Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL34426005M
Compliance #: HL34426006C

Date Concluded: July 15, 2022

Name, Address, and County of Licensee 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.

Initial Investigation Allegation(s):
Allegation 1. The alleged perpetrator neglected a resident when the resident (R4) had multiple bruises on her face and arms.
Allegation 2. The alleged perpetrator neglected a resident when the resident (R6) had eloped from the memory care unit.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated in relation to the first allegation. The facility was responsible for the maltreatment. The resident had several physical altercations with other residents, and the facility did not conduct a timely follow-up with resident's physician regarding the resident's increase in agitation and aggression. The facility did not attempt new interventions to address falls, after the resident had two falls with injuries. The facility also failed to ensure R4's medications were refilled as needed. Regarding the second allegation (resident R6), it was inconclusive whether maltreatment occurred.

Although the elopement was reported, there was no evidence corroborating whether the incident occurred or that any harm resulted from it.

The investigation of all allegations included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of medical records, incident reports, training records, relevant policies, and procedures.

Allegation 1:
The resident (R4) resided in an assisted living facility and R4's diagnoses included Alzheimer's disease, diabetes mellitus, and chronic venous hypertension. The resident's service plan indicated she received staff assistance for dressing, grooming, toileting, and bathing. R4's service plan indicated she was independent with transfers and mobility. Her service plan also indicated she needed staff assistance with mealtime tasks such as cutting food, opening cartons/packages, and menu selections. This same document indicated R4 had a history of anxiety and delusions.

R4's nurses notes indicated, since R4 was admitted to the facility, R4 had three physical altercations with three different residents resulting in physical injury, and one verbal altercation with another resident. R4's nursing assessment indicated when the resident was observed having physically or verbally aggressive behaviors, interventions such as redirection, reapproach, husband visits and resident activities should have been applied.

R4's Individual Abuse Prevention Plan (IAPP) indicated the goal for R4 was to remain safe, including safety when ambulating. The interventions to obtain these goals included anticipating R4's needs and conducting safety checks. The IAPP indicated R4's room was provided a room sensor (motion alarm) due to R4's history of unsafe wandering. Additional goals listed on R4's IAPP included R4 to remain free from falls and injury, as she was a high fall risk and bruised easily. This document indicated R4 to have several days of chronic anxiety which had caused staff to have difficulties in completion of activity of daily living (ADL) tasks.

The facility twenty-four hour report indicated R4 had a first fall at 4:45 a.m. one morning and was sent to the hospital due to a hematoma over the right eye. R4's nurses notes indicated R4 returned from the hospital that same afternoon and R4's physician orders were given to R4's family member.

The facility twenty-four hour report indicated R4 had another fall two days later on the night shift and a facility fall sheet was completed. This same document indicated R4 returned from the hospital and did not have a fracture or cranial bleed.

R4's medication administration record (MAR) was reviewed. For one out of three months reviewed, R4 refused medications eighty-eight times. ABH gel was ordered for R4, to be administered as needed, up to three times a day (ABH gel is a medication that is applied topically; contains Ativan, Benadryl, and Haldol; and is used to treat delirium). According to the

MAR for that same month, R4's ABH gel was not offered or administered to the resident. The facility twenty-four-hour report form indicated, on two occasions, R4 was out of ABH gel.

Review of facility documentation indicated that sixteen facility resident falls, including R4's falls, had occurred in a ten-day period. Four facility resident falls occurred during one weekend, while five facility resident falls occurred during a subsequent weekend with rest of the falls occurring throughout the month. The facility documentation did not indicate that new interventions were attempted after these falls to prevent recurrence of the falls.

The facility policy on medication management indicated when medications were refused by a resident, the refused medication would be documented in the resident's MAR and the prescribing physician would have been notified immediately or according to the physician perimeters. This same policy indicated a designated staff person would contact the pharmacy to obtain a prescription refill at least seven days prior to running out of a medication.

During an interview, an unlicensed direct care staff member stated s/he was informed on shift report that R4 had a physical altercation with a male resident on the night shift, that ended in R4 receiving a black eye. The unlicensed personnel stated a facility incident report was not completed. The unlicensed personnel also stated the facility had staffing shortages and not enough staff to give the resident's their meals.

During an interview, R4's family member stated he recalled two falls occurring during the month reviewed, and with both falls R4 sustained injury. With one fall, R4 had bruising under her eye and another to the head. The family member stated R4 was sent to the hospital both times. The family member requested reports of what happened in both falls and was informed by the facility that the records were only internal and could not be given to him. The family member stated that he believes the falls were not recorded or documented. This same family member stated he requested to have a copy of R4's medication administration record (MAR) and when the family member reviewed the MAR, he noticed many of her behavior medications were refused by R4. The family member had concerns regarding this because he noticed R4's behaviors were worsening. The family member had a video camera placed in R4's room and had concerns about R4's safety because staff did not check on R4 regularly on the night shift. The family member stated he had to call staff because he had seen other residents in R4's room in the middle of the night.

Allegation 2.

The resident (R6) resided in an assisted living facility and had diagnoses which included Creutzfeldt-Jakob Disease (a degenerative brain disorder that leads to dementia) and attention deficit hyperactivity disorder (ADHD). R6's nursing assessment indicated R6 needed staff assistance in dressing, grooming, bathing and was occasionally incontinent. This same document indicated R6 was able to ambulate independently and be at high risk for elopement.

R6' IAPP indicated R6 was verbal, but not oriented to person, place, and time. This same document indicated R6 would remain safe in the facility when staff monitored the whereabouts of R6, by conducting regular safety checks, as he was up and about in the secure environment.

During an interview, an unlicensed direct care staff member stated it was passed on to her during a verbal report, that R6 was walking behind a staff member around midnight, and without the staff member knowing it, had gotten outside of the facility when it was cold outside. The unlicensed personnel also stated R6 was not harmed by the incident.

During an interview, a family member stated R6 was an elopement risk prior to admission to the facility, so the family member hired private caregivers to give R6 additional supervision. R6 was diagnosed recently with Prion's disease and prescribed medications to assist with related behaviors. The family member stated R6's behaviors were more stable after this and the additional supervision was not needed as often. The family member stated he did not remember R6 eloping during his stay at the facility and does not remember receiving a phone call regarding R6 eloping from the memory care unit.

In conclusion, neglect of R4 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: No.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: N/A.

Action taken by facility:
Documentation of two falls in R4's nurse's notes. R4 transported to the emergency department after one of the falls.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34426	A. BUILDING: _____ B. WING _____	C 04/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELK RIDGE ALZHEIMER'S SPECIAL	1700 BEAM AVENUE MAPLEWOOD, MN 55109

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0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER 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. 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: #HL34426002C/#HL34426001M, #HL34426004C/#HL34426003M, and #HL34426006C/#HL34426005M 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. The following correction orders are issued for #HL34426002C/#HL34426001M, #HL34426004C/#HL34426003M, and #HL34426006C/#HL34426005M, tag identification: 0630, 1620, 1640, and 1890. The following correction order is issued for	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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0 000	Continued From page 1 HL34426001M, tag identification: 2360.	0 000		
0 630 SS=H	144G.42 Subd. 6 (b) 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 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. 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	0 630		

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0 630	Continued From page 2 than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1's medical record was reviewed. R1 was admitted to the licensee on September 24, 2021, with diagnoses of dementia, depression, and anxiety. 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. 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. 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.	0 630		

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0 630	Continued From page 3 R1's medication administration record (MAR) for the month of December 2021, indicated the following medications were ordered to be administered: - 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. 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. 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. R1's nurse's notes, dated January 17, 2022,	0 630		

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0 630	Continued From page 4 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. 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. After these incidents, R1's IAPP was not updated to reflect specific interventions to minimize her risk for being abused. 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. 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. 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	0 630		

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0 630	Continued From page 5 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. 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). 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. 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).	0 630		

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0 630	Continued From page 6 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 became verbally aggressive. The PCP was updated of these behaviors. 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. 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. 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. 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	0 630		

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0 630	Continued From page 7 during the incident, and both were removed from R2's room and R2's door was locked until R1 went to bed. 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. 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. 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. 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. R3's IAPP was not updated to reflect change in condition or interventions. R3's nurse's notes were not provided. During an interview on April 22, 2022 at 9:16	0 630		

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0 630	Continued From page 8 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. Admissions and Move-in Policy provided by the licensee, dated September 26, 2021, indicated residents are evaluated on an on-going basis, including: 1. Daily evaluations 2. One-month evaluations 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. TIME PERIOD TO CORRECT: Seven (7) days.	0 630		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision	01620		

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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
01620	Continued From page 9 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on 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. 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). Findings Include: R1 R1's medical record was reviewed. R1 was	01620		

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	34426	A. BUILDING: _____ B. WING _____	C 04/13/2022

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01620	Continued From page 10 admitted to the licensee on September 24, 2021 with the diagnoses of: dementia, depression, and anxiety. 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 subsequent nursing assessments, due 14 days after admission and 90 days after admission, were not provided. 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). R2's nursing assessment. dated February 9, 2022, indicated the resident was occasionally incontinent, needed assist of one staff for activites of daily living (ADLs), was verbally aggressive, had wandering, had angry outbursts, and had incidents of inappropriate sexual behaviors. R2's nurse's notes, dated February 22, 2022, indicated R2's 14-day assessment was completed. 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.	01620		

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01620	Continued From page 11 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. 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. 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. The licensee did not provide R3's nurses notes or any change in condition assessment following the December 2021 changes in resident needs. 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. 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	01620		

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01620	Continued From page 12	01620		

changes or updates.

R4's 90-day nursing assessments for the period from March 2021 to February 2022 were requested and not provided.

R5
R5's medical records reviewed. R5 was admitted on March 15, 2021 with the diagnoses of: Alzheimer's disease, aphasia, and insomnia.

R5's nurses notes, dated December 03, 2021, indicated R5 was re-admitted to hospice.

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.

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.

R5's initial and previous 90-day nursing assessments, from March 2021 to February 2022, were not provided.

Admissions and Move-in Policy provided by the licensee, dated September 26, 2021, indicated residents are evaluated on an on-going basis, including:

1. Daily evaluations
2. One-month evaluations

A job description titled: Clinical Services Director, provided by the licensee and dated: September 26, 2021, indicated this position is responsible for

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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	Continued From page 14 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. 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). Findings Include: 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. 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. 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	01640		

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01640	Continued From page 15 note that the service plan was emailed on February 25, 2022. 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. R2 R2's medical records were reviewed. R2's diagnoses included dementia, diabetes mellitus, and chronic kidney disease (CKD). 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. 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. R2's nurse's notes, dated February 22, 2022, indicated licensee staff would follow-up with service plan and signatures. 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.	01640		

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01640	Continued From page 16 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. 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. 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. 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. 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. R4's nurse's notes, dated February 22, 2022, indicated the licensee would follow-up with service plan signatures. R4's nurse's notes, dated February 25, 2022, indicated LALD-A emailed R4's family requesting service plan signatures.	01640		

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01640	Continued From page 17 R5 R5's medical records reviewed. R5 was admitted on March 15, 2021, with the diagnoses of: Alzheimer's disease, aphasia, and insomnia. 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. R5's nurse's notes, dated February 22, 2022, indicated staff would follow-up with service plan signatures. R5's nurse's notes, dated February 25, 2022, indicated the LALD emailed R5's family for service plan signatures. 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. TIME PERIOD TO CORRECT: Seven (7) days.	01640		
01890 SS=D	144G.71 Subd. 20 Prescription drugs 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.	01890		

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01890	Continued From page 18 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. 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). Findings include: 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. 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. R6's medication administration record (MAR), dated April 2022, included Diclofenac Sodium 1% gel, apply four grams topically four times daily. Manufacturer's instructions for Diclofenac Sodium gel, indicated the consumer should properly discard the medication when it is expired. A licensee provided Medication Management	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.	