Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL34426009M
Compliance #: HL34426010C

Date Concluded: May 13, 2022

Name, Address, and County of Licensee Investigated:
Elk Ridge Alzheimer's Special Care Center
1700 Beam Avenue
Maplewood, MN 55109
Ramsey County

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

Evaluator's Name: Jill Hagen, RN, Special Investigator

Finding: Substantiated, individual responsibility

Nature of Visit:

Allegation(s):
It is alleged: The alleged perpetrators (AP)1 and AP2, unlicensed staff, abused the resident when the resident refused cares, and AP1 and AP2 restrained the resident and forced him to change clothes. As a result, the resident's forearms were bruised, and the resident experienced increased back and hip pain.

Investigative Findings and Conclusion:
Abuse is substantiated. AP1 and AP2 were responsible for the maltreatment. Video surveillance from the resident's room showed AP1 and AP2 forcefully restraining the resident by holding him around the neck, holding down his arms and hands, and laying over the resident's upper body while attempting to change the residents' clothes. The resident refused care, however, AP1 and AP2 continued to force the residents' clothes on and off even when the resident stated, "No you're not", and "You're hurting me!" Following the incident, the resident had increased deep red bruising of both upper hands and wrists and had complaints of back and hip pain that required Tylenol, an analgesic, for pain relief.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator reviewed the residents medical record,

facility policy and procedures, staff schedules and training, contract staff training, and AP1 and AP2's employee files. The investigation also included a review of recorded video surveillance from the resident's room the night of the incident. In addition, law enforcement was contacted.

The residents medical record indicated diagnoses including Lewy Body dementia (a progressive dementia causing a decline in thinking, reasoning and independent functioning). The resident was admitted to the facility less than two weeks prior to the incident. The resident made his basic needs known but required the assistance of others for decision making. The resident required one staff assistance with dressing, grooming, bathing, and cues and reminders for toileting. The resident was independent with walking. The resident had a history of refusal of cares such as changing clothes and taking a shower. When the resident refused care, staff were directed to re-approach the resident at a later time. The residents medical record indicated the resident was not able to report abuse by others.

The resident's facility progress note indicated one evening the resident's family member (FM) came to the facility and reported to the nurse on duty, licensed practical nurse (LPN)-B, she observed an incident on the resident's video camera involving the resident and AP1 and AP2. The FM was watching the resident's live video feed from a camera which was set up in the resident's room. The FM stated AP1 and AP2 were forcing the resident to change his clothes. LPN-B spoke with the resident who stated he remembered the incident and talked about feeling like he could not breath. The note indicated the resident had new red bruises present on the top of both hands. Following the incident, the resident winced with movement complaining of back pain and pain of both wrists. LPN-B removed AP1 and AP2 from resident care.

The facility report indicated the video showed AP1 and AP2 hold the resident down and force him to change his clothes despite the resident's refusal. On the video the resident could be heard saying, "I can't breathe," and "stop".

Review of the recorded video footage from that evening began with AP2 holding down the resident's arms and hands with the resident on his back in bed. AP1 began to remove the resident's pants while AP2 held down the resident's arms and hands. After approximately one minute, the resident attempted to kick AP1 so AP2 laid across the resident's upper body with her right knee on the bed holding down the resident's arms and hands. AP1 told the resident to be "nice" and the resident responded, "I don't know how to do that" and AP 1 responded "That's why you're getting this treatment!" At one point, the resident said, "You're smothering me". During that time, the resident's fast breathing could be heard on the video. When AP1 and AP2 completed forcing on the resident's underwear and pants, AP1 demanded the resident stand up from the bed and in one quick motion AP1 and AP2 grabbed the resident under his armpits and yanked the resident to a standing position. The resident responded with "Oh, owe" with cursing. The entire undressing and dressing of the resident's lower body took AP1 and AP2 almost five minutes.

Next, the resident was standing and AP1 and AP2 pointed at the resident's upper body and told the resident, "Take this one off," pointing to the resident's shirt. The resident said, "I can't do everything at one time". AP1 and the resident were standing facing each other and AP1 pointed her finger at the resident's face and said, "Don't start cussing, don't start!" The resident's eyes became wide, and he clenched both fists. AP1 and AP2 approached the resident and began forcible removing his shirt while the resident stated, "Don't do it". AP1 stood behind the resident and when the resident resisted removing the shirt, AP1 brought her arm around the back of the resident's neck to his chest while AP2 stood in front and held the resident's arms and hands forcing the resident to sit on the bottom edge of his bed. After AP1 and AP2 forcible removed the resident's shirt despite the resident's continued refusals, AP1 and AP2 began putting on the resident's T-shirt and sweater at the same time. AP1 told the resident to "quit it," and the resident responded with "What the hell, what did I do?" During this time, the resident said "ouch" and AP1 said to the resident "stop fighting" "it's your shirt, put in on" and "you're going to give yourself a heart attack!" When putting on the shirt, AP2 put her right knee on the bed over the residents left hand to prevent the resident from using his hand. The resident's T-shirt and shirt were forcible pulled over the resident's elbows. The resident said, "Oh no. Oh no, it's three to one in here, just rip my skin off me first." During the entire incident, the resident breathing remained rapid. Taking off and putting on the resident's shirt took approximately four minutes.

During interview, AP1 stated she worked for a temporary staffing agency and was contracted by the facility to provide resident care and medication management. AP1 stated the day of the incident, AP1 worked both the morning and evening shifts. The resident refused care in the morning. AP1 stated that evening was the first time assisting the resident with cares, but she was aware the resident's care plan should be reviewed first. AP1 stated the resident continued to refuse cares including changing clothes and showers, and the executive director (ED) of the facility directed AP1 to "try" to clean up and change the resident's clothes. Once the resident resisted, AP1 stated both staff should have left him alone and not forced the cares. AP1 stated she had prior abuse and neglect training.

During interview, AP2 stated she was employed by the facility for approximately two weeks prior to the incident, to provide resident care and medication management. AP2 stated that evening was the first-time providing care to the resident. AP1 denied awareness of a care plan to direct staff on resident care and said she, "just took the lead from AP1". AP2 stated licensed practical nurse (LPN)-B told AP1 and AP2 to put the resident to bed that evening around 7 or 8 p.m. and failed to inform AP1 and AP 2 of the resident's behaviors. AP2 stated she restrained the resident but denied causing bruising on the resident's hand. AP2 stated when the resident said "No. No. No." to receiving the care, she should have stopped providing the care. When the resident care was completed AP2 stated, "I knew what we'd done was not okay". AP2 denied receiving any training from the facility.

Review of AP2's personnel file indicated the facility provided AP2 with all the required orientation and training including abuse and neglect training.

During interview, LPN-B stated she was the supervisor on-site the evening of the incident. LPN-B stated both AP1 and AP2 were familiar with the resident and his cares. The facility required staff signatures after reviewing the residents care plans. After viewing the video footage brought in by the resident's family member (FM) that evening, LPN-B notified management and sent AP1 and AP2 home. The resident had no prior behaviors and AP1 and AP2 knew the resident had the right to refuse care.

During interview, the resident's family member (FM) stated the resident had more confusion but was capable of dressing himself with assistance and guidance from staff. The FM placed the camera in the resident's room to ensure his safety. Following the incident, the resident had increased complaints of back and hip pain and increased bruising to the resident's hands and forearms. The FM showed the video to LPN-B that evening and stayed in the resident's room throughout the remainder of the night.

Review of the police report indicated the case remained open for ongoing investigation into the incident.

In conclusion, abuse was substantiated. AP1 and AP2 forced the resident to undress and dress despite the resident's constant refusals.

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.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451. A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;

(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening;

(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult; and
(4) use of any aversive or deprivation procedures for persons with developmental disabilities or related conditions not authorized under section 245.825.
(c) Any sexual contact or penetration as defined in section 609.341, between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.
(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another

Vulnerable Adult interviewed: No, unable due to cognition.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes, both AP1 and AP2.

Action taken by facility:
Management provided education to all staff regarding their policies and procedures including residents right to refuse care. The facility implemented a training protocol and policy for contracted pool staff. AP1 and AP2 are no longer employed by the facility.

Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:
https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html
If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies. You may also call 651-201-4890 to receive a copy via mail or email.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc: The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Ramsey County Attorney
Maplewood City Attorney
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 05/13/2022

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

(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: #HL34426010C/#HL34426009M On April 27, 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 provider's Assisted Living with Dementia Care license. The following revised immediate correction order is issued for #HL34426010C/#HL34426009M, tag identification 1350. The original correction order under 1350 was revised on May 12, 2022. On May 13, 2022, the immediacy of correction order 1350 has been removed, however non-compliance remains at a scope and level of F.	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 The following correction orders are issued which were not immediate for #HL34426010C/#HL34426009M, tag identification 1460, 1470, and 2360.	0 000		
01350 SS=I	144G.60 Subd. 5 Temporary staff When a facility contracts with a temporary staffing agency, those individuals must meet the same requirements required by this section for personnel employed by the facility and shall be treated as if they are staff of the facility. This MN Requirement is not met as evidenced by: Based on document review and interview, the licensee failed to provide contracted temporary agency staff orientation to assisted living licensing requirements and regulations as if employed by the facility for one of one unlicensed personnel (ULP)-D, with employee records reviewed. This had the potential to affect all residents receiving services from the licensee. This was issued as an immediate order when the facility indicated they could not provide evidence of training for ULP-D and their agency training policy did not include all the required components. The immediacy was removed on May 13, 2022, after the executive director(ED) provided evidence the licensee's orientation for contracted agency staff was revised to include the assisted living licensing requirements and regulations. In addition, the ED provided evidence that all contracted agency staff were provided orientation to the assisted living licensing requirements and regulation prior to beginning their shifts.	01350		

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01350	Continued From page 2 Non-compliance remains at a scope and severity of a F. 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: ULP-D was contracted by the licensee to provide medication administration and delegated nursing services to the licensee's residents as temporary contracted agency staff on March 9, 2022. ULP-D's employee record lacked evidence of orientation to the assisted living licensing requirements, regulations, and all training requirements as if employed by the facility. ULP-D was current on the nursing assistance registry. Review of video footage from a resident's room on April 6, 2022, around 8:00 p.m. showed ULP-D providing rough care by forcing the resident to undress and dress despite the resident's continued refusals. In addition, ULP-D restrained the resident by holding down the resident's arms and hands in order to forcefully remove the clothing. After the incident, the resident experienced increased dark red bruising of the upper hands with increased back and hip pain. ULP-D's employee files lacked evidence of having completed the following required content of orientation to assisted living:	01350		

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01350	Continued From page 3 -overview of assisted living statutes; -introduction and review of the provider's policies and procedures related to the provision of AL services; -handling of emergencies and use of emergency services; -compliance with reporting of maltreatment of vulnerable adults; -assisted living bill of rights; -handling of resident complaints, reporting of complaints, and where to report; -consumer advocacy services; -principles of person-centered planning and service delivery; and -review of the types of assisted living services the employee will be providing and the facility's category of license. During an interview on May 9, 2022, at 12:36 p.m. ULP-D stated she did not receive the required education from the licensee. An email correspondence from the licensee's executive director (ED) to the investigator on May 10, 2022, at 3:02 p.m. indicated ULP-D was not hired by the licensee, therefore, the licensee did not maintain a training personnel file for ULP-D. The ED did not have a copy of the orientation provided to agency staff for ULP-D. Review of the licensee's policy and procedure titled Agency Staff Orientation dated November 2017, stated, attached are policies and procedures important to review to help you understand our expectations. After a tour of the community please review with the supervisor on duty and sign at the bottom that you understand the attached policies and procedures and expectations. -Accidents, Incidents, and Unusual Occurrences	01350		

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01350	Continued From page 4 -Alarm System -Alert Charting -Call System -Change in Condition -Communication of Resident Information -Elopement/Missing Resident -Emergencies-Major Medical -Emergencies-Minor -Exit Alarms/Delayed Egress -Fall Management -Fire Safety -Resident Abuse and Neglect -Who to call in an emergency The policy and procedures continued with Licensed Nurses/Medication Aides were to review policies and procedures for: -Incident Reports -List of Reportable to Administrator and Health Service Director -Managing call-offs -Medication Management Policies -Quick MAR (medication administration record) -Orientation to current residents Review of the licensee's undated policy and procedure titled 144G.63 Orientation and Annual Training Requirements, Subdivision 1. indicated Orientation of staff and supervisors, stated, all staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. Time Period for Correction: Seven (7) days.	01350		
01460 SS=F	144G.63 Subdivision 1 Orientation of staff and supervisors	01460		

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01460	Continued From page 5 All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on document review and interview, the licensee failed to provide contracted temporary agency staff orientation to assisted living licensing requirements and regulations as if employed by the facility for one of one unlicensed personnel (ULP)-D, with employee records reviewed. This had the potential to affect all residents receiving services from the licensee. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: ULP-D was contracted by the licensee to provide medication administration and delegated nursing services to the licensee's residents as temporary contracted agency staff on March 9, 2022. ULP-D's employee record lacked evidence of orientation to the assisted living licensing requirements, regulations, and all training requirements as if employed by the facility.	01460		

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01460	Continued From page 6 ULP-D was current on the nursing assistance registry. ULP-D's employee files lacked evidence of having completed the following required content of orientation to assisted living: -overview of assisted living statutes; -introduction and review of the provider's policies and procedures related to the provision of AL services; -handling of emergencies and use of emergency services; -compliance with reporting of maltreatment of vulnerable adults; -assisted living bill of rights; -handling of resident complaints, reporting of complaints, and where to report; -consumer advocacy services; -principles of person-centered planning and service delivery; and -review of the types of assisted living services the employee will be providing and the facility's category of license. An email correspondence from the licensee's executive director (ED) to the investigator on May 10, 2022, at 3:02 p.m. indicated ULP-D was not hired by the licensee, therefore, the licensee did not maintain a training personnel file for ULP-D. The ED did not have a copy of the orientation provided to agency staff for ULP-D. During an interview on May 12, 2022, at 1:00 p.m. the ED stated the licensee's orientation for contracted agency staff did not contain all the components about assisted living requirements and regulations. Review of the licensee's policy and procedure titled Agency Staff Orientation dated November	01460		

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01460	Continued From page 7 2017, indicated the attached were policies and procedures important to review to help staff understand the facility expectations. After a tour of the community staff were to review with the supervisor on duty and sign at the bottom that they understood the attached policies and procedures and expectations, which included the information below: -Accidents, Incidents, and Unusual Occurrences -Alarm System -Alert Charting -Call System -Change in Condition -Communication of Resident Information -Elopement/Missing Resident -Emergencies-Major Medical -Emergencies-Minor -Exit Alarms/Delayed Egress -Fall Management -Fire Safety -Resident Abuse and Neglect -Who to call in an emergency The policy and procedures continued with Licensed Nurses/Medication Aides were to review policies and procedures for: -Incident Reports -List of Reportable to Administrator and Health Service Director -Managing call-offs -Medication Management Policies -Quick MAR (medication administration record) -Orientation to current residents Review of the licensee's undated policy and procedure titled 144G.63 Orientation and Annual Training Requirements, Subdivision 1. indicated Orientation of staff and supervisors, stated, all staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations	01460		

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01460	Continued From page 8 before providing assisted living services to residents. Time Period for Correction: Seven (7) days.	01460		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living	01470		

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	34426	A. BUILDING: _____ B. WING _____	C 05/13/2022

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

(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
01470	Continued From page 9 services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation 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 the challenges it poses to communication; (2) 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 document review and interview, the licensee failed to provide contracted temporary agency staff orientation to assisted living licensing requirements and regulations as if employed by the facility for one of one unlicensed personnel (ULP)-D, with employee records reviewed. This had the potential to affect all residents receiving services from the licensee. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive	01470		

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01470	Continued From page 10 or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: ULP-D was contracted by the licensee to provide medication administration and delegated nursing services to the licensee's residents as temporary contracted agency staff on March 9, 2022. ULP-D's employee record lacked evidence of orientation to the assisted living licensing requirements, regulations, and all training requirements as if employed by the facility. ULP-D was current on the nursing assistance registry. ULP-D's employee files lacked evidence of having completed the following required content of orientation to assisted living: -overview of assisted living statutes; -introduction and review of the provider's policies and procedures related to the provision of AL services; -handling of emergencies and use of emergency services; -compliance with reporting of maltreatment of vulnerable adults; -assisted living bill of rights; -handling of resident complaints, reporting of complaints, and where to report; -consumer advocacy services; -principles of person-centered planning and service delivery; and -review of the types of assisted living services the employee will be providing and the facility's category of license. An email correspondence from the licensee's executive director (ED) to the investigator on May	01470		

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01470	Continued From page 11 10, 2022, at 3:02 p.m. indicated ULP-D was not hired by the licensee, therefore, the licensee did not maintain a training personnel file for ULP-D. The ED did not have a copy of the orientation provided to agency staff for ULP-D. During an interview on May 12, 2022, at 1:00 p.m. the ED stated the licensee's orientation for contracted agency staff did not contain all the components about assisted living requirements and regulations. Review of the licensee's policy and procedure titled Agency Staff Orientation dated November 2017, stated, the attached policies and procedures were important to review to help staff understand the facility expectations. After a tour of the community staff were to review with the supervisor on duty and sign at the bottom that they understand the attached policies and procedures and expectations which included: -Accidents, Incidents, and Unusual Occurrences -Alarm System -Alert Charting -Call System -Change in Condition -Communication of Resident Information -Elopement/Missing Resident -Emergencies-Major Medical -Emergencies-Minor -Exit Alarms/Delayed Egress -Fall Management -Fire Safety -Resident Abuse and Neglect -Who to call in an emergency The policy and procedures continued with Licensed Nurses/Medication Aides were to review policies and procedures for: -Incident Reports -List of Reportable to Administrator and Health	01470		

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01470	Continued From page 12 Service Director -Managing call-offs -Medication Management Policies -Quick MAR (medication administration record) -Orientation to current residents Review of the licensee's undated policy and procedure titled 144G.63 Orientation and Annual Training Requirements, Subdivision 1. indicated Orientation of staff and supervisors, stated, all staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. Time Period for Correction: Seven (7) days.	01470		
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 interview and document review, the facility failed to ensure one of one of one residents reviewed, (R1) was free from maltreatment. R1 was abused. Findings include: On May 13, 2022, the Minnesota Department of Health (MDH) issued a determination that abuse occurred, and that an individual staff persons was responsible for the maltreatment, in connection with incidents which occurred at the facility. The	02360		

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02360	Continued From page 13 MDH concluded there was a preponderance of evidence that maltreatment occurred.	02360		