - Nuedexta 20-10 mg capsule, take one capsule, (po) two times per day (BID), for behaviors associated with dementia. Fourteen doses out of forty-eight were administered and missed doses were documented as medication was unavailable. - Quetiapine 200mg tablet, po, at bedtime for agitation. - Quetiapine 25mg tablet, po, morning and afternoon for agitation. - Sertraline 100mg tablet, take two tablets po, daily for depression. <p>A licensee report, dated January 4, 2022, completed by LALD-A, indicated the weekend of January 1, 2022 to January 2, 2022, the nurse found R2 engaging in sexual activity with R1 in R2's room. This same report indicated the residents were separated and that there had been previous interventions to relocate R2's room to be farther away from R1 and to lock R1 and R2's room doors when they were not in their rooms.</p> <p>R1's nurse's notes, dated January 6, 2022, late entry by LALD-A, indicated R1 was found in R2's bed engaged in sexual activity but was fully clothed.</p> <p>R1's nurse's notes, dated January 17, 2022,</p>	0 630		

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0 630	<p>Continued From page 4</p> <p>indicated R1 was found on R2's bed with her head on a pillow and R2 was touching her abdomen with his hand on top of her shirt. This same document indicated both R1 and R2 had clothing on during the incident, and then after the incident, staff members locked R2's room door when R1 and R2 were in the community area.</p> <p>A licensee (untitled) document, dated January 17, 2022, written by an unlicensed personnel (ULP)-F, indicated ULP-F observed R1 was upset, and R1 said she wanted R2 to stop touching her, but did not want to hurt his feelings.</p> <p>After these incidents, R1's IAPP was not updated to reflect specific interventions to minimize her risk for being abused.</p> <p>During an interview on April 13, 2022 at 2:02 p.m., ULP-D stated inappropriate touching of R1 by R2 continued after the incidents described above. ULP-D stated R2 will get R1 out of staff vision and touch her breasts and attempt to stick his hands in her pants. ULP-D stated these attempts to inappropriately touch R1 continued to be observed by ULP-D even after the interventions of locking the doors were implemented.</p> <p>During an interview on April 20, 2022 at 10:03 a.m., R1's family member (FM)-L stated there had been several of the same incidences between R1 and R2 since the initial incident, per licensee. FM-L stated when she had visited R1, FM-L observed R2 would not take his eyes off of R1.</p> <p>During an interview on April 22, 2022 at 12:05 p.m., R1's family member (FM)-M stated sexual activity continued between R1 and R2. FM-M</p>	0 630		

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0 630	<p>Continued From page 5</p> <p>stated ULP-D updated FM-M when R2 had been near R1. FM-M stated one week after one of the incidences, FM-M noted R1 grabbing her peri-area multiple times; FM-M informed nursing, who ordered a urinalysis (UA). FM-M did not remember the results of the UA. FM-M stated after the first incident between R1 and R2, R1 repeatedly mentioned being sorry for being a "bad girl" and wanting to go home.</p> <p>R2 R2's medical records were reviewed. R2 was admitted to the licensee on November 16, 2021 with the diagnoses of: dementia, diabetes mellitus and chronic kidney disease (CKD).</p> <p>R2's MAR for the month of December 2021, indicated the following medications were ordered to be administered: - Divalproex 125mg, take one tablet, po, every evening for agitation. Twenty-nine doses out of thirty-one were refused by R2. - Melatonin three mg tablet, take two tablets, po, at bedtime for insomnia. Thirty doses out of thirty-one were refused by R2. - Olanzapine five mg tablet, take one tablet, po, every four hours as needed (PRN), for agitation. None of this medication was documented as being given for the month of December 2021.</p> <p>R2's nursing notes, dated December 1, 2021, indicated R2, who was fully clothed, was found in bed with R1, who was not fully clothed, in R2's bed. R2 later denied the incident. Staff intervention was to relocate R2's room closer to the licensee nursing station for closer supervision and request an antianxiety medication from the primary care provider (PCP).</p>	0 630		

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0 630	<p>Continued From page 6</p> <p>R2's nurse's notes, dated December 6, 2021, indicated a follow-up visit with R2 was conducted by the nurse. During this visit, R2 and the nurse had a discussion regarding appropriate touch. In response, R2 denied touching other residents and called the staff members crazy. The nurse's notes for this date also indicated R2 refused medications and when receiving frequent reminders to not touch female residents, had become verbally aggressive. The PCP was updated of these behaviors.</p> <p>R2's nurse's notes, dated December 7, 2021, indicated R2 refused medications and needed further reminding to keep his hands off female residents. This same document indicated R2 had encouraged a female resident to a location away from staff.</p> <p>R2's nurse's notes, dated December 8, 2021, indicated R2's nurse practitioner had seen R2 and discontinued an order for Flomax and gave orders to continue to monitor and redirect R2 from touching female residents.</p> <p>R2's nurse's notes, dated December 11, 2021, indicated R2 had been reminded multiple times to keep his hands off female residents. This same note indicated the nurse had to separate R2 from R1 several times before R1 was found with R2 in R2's room on R2's bed.</p> <p>R2's nurse's notes, dated December 17, 2021, indicated R2 needed several reminders to keep his hands off of female residents and argued with staff when he stated he was not touching the female residents. This same document indicated R2 was found in his room with R1, laying on his bed. R2's had his hand on R1's abdomen, on top of her shirt. Both R2 and R1 were fully clothed</p>	0 630		

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0 630	<p>Continued From page 7</p> <p>during the incident, and both were removed from R2's room and R2's door was locked until R1 went to bed.</p> <p>R2's nursing assessment and IAPP for 2021 were not provided. An email provided by LALD-A on May 5, 2022, indicated the updated nursing assessment and IAPP was updated between January 14, 2022 and February 28, 2022 but the items were missing now.</p> <p>R3 R3's medical records were reviewed. R3 was admitted to the licensee on November 4, 2021, with the diagnoses of: Alzheimer's Disease, diabetes mellitus and syncope.</p> <p>R3's IAPP, dated November 4, 2021, indicated R3 to have a history of agitation, moderate fall risk, needing assistance of a caregiver for ADL's and medications.</p> <p>R3's family member (FM)-H, provided a time line which indicated on November 23, [2021], R3 woke up with a black eye. This document indicated on December 12, [2021], family was not notified of R3 having had three wounds on his forehead with scabs. This same document indicated R3 subsequently had a twelve by twelve dark bruise on R3's right side. This document indicated on December 27, [2021], R3's sons visited and observed R3 to be non-responsive while on isolation for COVID-19.</p> <p>R3's IAPP was not updated to reflect change in condition or interventions. R3's nurse's notes were not provided.</p> <p>During an interview on April 22, 2022 at 9:16</p>	0 630		

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0 630	<p>Continued From page 8</p> <p>a.m., FM-H stated R3 had decreased cognition which was the reason for admission to a memory care unit. FM-H stated she would place calls to licensee regarding concerns and not receive any return calls.</p> <p>Admissions and Move-in Policy provided by the licensee, dated September 26, 2021, indicated residents are evaluated on an on-going basis, including:</p> <ol style="list-style-type: none"> 1. Daily evaluations 2. One-month evaluations <p>A job description titled: Clinical Services Director, provided by the licensee and dated: September 26, 2021, indicated this position is responsible for all aspects of initial and ongoing assessments regarding resident care. This document also indicated work duties as listed under point # six: develops and maintains care plans and service plans for each resident updating as diagnosis and condition changes.</p> <p>TIME PERIOD TO CORRECT: Seven (7) days.</p>	0 630		
01620 SS=E	<p>144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring</p> <p>(c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment.</p> <p>(d) For residents only receiving assisted living services specified in section 144G.08, subdivision</p>	01620		

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NAME OF PROVIDER OR SUPPLIER ELK RIDGE ALZHEIMER'S SPECIAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1700 BEAM AVENUE MAPLEWOOD, MN 55109
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01620	<p>Continued From page 9</p> <p>9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review.</p> <p>(e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted required nursing assessments or reassessments for five out of six of residents (R1, R2, R3, R4, and R5) reviewed. The assessments were completed late and copies were not available when requested by the investigator.</p> <p>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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).</p> <p>Findings Include:</p> <p>R1 R1's medical record was reviewed. R1 was</p>	01620		
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01620	<p>Continued From page 10</p> <p>admitted to the licensee on September 24, 2021 with the diagnoses of: dementia, depression, and anxiety.</p> <p>R1's nursing assessment, dated September 24, 2021, indicated R1 ambulated independently and occasionally used a walker for assistance. This same document indicated R1 was an elopement risk, and had a history of anxiety, tearful episodes, wandering, and wanting to go home.</p> <p>R1's subsequent nursing assessments, due 14 days after admission and 90 days after admission, were not provided.</p> <p>R2 R2's medical records were reviewed. R2 was admitted to the licensee on November 16, 2021 with the diagnoses of: dementia, diabetes mellitus and chronic kidney disease (CKD).</p> <p>R2's nursing assessment, dated February 9, 2022, indicated the resident was occasionally incontinent, needed assist of one staff for activities of daily living (ADLs), was verbally aggressive, had wandering, had angry outbursts, and had incidents of inappropriate sexual behaviors.</p> <p>R2's nurse's notes, dated February 22, 2022, indicated R2's 14-day assessment was completed.</p> <p>An email provided by LALD-A on May 5, 2022, indicated an updated nursing assessment was completed between January 14, 2022 and February 28, 2022, but the items were missing now. R2's 14-day nursing assessment was also not provided.</p>	01620		

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01620	<p>Continued From page 11</p> <p>R3 R3's medical records were reviewed. R3 was admitted to the licensee on November 4, 2021, with the diagnoses of: Alzheimer's disease, diabetes mellitus and syncope.</p> <p>R3's nursing assessment, dated November 4, 2021, indicated R3 had periods of confusion, needed staff assistance with ADLs and was a moderate fall risk.</p> <p>R3's hospice medical records indicated R3 was admitted to a hospice program on December 15, 2021 with diagnoses of Alzheimer's Disease. These same documents indicated R3's aspirin was discontinued due to bruising on R3's right arm and flank area. R3's hospice medical records indicated on December 27, 2021, R3 was having a hard time swallowing. On December 30, 2021, R3's hospice medical records indicated R3 had declining status.</p> <p>The licensee did not provide R3's nurses notes or any change in condition assessment following the December 2021 changes in resident needs.</p> <p>R4 R4's medical record was reviewed. R4 was admitted on March 15, 2021 with the diagnoses of: Alzheimer's disease, diabetes mellitus and chronic venous hypertension.</p> <p>R4's nursing assessment, dated February 17, 2022, indicated R4 needed assistance of one staff for dressing, grooming, bathing, toileting, and oral care. This same documents was updated on March 1, 2022 and indicated no</p>	01620		

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01620	<p>Continued From page 12</p> <p>changes or updates.</p> <p>R4's 90-day nursing assessments for the period from March 2021 to February 2022 were requested and not provided.</p> <p>R5 R5's medical records reviewed. R5 was admitted on March 15, 2021 with the diagnoses of: Alzheimer's disease, aphasia, and insomnia.</p> <p>R5's nurses notes, dated December 03, 2021, indicated R5 was re-admitted to hospice.</p> <p>R5's nurse's notes, dated December 03, 2021, indicated R5 had a fall on November 19, 2021, and was sent to the hospital related to a right hip surgery.</p> <p>R5's nursing assessment, dated February 18, 2022, indicated R5 needed assistance of one staff with ambulating, a fall risk and uses a Broda Chair.</p> <p>R5's initial and previous 90-day nursing assessments, from March 2021 to February 2022, were not provided.</p> <p>Admissions and Move-in Policy provided by the licensee, dated September 26, 2021, indicated residents are evaluated on an on-going basis, including:</p> <ol style="list-style-type: none"> 1. Daily evaluations 2. One-month evaluations <p>A job description titled: Clinical Services Director, provided by the licensee and dated: September 26, 2021, indicated this position is responsible for</p>	01620		

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01620	Continued From page 13 all aspects of initial and ongoing assessments regarding resident care. This document also indicated work duties as listed under point # six: develops and maintains care plans and service plans for each resident updating as diagnosis and condition changes. TIME PERIOD TO CORRECT: Seven (7) days.	01620		
01640 SS=E	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. (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:	01640		

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01640	<p>Continued From page 14</p> <p>Based on interview and record review, the licensee failed to develop and implement a service plan for five of six residents (R1, R2, R3, R4, and R5) reviewed. For all five residents, the facility failed to obtain a signature or other authentication of agreement on the services to be provided.</p> <p>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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).</p> <p>Findings Include:</p> <p>R1 R1's medical record was reviewed. R1 was admitted to the licensee on September 24, 2021, with the diagnoses of dementia, depression, and anxiety.</p> <p>R1's nursing assessment, dated September 24, 2021, her admission date, indicated R1 ambulated independently, occasionally used a walker for assistance, and required assistance of one staff with activities of daily living (ADLs). This same document indicated R1 was an elopement risk, and had a history of anxiety, tearful episodes, wandering, and wanting to go home.</p> <p>R1's service plan, dated February 22, 2022, indicated R1 received assistance of one staff for ADLs, medication management, laundry and meals. This document was not signed by R1's family or power of attorney (POA) but indicated a</p>	01640		
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01640	<p>Continued From page 15</p> <p>note that the service plan was emailed on February 25, 2022.</p> <p>R1's nurse's notes, dated February 22, 2022, indicated R1's service plan was completed, and licensee staff would follow up with service plan signatures.</p> <p>R2 R2's medical records were reviewed. R2's diagnoses included dementia, diabetes mellitus, and chronic kidney disease (CKD).</p> <p>R2's nursing assessment, dated February 22, 2022, indicated the resident was occasionally incontinent, needed assist of one staff for ADLs, had incidents of being verbally aggressive, had wandering, and had incidents of inappropriate sexual behaviors.</p> <p>R2's service plan, dated February 9, 2022, indicated R2 received assistance of one staff member for behavior monitoring, medication management, laundry, and reminders from staff for ADLs. This document was not signed by R2's guardian but indicated it was emailed to R2's guardian on February 22, 2022.</p> <p>R2's nurse's notes, dated February 22, 2022, indicated licensee staff would follow-up with service plan and signatures.</p> <p>An email provided by LALD-A on May 5, 2022, indicated a lot of R2's documents were missing, and the updated nursing assessment was updated between January 14, 2022 and February 28, 2022.</p>	01640		

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01640	<p>Continued From page 16</p> <p>R3 R3's medical records were reviewed. R3 was admitted to the licensee on November 4, 2021, with diagnoses of Alzheimer's disease, diabetes mellitus and syncope.</p> <p>R3's nursing assessment, dated November 4, 2021, indicated R3 had periods of confusion, needed staff assistance with ADLs, and was a moderate fall risk.</p> <p>R3's service plan, dated November 9, 2021, indicated R3 received assistance of one staff for ADLs, medication management, transfer, laundry, and meals. This same document was not signed by a responsible party for the resident or by the licensee.</p> <p>R4 R4's medical record was reviewed. R4 was admitted on March 15, 2021 with diagnoses of Alzheimer's disease, diabetes mellitus and chronic venous hypertension.</p> <p>R4's service plan, dated January 25, 2022, indicated R4 received assistance with ADLs, medication management, meals and laundry. This same document was not signed by responsible party.</p> <p>R4's nurse's notes, dated February 22, 2022, indicated the licensee would follow-up with service plan signatures.</p> <p>R4's nurse's notes, dated February 25, 2022, indicated LALD-A emailed R4's family requesting service plan signatures.</p>	01640		

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01640	<p>Continued From page 17</p> <p>R5 R5's medical records reviewed. R5 was admitted on March 15, 2021, with the diagnoses of: Alzheimer's disease, aphasia, and insomnia.</p> <p>R5's service plan, dated January 25, 2022, indicated R5 received assistance with ADLs, medication management, meals and laundry. This same document was not signed by R5's responsible party.</p> <p>R5's nurse's notes, dated February 22, 2022, indicated staff would follow-up with service plan signatures.</p> <p>R5's nurse's notes, dated February 25, 2022, indicated the LALD emailed R5's family for service plan signatures.</p> <p>A licensee provided job description for: Clinical Services Director, dated September 26, 2021, indicated the clinical services director would develop and maintain service plans for each resident, updating as diagnosis and condition changes.</p> <p>TIME PERIOD TO CORRECT: Seven (7) days.</p>	01640		
01890 SS=D	<p>144G.71 Subd. 20 Prescription drugs</p> <p>A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug.</p>	01890		

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01890	<p>Continued From page 18</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were labeled correctly for one of six residents (R6) with records reviewed.</p> <p>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).</p> <p>Findings include:</p> <p>On April 13, 2022 at 11:39 a.m., the investigator observed unlicensed personnel (ULP)-Q apply Diclofenac Sodium gel to R6. The medication did not have an indicated open date on the prescription label.</p> <p>R6's medical records were reviewed. R6 was admitted on January 11, 2022 with the diagnoses of Creutzfeldt-Jacob Disease, Attention Deficit Hyperactivity Disorder (ADHD), and constipation.</p> <p>R6's medication administration record (MAR), dated April 2022, included Diclofenac Sodium 1% gel, apply four grams topically four times daily.</p> <p>Manufacturer's instructions for Diclofenac Sodium gel, indicated the consumer should properly discard the medication when it is expired.</p> <p>A licensee provided Medication Management</p>	01890		

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01890	Continued From page 19 Policy, dated September 26, 2021, which did not indicate topical medication opening dates. TIME PERIOD TO CORRECT: Seven (7) days.	01890		
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 two of two residents reviewed (R1 and R2) were free from maltreatment. R1 and R2 were neglected. Findings include: On May 26, 2022, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	