Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL361487504M
Compliance #: HL361486939C

Date Concluded: August 21, 2023

Name, Address, and County of Licensee Investigated:
Noble Cares LLC
3240 Sprague Avenue
Anoka, MN 55303
Anoka County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Barbara Axness, RN
Special Investigator

Finding: Substantiated, facility responsibility

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

Initial Investigation Allegation(s):
The facility neglected the resident when the resident displayed multiple behaviors and staff failed to assess and identify new vulnerabilities, susceptibilities to abuse, and/or new risks of harming others. No new interventions were implemented, and existing interventions were not evaluated.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to provide supervision to protect the resident's health and safety following multiple behavior related incidents including elopements and the resident exchanging nude photos of herself to people she met online for cigarettes. The facility was aware of the resident's impulsive behaviors and failed to assess, identify, and implement interventions to mitigate risk or prevent future incidents.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted law enforcement, the psychologist, and the case worker. The investigation included review of resident records including assessments, care plans, the service plan, progress notes, individual abuse prevention plans, and hospital records.

The resident resided in an assisted living facility. The resident's diagnoses included schizophrenia, traumatic brain injury, anxiety disorder, cognitive impairment, delusional disorder, and history of substance abuse. The resident's service plan included reminders for dressing, eating, oral hygiene, and grooming. The resident's assessment indicated the resident had unsuccessful prior placements due to "behavior disturbances." The assessment indicated the resident was resistive to cares and medication administration, had a history of physical aggression, verbal aggression, defiance, wandering, pacing, anger, inappropriate sexual behavior, cursing/swearing, and a history of self-harm. The resident was noted to be at risk for elopement with an intervention of "camera monitoring environment 24 hours, staff in facility 24 hours awake at night, lock exit doors with alarms on at 10pm daily." The resident's identified behaviors included agitation, hoarding, property destruction, repetitive behavior, verbal aggression, and high risk for elopement. The resident was noted to occasionally disrobe, required redirection, and was "fond of making inappropriate sexual comments," as well as being socially inappropriate by asking neighbors for cigarettes.

The resident's progress notes identified almost daily behaviors of the following: exposing herself to others, taking nude photographs of herself and sharing them with others and on the internet in exchange for cigarettes, ingesting various non-food items including paint and hand sanitizer, eloping or attempting to elope from the facility multiple times, binging on food, aggressive behaviors including frequent destruction of facility property, and frequent smoking throughout the day, including two incidents where the resident accidently lit her hair on fire.

The resident's care plan indicated she was to be supervised at all times. A prescriber's order written approximately two weeks after admission to the facility, indicated the resident was to have one to one staffing due to "behaviors that result in a safety risk to herself and others including eloping, running into traffic, getting into stranger's cars, physical aggression, stealing, inappropriate calling of 911, strangers, and others."

The facility's uniform disclosure of assisted living services and amenities (UDULSA) indicated the facility was prepared to manage challenging behaviors. The UDULSA identified the facility did not have a secured unit or building for wandering or exit seeking behavior. The facility did have a wander-alert system at facility exits and staff monitored the facility exits. The facility was able to conduct every 15-minute safety checks, had one to one staffing available, and was able to provide one to one staffing for special circumstances. The typical staffing pattern was one staff member per shift.

At least five incidents occurred where the resident invited men to the facility she had met online. Facility staff were also aware the resident was sending nude photos and videos to several of the men. The resident attempted to leave with the men on several occasions; getting in their car and telling them to leave. On one occasion, facility staff saw the pictures the resident had sent and described them as “very graphic” in a progress note. The resident told facility staff the men promised her money if she sent photos and she would often trade nude photos of herself in exchange for cigarettes. The resident was also overheard being asked by men she met online to provide her social security number and bank account information.

The resident attempted to elope or did elope, at least ten times over the three months she resided at the facility. Facility staff documented they were times they had to lock the doors so the resident couldn’t get outside, and police were called routinely each time she eloped. The doors were locked from the inside and a key was required to unlock the door. Facility documentation indicated police asked the facility to stop calling each time she eloped, so facility staff complied and stopped reporting her elopements.

The resident was also noted to ingest several non-food items, including chemicals, hand sanitizer, and paint. The resident was sent to the emergency room after she drank a cup of paint that was sitting unsecured in the facility’s garage.

Progress notes indicated the resident frequently left the facility to beg for cigarettes and despite multiple assessments indicating the resident was safe to smoke independently, there were two documented instances where the resident set herself on fire while smoking.

Despite ongoing elopements, staff aware the resident was being taken advantage of by people she met online, ongoing incidents of ingesting harmful non-food items, and several episodes of unsafe smoking, the facility failed to reassess the resident and failed to implement new interventions to keep the resident safe from abuse and self-harm over the three months the resident resided at the facility. Several incident reports were started but not completed or reviewed by the facility’s licensed assisted living director/clinical nurse supervisor (LALD/CNS). The resident was eventually sent to the emergency room and the facility refused to allow her to return and issued an immediate termination notice.

The LALD/CNS stated he completed numerous physical and behavioral assessments of the resident. The LALD/CNS recalled the resident admitted to the facility from jail because her previous facility refused to take her back. A police report was filed, but he did not obtain any records from her prior facility. The LALD/CNS confirmed the UDALSA said the facility could manage challenging behaviors, provide one to one care, and the facility installed cameras so they could better observe the resident. The LALD/CNS confirmed that while the UDALSA said they could staff to meet the resident's needs, "it wasn't available at that time." The LALD/CNS stated they were not able to hire anyone, the county wouldn't pay for extra care, so the facility did not provide it. The LALD/CNS stated some interventions were implemented and felt they were working. The LALD/CNS confirmed the facility locked the facility doors from the inside to

prevent elopements. The LALD/CNS also confirmed some incident reports had not been completed but stated the facility attempted to develop new interventions when they could.

The facility licensed practical nurse (LPN) stated staff implemented interventions like locking the resident in the facility; only someone with a key could open the door to exit and this helped the resident calm down and/or prevent elopements. The LPN stated staff followed the resident if she eloped and indicated this was considered an intervention. The LPN stated the resident frequently contacted men from online dating sites and the phone had "become an issue because of her brain injury, she doesn't know how to differentiate danger." The LPN stated they monitored the resident, redirected her as needed, and eventually the resident's dad took away her phone and "that was his decision, not our decision." The LPN stated other interventions in place included offering the resident juice or a snack.

The resident’s former case manager stated she reached out to facility staff a few times, as it seemed like some of the resident’s rights were restricted and she was treated more like a child than a vulnerable adult. The former case manager stated the resident had many behaviors which the facility seemed to not know how to manage. The former case manager said the facility would say they had plans on how to help the situation but "when it actually came down to it, it was more of them wanting me to figure it out and how to stop it."

The resident’s former psychiatric nurse practitioner stated the facility had not informed her of many of the resident's behaviors, including exchanging nude pictures for cigarettes, talking to men from online dating sites and inviting them over, or some of her many elopements. The psychiatric nurse practitioner was under the impression the facility was a “group home and was not aware it was an assisted living facility. The psychiatric nurse practitioner stated she was not informed of any termination notices or pretermination meetings and found out about the resident's discharge when law enforcement called to tell her the facility was refusing to take her back. The psychiatric nurse practitioner stated, "I wish they would have told me some of this stuff, I would have been happy to help them come up with interventions."

In conclusion, the Minnesota Department of Health determined 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 neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: Attempts to contact were unsuccessful.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
No action taken.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

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

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

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

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

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Anoka County Attorney
Anoka City Attorney
Anoka Police Department
Minnesota Board of Executives for Long Term Services and Supports
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36148	A. BUILDING: _____ B. WING _____	C 07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOBLE CARES LLC	3240 SPRAGUE AVENUE ANOKA, MN 55303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL361487504M #HL361486939C On July 27, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were three residents receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL361487504M/#HL361486939C, tag identification 0430, 0620, 0630, 1060, 1070, 2290, 2360, 3000.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. 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 surveyors' 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 subd. 1, 2, and 3.	
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to	0 430		

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0 430	Continued From page 1 prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the uniform checklist disclosure of services (UDALSA) accurately reflected services provided by the licensee. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect 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 the residents). The findings include: The licensee's UDALSA dated August 4, 2022,	0 430		

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0 430	Continued From page 2 indicated the facility was prepared to manage challenging behaviors. The facility did not have a secured unit or building for wandering or exit seeking behavior. The facility had a wander alert system at facility exits and staff monitored the facility's exits. The facility was able to do every 15-minute safety checks and had one to one staffing available and could do one to one staffing for special circumstances. The typical staffing pattern was one staff member per shift. On August 1, 2023, at 11:55 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the facility would not be able to offer one one one care as they didn't have the staff to offer it and that it was difficult to find people who wanted to work. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430		
0 620 SS=D	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury	0 620		

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0 620	Continued From page 3 which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event	0 620		

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0 620	Continued From page 4 meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to submit a report to the Minnesota Adult Abuse Reporting Center (MAARC) for one of one resident (R1) who eloped multiple times, lit her hair on fire while smoking on two occassions, ingested chemicals, and had repeated incidents of sharing nude photographs of herself online and with others. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee held a current assisted living license. R1's diagnoses included schizophrenia, traumatic brain injury, anxiety disorder, cognitive impairment, delusional disorder, and history of substance abuse. The resident admitted to the facility on August 5, 2022.	0 620		

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0 620	Continued From page 5 R1's service plan, dated August 5, 2022 , indicated the resident received reminders for dressing, eating, oral hygiene, and grooming. The resident's record contained a signed provider order dated August 16, 2022, indicating it was recommended R1 have "1:1 staffing due to her behaviors that result in safety risk to herself and others including eloping, running into traffic, getting into stranger's cars, physical aggression, stealing, inappropriate calling of 911, strangers and others." Facility schedules from October 31, 2022, through December 4, 2022, indicated only one staff member was working each shift. The resident's admission assessment, dated August 5, 2022, indicated the resident had unsuccessful prior placements due to "behavior disturbances." The assessment indicated the resident was resistive to cares and medications and had a history of physical aggression, verbal aggression, defiance, wandering, pacing, anger, inappropriate sexual behavior, cursing/swearing, and a history of self harm. Effective non pharmalogical interventions identified included "take a walk, get cigarette as a reward." A section for effective pharmalocical interventions read, "Effectiveness not ascertained." The resident was assessed to be a high risk for elopement. A 14 day assessment was completed on August 19, 2022, indicated the resident had been moved from the lower bedroom to the main floor for "close monitoring." The assessment noted the resident's appetite "seems to be uncontrollable. There's need to lock up extra foods and bring out only when needed. Resident's behavior also includes walking out of the house to the road and	0 620		

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0 620	Continued From page 6 other people's homes to beg for cigarettes." The service plan was updated to include "make cigarette available for resident every two hours." No other behavioral interventions were identified or implemented. An assessment was completed on September 17, 2022, due to a new behavior of drinking hand sanitizer and the liquid from wet wipes. An intervention identified was to "lock up everything and keep them out of sight" and to bring out hand sanitizer, wet wipes, and syrup only when needed. In the assessment, the resident was identified to be at risk to be abused and was to be monitored at home at all times and accompanied at all times when out of the facility. The resident was noted to have difficulty weighing advice due to impaired judgment and "may be exposed to predators." The resident was noted to be at risk for elopement with an intervention listed as "camera monitoring environment 24 hours, staff in facility 24 hours awake at night, lock exit doors with alarms on at 10pm daily." The resident had behaviors including agitation, hoarding, property destruction, repetitive behavior, verbal aggression, and was a high risk for elopement. The resident was noted to disrobe occasionally and needed redirection, and was "fond of making inappropriate sexual comments," as well as being socially inappropriate by asking neighbors for cigarettes. No other behavioral interventions were identified or implemented. R1's undated, unsigned discharge summary lacked documentation of the events leading up to her being sent to the emergency room and the subsequent termination notice. A termination notice dated November 23, 2022, indicated the notice was a "sequel to the meeting	0 620		

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0 620	Continued From page 7 held on November 2, 2022, Noble Cares LLC is terminating contract and referring the resident to a higher level of care." The notice was effective November 23, 2022, due to the resident's "extremely dangerous behaviors to self and others and non-compliance with house rules." The termination notice lacked information on who the resident could contact to discuss the termination notice and read, "Insert name and contact information of person at the facility the resident can contact." The signature line for facility staff was left blank. The notice was not signed by the resident or a responsible party. The resident's most recent care plan, last updated October 2, 2022, by LALD/CNS-A indicated the resident was to be monitored at home at all times. The resident was noted to have agitation, be a high risk for elopement, had a history of hoarding, was physically aggressive when she can't have her way, had a history of property destruction, and was socially inappropriate and would go to neighbors to beg for cigarettes. The resident was also noted to insist on doing things even if it's going to hurt, had a history of self injurious behavior, and would eat and drink anything she can find including bottles of syrup and hand sanitizer. Staff were to lock exit doors and alarm them at 10:00 p.m. daily. The care plan lacked specific interventions or guidance for staff on how to handle behaviors. The licensee did not have an assisted living with dementia care license that would allow exit doors to be locked. Progress notes indicated the resident had almost daily behaviors since she was admitted, including exposing herself to others, taking nude photographs of herself and sharing them with others and on the internet, ingesting various	0 620		

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0 620	Continued From page 8 non-food items including paint and hand sanitizer, eloping from the facility, binging on food, aggressive behaviors including frequent destruction of facility property, and frequent smoking throughout the day, including two incidents where the resident accidentally lit her hair on fire. On August 11, 2022, an unlicensed personnel (ULP) documented the resident "received a phone call today from a person on EHarmony [online dating site] staff told her not to give out the address to whom she was talking to she walked into the bathroom and stayed in there for about 5 minutes talking. Now at 6pm she was on her phone texting and asked staff for the address here staff asked her why she needed it and she said that she was texting it to her sister and staff told her that her sister had it so she put her phone down. So if other staff can keep a ear out so she doesn't give out to theses people that she is talking to on EHarmony. Staff did hear her ask where he lived and she said coon rapids that's not far from here so just keep ears opened." Later that evening, licensed practical nurse (LPN)-D wrote that the resident asked if she could have a male friend that she just met online over and that LPN-D "advised that she take things slow online for her safety but that last just a few minutes because after that discussion, she sent the house address to someone else online." Around 10:00 p.m. that evening, the resident was on the patio and "ran off," after "one of the guys she met online showed up and she got in the call [car] and asked the guy to drive off but writer flagged him to roll his windows down which he did." The resident got out of car and went back in the house. A progress note completed by LALD/CNS-A included part of an email between him and the resident's case manager after they	0 620		

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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
0 620	Continued From page 9 had been updated on the resident's behaviors from August 11th. The progress note included the following, "...Police arrived later, pulled the record of the guy with the number plate. They reported that the guy doesn't have a good record. We have a woman here who's beginning to have a bad influence on [R1] But she left on her own 2 days ago. We anticipated the behaviors we are seeing with [R1]. She had to be placed 1:1 to meet certain demands and ensure she doesn't elope. What happened last night could have been worse." An incident report was completed on August 11, 2022, after the resident eloped. The resident was noted to have "ran off" after "one of the guys she met online showed up" and she got in the car. The resident attempted to leave with the man. The resident eventually got out of the car and came back in the house and the police were called. The incident report indicated the elopement was not reported to the state. LALD/CNS-A reviewed the incident report and the supervisor's review of the elopement read "resident continued to make effort to elope. Staff continues to monitor her closely especially when she outside the house (sic)." On August 12, 2022, LPN-D documented the resident "continued to give her home address to guys online." On August 14, 2022, LPN-D documented the "resident asked for her vape immediately she came upstairs from her room and writer gave it to her as writer was about to open the door resident asked why the doors are knocked at night as she will like to leave the house when ever she wanted, writer explained that the door is knocked at night for everybody's safety." Later that day, it	0 620		

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	36148	A. BUILDING: _____ B. WING _____	C 07/27/2023

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0 620	Continued From page 10 was noted the resident had been very agitated and "has been trying to elope." LPN-D wrote she followed the resident down the driveway and the resident asked why she can't be allowed to go on dates with the people she meets online. Around 10:45 p.m. that evening, LPN-D documented the resident was "online at the moment trying to talk to a guy online to get her cigarette, whiskey, or any other drink, she also ask that he send her some of his pics, writer has redirected her several times already during this shift about giving out house address to random guys online for everyone's safety, but she continues to do so not just to any person but several of them." The licensee failed to submit a MAARC report or take other measures to keep the resident safe. On August 15, 2022, a ULP documented the resident has been "trying to walk out on the street and ask everyone for a smoke she also asked the men if they wanted to date her. Staff told her that is inappropriate she then told staff to fuck off and she came back in she also told staff that she took some nude photos and put them on that dating site EHarmony staff told her that she shouldn't be doing that and she told staff to mind her own business cause she said that she is old enough to make her own mind up on what she does. Staff did call her father to let him know what she was doing and he said that he will talk to her about the phone issue." On August 17, 2022, LPN-D documented the resident "went to the street twice barefoot with writer following behind as she will to follow direction not to do so." On August 23, 2022, a ULP documented "...she kept asking to go outside and asked if her friends online could come visit her, told her no I'll call the	0 620		

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0 620	Continued From page 11 cops if anyone showed up." On August 25, 2022, a ULP documented "...we went to the dog park so she could play whit the dogs but she didn't get out of the car because she wanted to buy the dog and not play with them. She called a guy friend to come pick her up and I told her that she can not leave with him and if she does I will call the police. They sat in the car for a while and when I told the guy that I was calling the police he left." On August 27, 2022, LPN-D documented the "resident has been outside with writer close by, writer has redirected her several times to come inside but she refuse. She is still outside at the moment." On August 28, 2022, LPN-D documented the "resident tried to open the kitchen door leading to the patio at night but was unsuccessful. Then she went back to bed..." On August 30, 2022, a ULP documented the resident had "asked staff for a cigarette like five times today staff reminded her that staff can not give her smokes. She then took her lighter and went and sat out at the table in the breeze way and try to light her hair on fire. Staff took her lighter away she did not burn her head but did singe her hair...Also she was on her phone in the front room and she had it on speaker so staff heard the conversation this guy she said that is her boyfriend asked her for her social security number and for her bank account number he said that he is going to get her a credit card he also said that he sent her money in the sum of five dollars she can get it from the ATM at the gas station so she asked staff to take her and staff said no that was not going to happen so she went	0 620		

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0 620	Continued From page 12 into her room and staff went back to check on her staff knocked on the door and she said to come in she was taking pictures of her breast staff asked her what she was doing she said she was sending pictures to her boyfriend. Staff did tell her that was right and she should not do that she then told staff to mind her own business...She is currently on the phone with her boyfriend and she asked him to come over here and staff reminded her not a good idea and staff would call the police on this man for he wants her bank information so she went into her room." On August 31, 2022, a ULP documented the resident kept insisting she wanted to go to the store and wanted to leave by herself and walked to the door. Staff had to lock the doors so she could not leave. Later that day, the resident was noted to be outside asking people for cigarettes and staff had to bring her back in the house. On September 3, 2022, LPN-D documented the "resident reported to this writer and in the in coming staff (sic) that she has been sending nude pictures to a guy she met online, writer explained to her that it was to safe and not a good practice, she stated that the guy promised her money but is yet to send her the money." Later that day, a ULP documented staff had asked the resident if she put some graphic pictures on the internet and she said yes "so she was asked to please show us and she did and they are very graphic. Staff asked her to not do that anymore and the clients [resident's] remarks were that is how she lost her phone before so staff said that just might happen here to and she said that she would try not to do that again but she said her boyfriend wants her to send him pictures of her like that cause she said that he told her he loves her and that he also wanted her	0 620		

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0 620	Continued From page 13 social security number. Staff said to please not give him that number." On September 4, 2022, a ULP documented the resident left and walked to the ATM to get money and staff followed her in a truck and went to the gas station. Later that day, the resident called her boyfriend and she "told him that staff was locking her in the house and she couldn't get out he wanted to talk to staff and staff said no thank you." The resident also called her father and told him that she had eloped. On September 5, 2022, LALD/CNS-A documented the resident's father came for a visit and the inappropriate phone use was reported to him. The progress note indicated the "resident have been calling guys she found online and requesting for money/cigarette in exchange for nude pictures/videos. The said guys drives tot he house to give her cigarette. More than one car/person have shown up in the house. Each of those times she goes out to meet with the person in the guy, threatening to elope with them. Anoka police was called about three times to assist so resident doesn't elope. We stopped calling when we were told not to call for this same issue any longer. Resident became riskier when Anoka police spoke with her. Police specifically told her they would not come to the house for this issue. Resident's dad also brought an electric shaver. The plan is to have her shave her head once a week to keep it low. Resident had set her hair on fire with lighter 2 times this past week. Staff intervened immediately to stop her from getting hurting herself. Recently, she started putting off cigarette smoke using the sole of her foot." On September 9, 2022, LALD/CNS-A documented that adult protection Anoka county	0 620		

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0 620	Continued From page 14 called today to follow up to adult protection that was filed on behalf of resident. LALD/CNS-A failed to submit a MAARC report or identify any new interventions to ensure the resident was not at risk for abuse. On September 13, 2022, a ULP documented after supper, the resident went outside to smoke and she "lifted up her shirt over her breast and staff asked her to stop she did this three times and finally staff just asked her to come in the house. Staff asked her why she was doing that and she said that she liked the sun on her breasts staff explained to her that she can't be doing that outside cause the neighbors would get upset so we are currently sitting in the front room watching a movie." On September 17, 2022, a ULP documented after resident took her noon medication, she asked staff for an alcoholic beverage, but was told no. As she was going back to her room, she "immediately picked up the hand sanitizer and drank, writer rushed to get it from her but she drank. No injuries noted." Later that evening, LPN-D wrote, "...she got out jam from the refrigerator and eat with a spoon like ice cream again writer redirected her about few minutes later she opened one of the kitchen pantry and took a bottle of syrup and just drank it writer redirected her and asked for it but she got agitated when she finished she put the bottle back in it place." LALD/CNS-A wrote a follow up note that day that included "[R1] eats and drinks 'anything' she can find. 9/17/2022 she opened a bottle of hand sanitizer, poured the content into a cup and rapidly drank it before staff could retrieve it from her. Later in the evening, she opened a container of wet wipes, and attempt to pour the liquid content into a cup so she can drink it. Staff	0 620		

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0 620	Continued From page 15 intervened and took it from her. [R1] has been drinking Waffle/Pancake syrup. She pours it into a cup and drinks from it. She also drinks milk until she empties the gallon. Plan of action: Lock up everything and keep them out of sight. Bring out wet wipes, hand-sanitizers only when needed. Also, bring out syrup bottle only when needed." A MAARC report was not filed. On September 22, 2022, LPN-D wrote the "resident has been restless for the most part of the evening, tried to break the house laptop and computer monitor, she also ate endless this evening, she ransacked the kitchen and refrigerator and ate anything she found, when redirected she gets aggressive like trying to hit staff..." On September 24, 2022, a ULP wrote the resident asked for another cigarette 15 minutes after finishing her last one. After being told she should wait two hours, the resident left the house and walked two miles and sat in the middle of the street. An incident report was completed on September 30, 2022, after the resident "broke into the garage and poured paint in the cup and has drunk some of it." The resident was taken to the emergency room. Actions taken to prevent further injury were "provide supervision more closely. Provide extra lock to garage. Lock up all liquid soap and hand sanitizers." The section for if the incident was reported to the state indicated "ER did not report any complication with treatment." LALD/CNS-A reviewed the incident report and the supervisor's review of the elopement read "no injury involved." No new interventions were identified or implemented. A MAARC report was not filed.	0 620		

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0 620	Continued From page 16 On October 7, 2022, LPN-D wrote that the "resident went through the refrigerator, got cheese, after than was done she went through all the kitchen cabinet, eating anything she can find, she even ate some food seasoning, each time writer tried to redirect her she will respond by saying my dad doesn't care if I eat it, she had snack but that didn't not stop her from asking for more, writer redirected severe times to go to bed as it was bedtime and late, she refused sat on the floor and cried..." An incident report was completed on October 14, 2022, due to aggressive behavior towards staff. A description of the incident indicated staff were giving the resident her cigarettes when she asked for some candy. As staff were getting the candy, she became aggressive and pushed staff towards the cabinet. LALD/CNS-A completed a supervisor's summary of the incident and wrote, "Education reinforced to staff person. [R1]cannot be around staff when staff is opening the cabinet." Besides reminding staff to tell R1 to "sit still when medication cabinet and the cabinet where cigarette is kept is being opened," no new interventions were identified or implemented. On October 16, 2022, LALD/CNS-A documented the resident went to neighbor's house to get cigarette. "She brought it to the house, used an electric stove to lit it and set off all smoke alarms. She left the house twice." A MAARC report was not filed. A progress note from October 19, 2022, included parts of email correspondence between LALD/CNS-A and the resident's case managers. LALD/CNS-A wrote, "[R1] continues to make all kinds of demands. She's never satisfied. Her quest for anything and everything seems	0 620		

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0 620	Continued From page 17 unending. It isn't that we didn't anticipate some of these behaviors, but we have to report whenever new things come up....[R1] grabbed a bottle of hand sanitizer and drank the content before staff could take it from her. Since then, we've been locking them up. Same with wet wipes, she looks into it to drink the liquid content of it. Just today again, a staff member took her to the store to buy personal items. She walked away from the staff, went to the shelf where they have hand sanitizers in the store, and drank from one of the bottles. Then she said it makes me feel good. We've been locking things up due to her insatiable nature. I took her to the ER yesterday evening for further evaluation. She was observed throughout the night with lab draws every 4 hours. She was discharged from the ER to the house this morning after she was deemed okay. Part of the plan is to limit her frequency going out of the house to the store for now. We cannot lock up everything related to food, but we did for some. Her craving is out of control. She has gained 9lb since she came. We're also trying to avoid having her break the cabinets or having outbursts or being confrontational." A reply from the provider was noted to include "I saw [R1] this morning and unfortunately she is not doing well. I am hoping that [LALD/CNS-A] has kept her team in the loop. She has been eloping constantly, running into traffic, stating she wants to kill herself, trying to break into neighbor's houses to find alcohol or cigarettes, and being physically aggressive with the staff in order to steal food, drinks, hand sanitizer, whatever she can get her hands on. She is also calling 911 non stop regarding wanting caffeine, etc. I have instructed them to take her to the ER the next time she does something dangerous like the above, and to tell them that I have recommended	0 620		

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0 620	Continued From page 18 she be admitted to a psychiatric unit. The staff are trying to do what they can to keep her safe but with the current severity of her mental illness and neurocognitive disorder symptoms, they are not able to keep her safe. In my opinion she needs a higher level of care. She went to the ER on Saturday and was kept for 3 hours then sent home with no changes." On October 23, 2022, a ULP documented the resident told staff that she wants to kill someone. Staff tried to ask her why but she called the police, who came and talked to her. On October 25, 2022, a ULP documented they were surprised to see the resident standing out side with some police officers. "The staff immediately went out side to find out what was the issued (sic). The resident explained that she went to the next neighbor to ask for their phone to call the police. The police arrived, and the resident told the police that she wants to kill and go to jail. The staff immediately call the supervisor, and the supervisor advised the police to take the resident to the hospital probably because of mental issues." The police took the resident to the hospital. The resident returned from the ER a few hours later. An incident report was completed on October 25, 2022, due to a mental health emergency when staff saw the resident across the street with some police officers. The resident "made the police to understand that she want to kill someone and go to jail (sic)." The incident report indicated the event was not a reportable event to the state and policies and procedures were followed. No further action was taken as the resident was seen at the emergency room and the "ER did not see any reason why resident should be admitted to psych	0 620		

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0 620	Continued From page 19 unit." The resident returned home. No new interventions were identified or implemented. A MAARC report was not filed. An incident report was completed on November 2, 2022, after the resident eloped. A description of the elopement indicated the resident had just finished speaking with her dad on the phone and staff heard the kitchen door open and saw the resident walking away. LPN-D attempted to redirect her back to the house but she refused to return. LPN-D followed the resident and asked her why she wanted to elope. The resident was noted to have told LPN-D, "I was thinking I can pick up a man if I walk down." LPN-D offered the resident a can of pop and she agreed to return to the home. The report indicated the elopement was not reported to the state. LALD/CNS-A reviewed the incident report and the supervisor's review of the elopement read "resident returned to the house without any incidence (sic)." No new interventions were identified or implemented to prevent R1 from eloping. A MAARC report was not filed. An incident report was completed on November 3, 2022, after the resident eloped. The partially completed report indicated the resident had gone out back to smoke while LPN-D took the garbage out. When LPN-D returned "less than 2 minutes" later, R1 was gone and not on the street. LPN-D documented she was about to call 911 when she spotted the resident at a neighbor's house. Sections for if the family and medical provider were notified, was the elopement reported to the state, and supervisory review of the elopement were blank. The incident report was not reviewed by LALD/CNS-A. No new interventions were identified or implemented to prevent R1 from eloping. A MAARC report was not filed.	0 620		

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0 620	Continued From page 20 On November 8, 2022, LPN-D documented the resident had been restless all day, in and out of her and the bathroom. "She also made several demands for extra food and snack through the duration of this shift. Redirecting resident doesn't seem to be working." On November 10, 2022, LPN-D documented the resident grabbed her phone and the house phone and refused to give it back. The resident called 911 and two police officers responded. The resident reported to the police she didn't like the kind of coffee she drinks and that she can't smoke more than every two hours. A partially completed incident report was initiated on November 10, 2022, for a 911 call after the resident was upset her dad did not order her buffalo chicken. No new interventions were identified or implemented and LALD/CNS-A did not review the incident report. On November 12, 2022, a ULP documented the resident "had a calm day mostly but later during the day got very agitated, kept repeating that she's scared..." On November 14, 2022, a ULP documented while staff were cleaning the kitchen, he resident grabbed the sanitizer spray, sprayed it on the counter, and licked it. Staff quickly removed the cleaner. A partially completed incident report was initiated on November 14, 2022, for possible abuse after the resident tried to lick sanitizer. Sections for if the family or medical provider were notified, what actions were put in place to minimize/end the abuse, and if the abuse was reported to the state	0 620		

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0 620	Continued From page 21 were blank. LALD/CNS-A did not review or finish the incident report. On November 16, 2022, LPN-D documented the "resident has been trying to get in the locked cabinet under the kitchen sink, she also tried to break into the kitchen pantry several time but was unable to break off the lock to both of the cabinet while she was doing it, she asked that writer call 911 and let them know that resident is trying to break the cabinets." Later that evening, LPN-D wrote the resident had several episodes of anxiety and agitation during this shift at "one point she walked out of the front door without a jacket or shoes on," LALD/CNS-A had to go outside and look for her and "it took a few minutes for her to walk back in the house." The last progress note in the resident's record was dated November 22, 2022, at 6:21 a.m., the resident was noted to have slept all night and was still in bed sleeping. A partially completed incident report was initiated on November 23, 2022 after the resident was aggressive toward staff and property. A description of the incident indicated the "Resident came out of her room and asked writer to call 911, writer asked why she responded by saying she want to go to jail, writer explained that he can't call 911 just because resident feeling like going to jail, at that point she walked over to the kitchen area and started destroying thing, first she pushed the computer monitor off the table, then went grabbed the laptop and totally destroyed it, then broke one of the kitchen window." A supervisor's summary of the incident was left blank and LALD/CNS-A did not review the incident report.	0 620		

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0 620	Continued From page 22 Hospital records indicated the resident spent 11 days in the emergency room after the licensee refused to accept the resident back. The resident arrived in the ER around 4:00 p.m. on November 23, 2022 for evaluation of a mental health issue. A hospital social worker called LALD/CNS-A around 4:45 p.m. on November 23, 2022 and documented that LALD/CNS-A told her they had been trying to manage R1's behavior and that she hasn't had any major changes. R1 was throwing things, broke a laptop, and threw a cup of pencils at staff before she was sent to the ER and wasn't listening or following directions. The social worker note indicated LALD/RN-A stated they were not able to manage her behaviors and she couldn't come back to the "group home." A psychiatric consult note completed on November 24, 2022, indicated the resident had suicide attempts on September 20, 2022 and September 30, 2022, and had a history of violence or aggressive behaviors. The behaviors were noted to have not changed or increased in frequency. The resident did not meet criteria to be admitted to inpatient psych. On July 28, 2023, at 11:30 a.m., case manager (CM)-B stated she had reached out to facility staff a few times as it seemed like some of R1's rights were being restricted and she was being treated more like a child than a vulnerable adult. CM-B stated she did not receive a termination notice until after the resident had been sent to the emergency room on November 23, 2022, and the resident was not given a meeting to discuss the termination and was just told they were terminating her contract effective November 23, 2022. CM-B stated the resident had many behaviors and the facility seemed to not know what to do about it and they'd say they had plans on how to help with the situation but "when it	0 620		

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0 620	Continued From page 23 actually came down to it, it was more them wanting me to figure it out and how to stop it." On August 1, 2023, at 11:50 a.m., LALD/CNS-A stated he had completed all kinds of assessments on the resident, including physical and behavioral ones. LALD/CNS-A stated the resident had admitted to the facility from jail and the facility she was at previously had refused to take her back and they had filed a police report but he did not obtain any records from her prior facility. LALD/CNS-A confirmed the UDALSA said they could manage challenging behaviors and provide one to one care and the facility had installed cameras so they could watch the resident. LALD/CNS-A confirmed that while the UDALSA said they could staff to meet the resident's needs, "it wasn't available at that time." LALD/CNS-A stated they weren't able to hire anyone and the county wouldn't pay for the extra care so they did not provide it. LALD/CNS-A stated they had implemented some interventions and felt they were working. LALD/CNS-A confirmed the facility would lock the facility doors from the inside as a way to prevent elopements. LALD/CNS-A confirmed some incident reports had not been completed but stated they try to find new interventions when they can. On August 1, 2023, at 1:15 p.m., LPN-D stated they would implement interventions like locking the resident in the home so only someone with a key would be able to open the door to exit to help the resident calm down or prevent elopements. LPN-D stated staff would follow the resident if she eloped from the house and that was an intervention. LPN-D stated they did not provide one to one staffing because the county wouldn't pay for it. LPN-D stated the resident would freqently contact men from online dating sites and	0 620		

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0 620	Continued From page 24 the phone had "become an issue because of her brain injury she doesn't know how to differentiate danger." LPN-D stated they would monitor the resident and redirect her as needed and eventually the resident's dad took her phone and "that was his decision, not our decision." LPN-D stated other interventions included offering the resident juice or a snack. On August 1, 2023, at 1:40 p.m., psychiatric nurse practitioner (NP)-E stated the facility had not informed her of many of the resident's behaviors, including exchanging nude pictures for cigarettes, talking to men from online dating sites and inviting them over, or some of her many elopements. NP-E stated she was under the impression the facility was a group home and was not aware it was an assisted living facility. NP-E stated she had not been informed of any termination notices or pretermination meetings and only found out about the resident's November 23, 2022, emergency room visit when law enforcement called to tell her the facility was refusing to take her back. NP-E stated, "I wish they would have told me some of this stuff, I would have been happy to help them come up with interventions." On August 2, 2023, at 1:00 p.m., the resident's primary care nurse practitioner (NP)-F stated she had not been made aware of many of the behavioral issues displayed by the resident and thought the resident was residing in a group home, not an assisted living. NP-F stated the resident was a high care patient needing constant supervision and she had told facility staff they weren't built to provide that level of care and they need to find a different place for the resident. The licensee's undated Vulnerable Adult	0 620		

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0 620	Continued From page 25 Maltreatment-Prevention & Reporting policy indicated the maltreatment of residents is strictly prohibited. If a staff member suspected maltreatment (abuse, financial exploitation, or neglect) of a resident, they were to take the following steps: Take immediate action to ensure the safety and well-being of the affected resident. Call 911 if emergency assistance is required. Inform the Clinical Nurse Supervisor if medical attention is needed. Contact the Assisted Living Director.The Assisted Living Director or Clinical Nurse Supervisor will promptly assess the situation and take necessary measures to protect other residents from potential maltreatment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
0 630 SS=G	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	0 630		

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0 630	Continued From page 26 licensee failed to ensure an individualized abuse prevention plan (IAPP) was implemented for one of one residents (R1). R1's IAPP failed to identify interventions for the resident's behaviors or ways to minimize the risk of abuse and their susceptibility to abuse from others. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The facility failed to provide supervision to protect R1's health and safety following multiple behavior related incidents including elopements and the resident exchanging nude photos of herself to people she met online for cigarettes. The facility was aware the resident had impulsive behaviors and failed to assess, identify, and implement interventions to mitigate risk or prevent future incidents. The licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) dated August 4, 2022, indicated the facility was prepared to manage challenging behaviors. The facility did not have a secured unit or building for wandering or exit seeking behavior. The facility had a wander alert system at facility exits and staff monitored the facility's exits. The facility was able to do every 15-minute safety checks and had one to one staffing available and could do one to one staffing for special circumstances. The	0 630		

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0 630	Continued From page 27 typical staffing pattern was one staff member per shift. R1's diagnoses included schizophrenia, traumatic brain injury, anxiety disorder, cognitive impairment, delusional disorder, and history of substance abuse. The resident admitted to the facility on August 5, 2022. R1's service plan, dated August 5, 2022 , indicated the resident received reminders for dressing, eating, oral hygiene, and grooming. The resident's record contained a signed provider order dated August 16, 2022, indicating it was recommended R1 have "1:1 staffing due to her behaviors that result in safety risk to herself and others including eloping, running into traffic, getting into stranger's cars, physical aggression, stealing, inappropriate calling of 911, strangers and others." Facility schedules from October 31, 2022, through December 4, 2022, indicated only one staff member was working each shift. The resident's admission assessment, dated August 5, 2022, indicated the resident had unsuccessful prior placements due to "behavior disturbances." The assessment indicated the resident was resistive to cares and medications and had a history of physical aggression, verbal aggression, defiance, wandering, pacing, anger, inappropriate sexual behavior, cursing/swearing, and a history of self harm. Effective non pharmalogical interventions identified included "take a walk, get cigarette as a reward." A section for effective pharmalocical interventions read,	0 630		

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0 630	Continued From page 28 "Effectiveness not ascertained." The resident was assessed to be a high risk for elopement. A 14 day assessment was completed on August 19, 2022, indicated the resident had been moved from the lower bedroom to the main floor for "close monitoring." The assessment noted the resident's appetite "seems to be uncontrollable. There's need to lock up extra foods and bring out only when needed. Resident's behavior also includes walking out of the house to the road and other people's homes to beg for cigarettes." The service plan was updated to include "make cigarette available for resident every two hours." No other behavioral interventions were identified or implemented. An assessment was completed on September 17, 2022, due to a new behavior of drinking hand sanitizer and the liquid from wet wipes. An intervention identified was to "lock up everything and keep them out of sight" and to bring out hand sanitizer, wet wipes, and syrup only when needed. In the assessment, the resident was identified to be at risk to be abused and was to be monitored at home at all times and accompanied at all times when out of the facility. The resident was noted to have difficulty weighing advice due to impaired judgment and "may be exposed to predators." The resident was noted to be at risk for elopement with an intervention listed as "camera monitoring environment 24 hours, staff in facility 24 hours awake at night, lock exit doors with alarms on at 10pm daily." The resident had behaviors including agitation, hoarding, property destruction, repetitive behavior, verbal aggression, and was a high risk for elopement. The resident was noted to disrobe occasionally and needed redirection, and was "fond of making inappropriate sexual comments," as well as being	0 630		

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0 630	Continued From page 29 socially inappropriate by asking neighbors for cigarettes. No other behavioral interventions were identified or implemented. R1's undated, unsigned discharge summary lacked documentation of the events leading up to her being sent to the emergency room and the subsequent termination notice. A termination notice dated November 23, 2022, indicated the notice was a "sequel to the meeting held on November 2, 2022, Noble Cares LLC is terminating contract and referring the resident to a higher level of care." The notice was effective November 23, 2022, due to the resident's "extremely dangerous behaviors to self and others and non-compliance with house rules." The termination notice lacked information on who the resident could contact to discuss the termination notice and read, "Insert name and contact information of person at the facility the resident can contact." The signature line for facility staff was left blank. The notice was not signed by the resident or a responsible party. The resident's most recent care plan, last updated October 2, 2022, by LALD/CNS-A indicated the resident was to be monitored at home at all times. The resident was noted to have agitation, be a high risk for elopement, had a history of hoarding, was physically aggressive when she can't have her way, had a history of property destruction, and was socially inappropriate and would go to neighbors to beg for cigarettes. The resident was also noted to insist on doing things even if it's going to hurt, had a history of self injurious behavior, and would eat and drink anything she can find including bottles of syrup and hand sanitizer. Staff were to lock exit doors and alarm them at 10:00 p.m. daily. The	0 630		

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0 630	Continued From page 30 care plan lacked specific interventions or guidance for staff on how to handle behaviors. The licensee did not have an assisted living with dementia care license that would allow exit doors to be locked. Progress notes indicated the resident had almost daily behaviors since she was admitted, including exposing herself to others, taking nude photographs of herself and sharing them with others and on the internet, ingesting various non-food items including paint and hand sanitizer, eloping from the facility, binging on food, aggressive behaviors including frequent destruction of facility property, and frequent smoking throughout the day, including two incidents where the resident accidentally lit her hair on fire. On August 11, 2022, an unlicensed personnel (ULP) documented the resident "received a phone call today from a person on EHarmony [online dating site] staff told her not to give out the address to whom she was talking to she walked into the bathroom and stayed in there for about 5 minutes talking. Now at 6pm she was on her phone texting and asked staff for the address here staff asked her why she needed it and she said that she was texting it to her sister and staff told her that her sister had it so she put her phone down. So if other staff can keep a ear out so she doesn't give out to theses people that she is talking to on EHarmony. Staff did hear her ask where he lived and she said coon rapids that's not far from here so just keep ears opened." Later that evening, licensed practical nurse (LPN)-D wrote that the resident asked if she could have a male friend that she just met online over and that LPN-D "advised that she take things slow online for her safety but that last just	0 630		

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0 630	Continued From page 31 a few minutes because after that discussion, she sent the house address to someone else online." Around 10:00 p.m. that evening, the resident was on the patio and "ran off," after "one of the guys she met online showed up and she got in the call [car] and asked the guy to drive off but writer flagged him to roll his windows down which he did." The resident got out of car and went back in the house. A progress note completed by LALD/CNS-A included part of an email between him and the resident's case manager after they had been updated on the resident's behaviors from August 11th. The progress note included the following, "...Police arrived later, pulled the record of the guy with the number plate. They reported that the guy doesn't have a good record. We have a woman here who's beginning to have a bad influence on [R1] But she left on her own 2 days ago. We anticipated the behaviors we are seeing with [R1]. She had to be placed 1:1 to meet certain demands and ensure she doesn't elope. What happened last night could have been worse." An incident report was completed on August 11, 2022, after the resident eloped. The resident was noted to have "ran off" after "one of the guys she met online showed up" and she got in the car. The resident attempted to leave with the man. The resident eventually got out of the car and came back in the house and the police were called. The incident report indicated the elopement was not reported to the state. LALD/CNS-A reviewed the incident report and the supervisor's review of the elopement read "resident continued to make effort to elope. Staff continues to monitor her closely especially when she outside the house (sic)." On August 12, 2022, LPN-D documented the	0 630		

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0 630	Continued From page 32 resident "continued to give her home address to guys online." On August 14, 2022, LPN-D documented the "resident asked for her vape immediately she came upstairs from her room and writer gave it to her as writer was about to open the door resident asked why the doors are knocked at night as she will like to leave the house when ever she wanted, writer explained that the door is knocked at night for everybody's safety." Later that day, it was noted the resident had been very agitated and "has been trying to elope." LPN-D wrote she followed the resident down the driveway and the resident asked why she can't be allowed to go on dates with the people she meets online. Around 10:45 p.m. that evening, LPN-D documented the resident was "online at the moment trying to talk to a guy online to get her cigarette, whiskey, or any other drink, she also ask that he send her some of his pics, writer has redirected her several times already during this shift about giving out house address to random guys online for everyone's safety, but she continues to do so not just to any person but several of them." The licensee failed to submit a MAARC report or take other measures to keep the resident safe. On August 15, 2022, a ULP documented the resident has been "trying to walk out on the street and ask everyone for a smoke she also asked the men if they wanted to date her. Staff told her that is inappropriate she then told staff to fuck off and she came back in she also told staff that she took some nude photos and put them on that dating site EHarmony staff told her that she shouldn't be doing that and she told staff to mind her own business cause she said that she is old enough to make her own mind up on what she does. Staff did call her father to let him know what she was	0 630		

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0 630	Continued From page 33 doing and he said that he will talk to her about the phone issue." On August 17, 2022, LPN-D documented the resident "went to the street twice barefoot with writer following behind as she will to follow direction not to do so." On August 23, 2022, a ULP documented "...she kept asking to go outside and asked if her friends online could come visit her, told her no I'll call the cops if anyone showed up." On August 25, 2022, a ULP documented "...we went to the dog park so she could play whit the dogs but she didn't get out of the car because she wanted to buy the dog and not play with them. She called a guy friend to come pick her up and I told her that she can not leave with him and if she does I will call the police. They sat in the car for a while and when I told the guy that I was calling the police he left." On August 27, 2022, LPN-D documented the "resident has been outside with writer close by, writer has redirected her several times to come inside but she refuse. She is still outside at the moment." On August 28, 2022, LPN-D documented the "resident tried to open the kitchen door leading to the patio at night but was unsuccessful. Then she went back to bed..." On August 30, 2022, a ULP documented the resident had "asked staff for a cigarette like five times today staff reminded her that staff can not give her smokes. She then took her lighter and went and sat out at the table in the breeze way and try to light her hair on fire. Staff took her	0 630		

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0 630	Continued From page 34 lighter away she did not burn her head but did singe her hair...Also she was on her phone in the front room and she had it on speaker so staff heard the conversation this guy she said that is her boyfriend asked her for her social security number and for her bank account number he said that he is going to get her a credit card he also said that he sent her money in the sum of five dollars she can get it from the ATM at the gas station so she asked staff to take her and staff said no that was not going to happen so she went into her room and staff went back to check on her staff knocked on the door and she said to come in she was taking pictures of her breast staff asked her what she was doing she said she was sending pictures to her boyfriend. Staff did tell her that was right and she should not do that she then told staff to mind her own business...She is currently on the phone with her boyfriend and she asked him to come over here and staff reminded her not a good idea and staff would call the police on this man for he wants her bank information so she went into her room." On August 31, 2022, a ULP documented the resident kept insisting she wanted to go to the store and wanted to leave by herself and walked to the door. Staff had to lock the doors so she could not leave. Later that day, the resident was noted to be outside asking people for cigarettes and staff had to bring her back in the house. On September 3, 2022, LPN-D documented the "resident reported to this writer and in the in coming staff (sic) that she has been sending nude pictures to a guy she met online, writer explained to her that it was to safe and not a good practice, she stated that the guy promised her money but is yet to send her the money." Later that day, a ULP documented staff had	0 630		

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0 630	Continued From page 35 asked the resident if she put some graphic pictures on the internet and she said yes "so she was asked to please show us and she did and they are very graphic. Staff asked her to not do that anymore and the clients [resident's] remarks were that is how she lost her phone before so staff said that just might happen here to and she said that she would try not to do that again but she said her boyfriend wants her to send him pictures of her like that cause she said that he told her he loves her and that he also wanted her social security number. Staff said to please not give him that number." On September 4, 2022, a ULP documented the resident left and walked to the ATM to get money and staff followed her in a truck and went to the gas station. Later that day, the resident called her boyfriend and she "told him that staff was locking her in the house and she couldn't get out he wanted to talk to staff and staff said no thank you." The resident also called her father and told him that she had eloped. On September 5, 2022, LALD/CNS-A documented the resident's father came for a visit and the inappropriate phone use was reported to him. The progress note indicated the "resident have been calling guys she found online and requesting for money/cigarette in exchange for nude pictures/videos. The said guys drives tot he house to give her cigarette. More than one car/person have shown up in the house. Each of those times she goes out to meet with the person in the guy, threatening to elope with them. Anoka police was called about three times to assist so resident doesn't elope. We stopped calling when we were told not to call for this same issue any longer. Resident became riskier when Anoka police spoke with her. Police specifically told her	0 630		

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0 630	Continued From page 36 they would not come to the house for this issue. Resident's dad also brought an electric shaver. The plan is to have her shave her head once a week to keep it low. Resident had set her hair on fire with lighter 2 times this past week. Staff intervened immediately to stop her from getting hurting herself. Recently, she started putting off cigarette smoke using the sole of her foot." On September 9, 2022, LALD/CNS-A documented that adult protection Anoka county called today to follow up to adult protection that was filed on behalf of resident. LALD/CNS-A failed to submit a MAARC report or identify any new interventions to ensure the resident was not at risk for abuse. On September 13, 2022, a ULP documented after supper, the resident went outside to smoke and she "lifted up her shirt over her breast and staff asked her to stop she did this three times and finally staff just asked her to come in the house. Staff asked her why she was doing that and she said that she liked the sun on her breasts staff explained to her that she can't be doing that outside cause the neighbors would get upset so we are currently sitting in the front room watching a movie." On September 17, 2022, a ULP documented after resident took her noon medication, she asked staff for an alcoholic beverage, but was told no. As she was going back to her room, she "immediately picked up the hand sanitizer and drank, writer rushed to get it from her but she drank. No injuries noted." Later that evening, LPN-D wrote, "...she got out jam from the refrigerator and eat with a spoon like ice cream again writer redirected her about few minutes later she opened one of the kitchen pantry and	0 630		

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0 630	Continued From page 37 took a bottle of syrup and just drank it writer redirected her and asked for it but she got agitated when she finished she put the bottle back in it place." LALD/CNS-A wrote a follow up note that day that included "[R1] eats and drinks 'anything' she can find. 9/17/2022 she opened a bottle of hand sanitizer, poured the content into a cup and rapidly drank it before staff could retrieve it from her. Later in the evening, she opened a container of wet wipes, and attempt to pour the liquid content into a cup so she can drink it. Staff intervened and took it from her. [R1] has been drinking Waffle/Pancake syrup. She pours it into a cup and drinks from it. She also drinks milk until she empties the gallon. Plan of action: Lock up everything and keep them out of sight. Bring out wet wipes, hand-sanitizers only when needed. Also, bring out syrup bottle only when needed." A MAARC report was not filed. On September 22, 2022, LPN-D wrote the "resident has been restless for the most part of the evening, tried to break the house laptop and computer monitor, she also ate endless this evening, she ransacked the kitchen and refrigerator and ate anything she found, when redirected she gets aggressive like trying to hit staff..." On September 24, 2022, a ULP wrote the resident asked for another cigarette 15 minutes after finishing her last one. After being told she should wait two hours, the resident left the house and walked two miles and sat in the middle of the street. An incident report was completed on September 30, 2022, after the resident "broke into the garage and poured paint in the cup and has drunk some of it." The resident was taken to the emergency	0 630		

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0 630	Continued From page 38 room. Actions taken to prevent further injury were "provide supervision more closely. Provide extra lock to garage. Lock up all liquid soap and hand sanitizers." The section for if the incident was reported to the state indicated "ER did not report any complication with treatment." LALD/CNS-A reviewed the incident report and the supervisor's review of the elopement read "no injury involved." No new interventions were identified or implemented. A MAARC report was not filed. On October 7, 2022, LPN-D wrote that the "resident went through the refrigerator, got cheese, after than was done she went through all the kitchen cabinet, eating anything she can find, she even ate some food seasoning, each time writer tried to redirect her she will respond by saying my dad doesn't care if I eat it, she had snack but that didn't not stop her from asking for more, writer redirected severe times to go to bed as it was bedtime and late, she refused sat on the floor and cried..." An incident report was completed on October 14, 2022, due to aggressive behavior towards staff. A description of the incident indicated staff were giving the resident her cigarettes when she asked for some candy. As staff were getting the candy, she became aggressive and pushed staff towards the cabinet. LALD/CNS-A completed a supervisor's summary of the incident and wrote, "Education reinforced to staff person. [R1]cannot be around staff when staff is opening the cabinet." Besides reminding staff to tell R1 to "sit still when medication cabinet and the cabinet where cigarette is kept is being opened," no new interventions were identified or implemented. On October 16, 2022, LALD/CNS-A documented the resident went to neighbor's house to get	0 630		

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0 630	Continued From page 39 cigarette. "She brought it to the house, used an electric stove to lit it and set off all smoke alarms. She left the house twice." A MAARC report was not filed. A progress note from October 19, 2022, included parts of email correspondence between LALD/CNS-A and the resident's case managers. LALD/CNS-A wrote, "[R1] continues to make all kinds of demands. She's never satisfied. Her quest for anything and everything seems unending. It isn't that we didn't anticipate some of these behaviors, but we have to report whenever new things come up....[R1] grabbed a bottle of hand sanitizer and drank the content before staff could take it from her. Since then, we've been locking them up. Same with wet wipes, she looks into it to drink the liquid content of it. Just today again, a staff member took her to the store to buy personal items. She walked away from the staff, went to the shelf where they have hand sanitizers in the store, and drank from one of the bottles. Then she said it makes me feel good. We've been locking things up due to her insatiable nature. I took her to the ER yesterday evening for further evaluation. She was observed throughout the night with lab draws every 4 hours. She was discharged from the ER to the house this morning after she was deemed okay. Part of the plan is to limit her frequency going out of the house to the store for now. We cannot lock up everything related to food, but we did for some. Her craving is out of control. She has gained 9lb since she came. We're also trying to avoid having her break the cabinets or having outbursts or being confrontational." A reply from the provider was noted to include "I saw [R1] this morning and unfortunately she is not doing well. I am hoping that [LALD/CNS-A]	0 630		

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0 630	Continued From page 40 has kept her team in the loop. She has been eloping constantly, running into traffic, stating she wants to kill herself, trying to break into neighbor's houses to find alcohol or cigarettes, and being physically aggressive with the staff in order to steal food, drinks, hand sanitizer, whatever she can get her hands on. She is also calling 911 non stop regarding wanting caffeine, etc. I have instructed them to take her to the ER the next time she does something dangerous like the above, and to tell them that I have recommended she be admitted to a psychiatric unit. The staff are trying to do what they can to keep her safe but with the current severity of her mental illness and neurocognitive disorder symptoms, they are not able to keep her safe. In my opinion she needs a higher level of care. She went to the ER on Saturday and was kept for 3 hours then sent home with no changes." On October 23, 2022, a ULP documented the resident told staff that she wants to kill someone. Staff tried to ask her why but she called the police, who came and talked to her. On October 25, 2022, a ULP documented they were surprised to see the resident standing out side with some police officers. "The staff immediately went out side to find out what was the issued (sic). The resident explained that she went to the next neighbor to ask for their phone to call the police. The police arrived, and the resident told the police that she wants to kill and go to jail. The staff immediately call the supervisor, and the supervisor advised the police to take the resident to the hospital probably because of mental issues." The police took the resident to the hospital. The resident returned from the ER a few hours later.	0 630		

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0 630	Continued From page 41 An incident report was completed on October 25, 2022, due to a mental health emergency when staff saw the resident across the street with some police officers. The resident "made the police to understand that she want to kill someone and go to jail (sic)." The incident report indicated the event was not a reportable event to the state and policies and procedures were followed. No further action was taken as the resident was seen at the emergency room and the "ER did not see any reason why resident should be admitted to psych unit." The resident returned home. No new interventions were identified or implemented. A MAARC report was not filed. An incident report was completed on November 2, 2022, after the resident eloped. A description of the elopement indicated the resident had just finished speaking with her dad on the phone and staff heard the kitchen door open and saw the resident walking away. LPN-D attempted to redirect her back to the house but she refused to return. LPN-D followed the resident and asked her why she wanted to elope. The resident was noted to have told LPN-D, "I was thinking I can pick up a man if I walk down." LPN-D offered the resident a can of pop and she agreed to return to the home. The report indicated the elopement was not reported to the state. LALD/CNS-A reviewed the incident report and the supervisor's review of the elopement read "resident returned to the house without any incidence (sic)." No new interventions were identified or implemented to prevent R1 from eloping. A MAARC report was not filed. An incident report was completed on November 3, 2022, after the resident eloped. The partially completed report indicated the resident had gone out back to smoke while LPN-D took the garbage	0 630		

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0 630	Continued From page 42 out. When LPN-D returned "less than 2 minutes" later, R1 was gone and not on the street. LPN-D documented she was about to call 911 when she spotted the resident at a neighbor's house. Sections for if the family and medical provider were notified, was the elopement reported to the state, and supervisory review of the elopement were blank. The incident report was not reviewed by LALD/CNS-A. No new interventions were identified or implemented to prevent R1 from eloping. A MAARC report was not filed. On November 8, 2022, LPN-D documented the resident had been restless all day, in and out of her and the bathroom. "She also made several demands for extra food and snack through the duration of this shift. Redirecting resident doesn't seem to be working." On November 10, 2022, LPN-D documented the resident grabbed her phone and the house phone and refused to give it back. The resident called 911 and two police officers responded. The resident reported to the police she didn't like the kind of coffee she drinks and that she can't smoke more than every two hours. A partially completed incident report was initiated on November 10, 2022, for a 911 call after the resident was upset her dad did not order her buffalo chicken. No new interventions were identified or implemented and LALD/CNS-A did not review the incident report. On November 12, 2022, a ULP documented the resident "had a calm day mostly but later during the day got very agitated, kept repeating that she's scared..." On November 14, 2022, a ULP documented while	0 630		

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0 630	Continued From page 43 staff were cleaning the kitchen, he resident grabbed the sanitizer spray, sprayed it on the counter, and licked it. Staff quickly removed the cleaner. A partially completed incident report was initiated on November 14, 2022, for possible abuse after the resident tried to lick sanitizer. Sections for if the family or medical provider were notified, what actions were put in place to minimize/end the abuse, and if the abuse was reported to the state were blank. LALD/CNS-A did not review or finish the incident report. On November 16, 2022, LPN-D documented the "resident has been trying to get in the locked cabinet under the kitchen sink, she also tried to break into the kitchen pantry several time but was unable to break off the lock to both of the cabinet while she was doing it, she asked that writer call 911 and let them know that resident is trying to break the cabinets." Later that evening, LPN-D wrote the resident had several episodes of anxiety and agitation during this shift at "one point she walked out of the front door without a jacket or shoes on," LALD/CNS-A had to go outside and look for her and "it took a few minutes for her to walk back in the house." The last progress note in the resident's record was dated November 22, 2022, at 6:21 a.m., the resident was noted to have slept all night and was still in bed sleeping. A partially completed incident report was initiated on November 23, 2022, after the resident was aggressive toward staff and property. A description of the incident indicated the "Resident came out of her room and asked writer to call 911, writer asked why she responded by saying	0 630		

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0 630	Continued From page 44 she want to go to jail, writer explained that he can't call 911 just because resident feeling like going to jail, at that point she walked over to the kitchen area and started destroying thing, first she pushed the computer monitor off the table, then went grabbed the laptop and totally destroyed it, then broke one of the kitchen window." A supervisor's summary of the incident was left blank and LALD/CNS-A did not review the incident report. Hospital records indicated the resident spent 11 days in the emergency room after the licensee refused to accept the resident back. The resident arrived in the ER around 4:00 p.m. on November 23, 2022 for evaluation of a mental health issue. A hospital social worker called LALD/CNS-A around 4:45 p.m. on November 23, 2022 and documented that LALD/CNS-A told her they had been trying to manage R1's behavior and that she hasn't had any major changes. R1 was throwing things, broke a laptop, and threw a cup of pencils at staff before she was sent to the ER and wasn't listening or following directions. The social worker note indicated LALD/RN-A stated they were not able to manage her behaviors and she couldn't come back to the "group home." A psychiatric consult note completed on November 24, 2022, indicated the resident had suicide attempts on September 20, 2022, and September 30, 2022, and had a history of violence or aggressive behaviors. The behaviors were noted to have not changed or increased in frequency. The resident did not meet criteria to be admitted to inpatient psych. On July 28, 2023, at 11:30 a.m., case manager (CM)-B stated she had reached out to facility staff a few times as it seemed like some of R1's rights were being restricted and she was being treated	0 630		

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0 630	Continued From page 45 more like a child than a vulnerable adult. CM-B stated she did not receive a termination notice until after the resident had been sent to the emergency room on November 23, 2022, and the resident was not given a meeting to discuss the termination and was just told they were terminating her contract effective November 23, 2022. CM-B stated the resident had many behaviors and the facility seemed to not know what to do about it and they'd say they had plans on how to help with the situation but "when it actually came down to it, it was more them wanting me to figure it out and how to stop it." On August 1, 2023, at 11:50 a.m., LALD/CNS-A stated he had completed all kinds of assessments on the resident, including physical and behavioral ones. LALD/CNS-A stated the resident had admitted to the facility from jail and the facility she was at previously had refused to take her back and they had filed a police report but he did not obtain any records from her prior facility. LALD/CNS-A confirmed the UDALSA said they could manage challenging behaviors and provide one to one care and the facility had installed cameras so they could watch the resident. LALD/CNS-A confirmed that while the UDALSA said they could staff to meet the resident's needs, "it wasn't available at that time." LALD/CNS-A stated they weren't able to hire anyone and the county wouldn't pay for the extra care so they did not provide it. LALD/CNS-A stated they had implemented some interventions and felt they were working. LALD/CNS-A confirmed the facility would lock the facility doors from the inside as a way to prevent elopements. LALD/CNS-A confirmed some incident reports had not been completed but stated they try to find new interventions when they can.	0 630		

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0 630	Continued From page 46 On August 1, 2023, at 1:15 p.m., LPN-D stated they would implement interventions like locking the resident in the home so only someone with a key would be able to open the door to exit to help the resident calm down or prevent elopements. LPN-D stated staff would follow the resident if she eloped from the house and that was an intervention. LPN-D stated they did not provide one to one staffing because the county wouldn't pay for it. LPN-D stated the resident would freqently contact men from online dating sites and the phone had "become an issue because of her brain injury she doesn't know how to differentiate danger." LPN-D stated they would monitor the resident and redirect her as needed and eventually the resident's dad took her phone and "that was his decision, not our decision." LPN-D stated other interventions included offering the resident juice or a snack. On August 1, 2023, at 1:40 p.m., psychiatric nurse practitioner (NP)-E stated the facility had not informed her of many of the resident's behaviors, including exchanging nude pictures for cigarettes, talking to men from online dating sites and inviting them over, or some of her many elopements. NP-E stated she was under the impression the facility was a group home and was not aware it was an assisted living facility. NP-E stated she had not been informed of any termination notices or pretermination meetings and only found out about the resident's November 23, 2022, emergency room visit when law enforcement called to tell her the facility was refusing to take her back. NP-E stated, "I wish they would have told me some of this stuff, I would have been happy to help them come up with interventions." On August 2, 2023, at 1:00 p.m., the resident's	0 630		

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0 630	Continued From page 47 primary care nurse practitioner (NP)-F stated she had not been made aware of many of the behavioral issues displayed by the resident and thought the resident was residing in a group home, not an assisted living. NP-F stated the resident was a high care patient needing constant supervision and she had told facility staff they weren't built to provide that level of care and they need to find a different place for the resident. The licensee's undated Vulnerable Adult Maltreatment- Prevention & Reporting policy indicated personalized vulnerable adult abuse prevention plans were developed to identify potential risks and establish measures to minimize maltreatment based on the information obtained. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of	01060		

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01060	Continued From page 48 Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content to the resident, legal representative, and designated representative; and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) when the resident did not return from the emergency relocation within four days for one of one residents (R1).	01060		

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01060	Continued From page 49 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 R1's progress notes indicated the resident was sent to the emergency room (ER) for a psychiatric evaluation of behaviors on November 23, 2022, after becoming upset with facility staff when she was refused a cup of coffee. The resident was unable to return to the facility and spent 11 days in the ER while alternative placement was secured. R1's record lacked a written notice that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the OOLTC; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal.	01060		

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01060	Continued From page 50 In addition, R1's record lacked notification to the OOLTC that the resident had been relocated and had not returned to the facility within four days and lacked notification the resident or her representative received the termination notice. A termination notice dated November 23, 2022, indicated the notice was a "sequel to the meeting held on November 2, 2022, Noble Cares LLC is terminating contract and referring the resident to a higher level of care." The notice was effective November 23, 2022, due to the resident's "extremely dangerous behaviors to self and others and non-compliance with house rules." The termination notice lacked information on who the resident could contact to discuss the termination notice and read, "Insert name and contact information of person at the facility the resident can contact." The signature line for facility staff was left blank. The notice was not signed by the resident or a responsible party. On August 1, 2023, at 11:30 a.m., R1's guardian stated he could not recall receiving a termination notice or attending a pre termination meeting. On On August 1, 2023, at 11:50 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated he had met with the resident and her father and case managers on November 2, 2022. LALD/CNS-A was asked why there was no documentation of the meeting and why the attendees did not recall the meeting happening. LALD/CNS-A stated he had video recorded the meeting and was going to document it but never did. LALD/CNS-A stated he had faxed the termination notice to the hospital. The licensee's Notice of Contract Termination	01060		

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01060	Continued From page 51 policy, dated August 1, 2022, indicated the licensee would follow the proper procedures for terminating an assisted living contract with a resident. A pre termination notice would be issued in writing to the resident and the resident's representatives at least five (5) business days in advance of the scheduled meeting. The written notice would include: a proposed time, date, and location of the meeting, a detailed explanation of the reason or reasons for the proposed termination, a list of facility individuals who will attend the meeting, an explanation that the resident may invite family members, representatives, relevant health professionals, a representative from the Office of Ombudsman for Long-Term Care, and other individuals of the resident's choosing to participate in the pre-termination meeting, contact information for the Office of Ombudsman for Long-Term Care and the Office for Ombudsman for Mental Health and Developmental Disabilities and a statement that the ombudsman offices provide advocacy services to residents, the name and contact information of an individual at the facility whom the resident may contact about the meeting or to request an accommodation notice that attendees may request reasonable accommodations for a communication disability or if they speak a language other than English; and notice that if the resident's housing or services are terminated, the resident has the right to appeal under Minnesota Statutes, section 144G.54 and Rule 4659.0210 The facility would schedule and participate in the pre-termination meeting and make reasonable efforts to ensure that the resident and the resident's representatives are able to attend the meeting. In addition, if a pre-termination meeting was held after an emergency relocation, the licensee would issue a notice to the resident, the resident's representatives, and the resident's	01060		

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01060	Continued From page 52 case manager, if applicable, containing the information above at least 24 hours in advance of the pre-termination meeting. The policy further indicated the licensee would not terminate the assisted living contract if the underlying reason for termination may be resolved by the resident obtaining services from another provider of the resident's choosing and the resident obtains those services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
01070 SS=D	144G.52 Subd. 10 Right to return If a resident is absent from a facility for any reason, including an emergency relocation, the facility shall not refuse to allow a resident to return if a termination of housing has not been effectuated. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to allow the return of one of one residents (R1) after she was sent to the emergency room, although the licensee had not issued a notice of termination of services or housing. Hospital records indicated the licensee would not accept R1 back after being medically cleared to return to the facility, due to the resident's behaviors. R1 spent 11 days in the emergency room while other placement was secured. However, the licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) indicated the licensee could provide the additional services R1 required	01070		

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01070	Continued From page 53 including one to one staffing for special circumstances and the ability to manage challenging behaviors. The licensee failed to offer any option for R1 to return as a housing-only resident with the necessary services provided by another agency. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: The licensee's UDALSA dated August 4, 2022, indicated the facility was prepared to manage challenging behaviors. The facility did not have a secured unit or building for wandering or exit seeking behavior. The facility had a wander alert system at facility exits and staff monitored the facility's exits. The facility was able to do every 15-minute safety checks and had one to one staffing available and could do one to one staffing for special circumstances. The typical staffing pattern was one staff member per shift. R1's diagnoses included schizophrenia, traumatic brain injury, anxiety disorder, cognitive impairment, delusional disorder, and history of substance abuse. The resident admitted to the facility on August 5, 2022. R1's Resident Contract for Assisted Living	01070		

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01070	Continued From page 54 indicated on page five the facility "may terminate this Agreement on an expedited basis by providing 15 days' advance written notice to you [Note: We are required to give 15 days' minimum notice period for expedited termination.]" Page six indicated the resident may be removed from the facility in an emergency if doing so was necessary to meet urgent medical needs or if you pose an imminent risk to the health and safety of another resident or staff member. The paragraph indicated an emergency relocation was not a termination of the agreement. R1's service plan, dated August 5, 2022, indicated the resident received reminders for dressing, eating, oral hygiene, and grooming. The resident's record contained a signed provider order dated August 16, 2022, indicating it was recommended R1 have "1:1 staffing due to her behaviors that result in safety risk to herself and others including eloping, running into traffic, getting into stranger's cars, physical aggression, stealing, inappropriate calling of 911, strangers and others." Facility schedules from October 31, 2022, through December 4, 2022, indicated only one staff member was working each shift. The resident's admission assessment, dated August 5, 2022, indicated the resident had unsuccessful prior placements due to "behavior disturbances." The assessment indicated the resident was resistive to cares and medications and had a history of physical aggression, verbal aggression, defiance, wandering, pacing, anger, inappropriate sexual behavior, cursing/swearing, and a history of self harm. Effective non pharmalogical interventions identified included	01070		

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01070	Continued From page 55 "take a walk, get cigarette as a reward." A section for effective pharmacological interventions read, "Effectiveness not ascertained." The resident was assessed to be a high risk for elopement. A 14 day assessment was completed on August 19, 2022, indicated the resident had been moved from the lower bedroom to the main floor for "close monitoring." The assessment noted the resident's appetite "seems to be uncontrollable. There's need to lock up extra foods and bring out only when needed. Resident's behavior also includes walking out of the house to the road and other people's homes to beg for cigarettes." The service plan was updated to include "make cigarette available for resident every two hours." No other behavioral interventions were identified or implemented. An assessment was completed on September 17, 2022, due to a new behavior of drinking hand sanitizer and the liquid from wet wipes. An intervention identified was to "lock up everything and keep them out of sight" and to bring out hand sanitizer, wet wipes, and syrup only when needed. In the assessment, the resident was identified to be at risk to be abused and was to be monitored at home at all times and accompanied at all times when out of the facility. The resident was noted to have difficulty weighing advice due to impaired judgment and "may be exposed to predators." The resident was noted to be at risk for elopement with an intervention listed as "camera monitoring environment 24 hours, staff in facility 24 hours awake at night, lock exit doors with alarms on at 10pm daily." The resident had behaviors including agitation, hoarding, property destruction, repetitive behavior, verbal aggression, and was a high risk for elopement. The resident was noted to disrobe occasionally	01070		

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01070	Continued From page 56 and needed redirection, and was "fond of making inappropriate sexual comments," as well as being socially inappropriate by asking neighbors for cigarettes. No other behavioral interventions were identified or implemented. R1's undated, unsigned discharge summary lacked documentation of the events leading up to her being sent to the emergency room and the subsequent termination notice. A termination notice dated November 23, 2022, indicated the notice was a "sequel to the meeting held on November 2, 2022, Noble Cares LLC is terminating contract and referring the resident to a higher level of care." The notice was effective November 23, 2022, due to the resident's "extremely dangerous behaviors to self and others and non-compliance with house rules." The termination notice lacked information on who the resident could contact to discuss the termination notice and read, "Insert name and contact information of person at the facility the resident can contact." The signature line for facility staff was left blank. The notice was not signed by the resident or a responsible party. Progress notes indicated the resident had almost daily behaviors since she was admitted, including exposing herself to others, taking nude photographs of herself and sharing them with others and on the internet, ingesting various non-food items including paint and hand sanitizer, eloping from the facility, binging on food, aggressive behaviors including frequent destruction of facility property, and frequent smoking throughout the day, including two incidents where the resident accidentally lit her hair on fire.	01070		

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01070	Continued From page 57 The resident's most recent care plan, last updated October 2, 2022, by licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A indicated the resident was to be monitored at home at all times. The resident was noted to have agitation, be a high risk for elopement, had a history of hoarding, was physically aggressive when she can't have her way, had a history of property destruction, and was socially inappropriate and would go to neighbors to beg for cigarettes. The resident was also noted to insist on doing things even if it's going to hurt, had a history of self injurious behavior, and would eat and drink anything she can find including bottles of syrup and hand sanitizer. Staff were to lock exit doors and alarm them at 10:00 p.m. daily. The care plan lacked specific interventions or guidance for staff on how to handle behaviors. Hospital records indicated the resident spent 11 days in the emergency room after the licensee refused to accept the resident back. The resident arrived in the ER around 4:00 p.m. on November 23, 2022, for evaluation of a mental health issue. A hospital social worker called LALD/CNS-A around 4:45 p.m. on November 23, 2022, and documented that LALD/CNS-A told her they had been trying to manage R1's behavior and that she hasn't had any major changes. R1 was throwing things, broke a laptop, and threw a cup of pencils at staff before she was sent to the ER and wasn't listening or following directions. The social worker note indicated LALD/RN-A stated they were not able to manage her behaviors and she couldn't come back to the "group home." LALD/CNS-A stated he would fax her "termination paperwork from our group home." The hospital social worker documented a second interaction with LALD/RN-A on November 25, 2022, but he was	01070		

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01070	Continued From page 58 "unwilling to discuss the patient's return, stating he has already referred us to the patient's case manager, then abruptly ended the call." A psychiatric consult note completed on November 24, 2022, indicated the resident had suicide attempts on September 20, 2022 and September 30, 2022, and had a history of violence or aggressive behaviors. The behaviors were noted to have not changed or increased in frequency. The resident did not meet criteria to be admitted to inpatient psych. On July 28, 2023, at 11:30 a.m., case manager (CM)-B stated she had reached out to facility staff a few times as it seemed like some of R1's rights were being restricted and she was being treated more like a child than a vulnerable adult. CM-B stated she did not receive a termination notice until after the resident had been sent to the emergency room on November 23, 2022, and the resident was not given a meeting to discuss the termination and was just told they were terminating her contract effective November 23, 2022. CM-B stated the resident had many behaviors and the facility seemed to not know what to do about it and they'd say they had plans on how to help with the situation but "when it actually came down to it, it was more them wanting me to figure it out and how to stop it." On August 1, 2023, at 11:50 a.m., LALD/CNS-A stated he had met with the resident and her father and case managers on November 2, 2022. LALD/CNS-A was asked why there was no documentation of the meeting and why the attendees did not recall the meeting happening. LALD/CNS-A stated he had video recorded the meeting and was going to document it but never did.	01070		

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01070	Continued From page 59 On August 1, 2023, at 1:40 p.m., psychiatric nurse practitioner (NP)-E stated she had not been notified by the facility they were considering terminating services and was not aware a meeting was held on November 2, 2022. CNS-E stated she found out the resident was not allowed to return to the facility when law enforcement called her on November 23, 2022. NP-E stated she did not receive any notification from the facility they weren't taking the resident back. The licensee's Notice of Contract Termination policy, dated August 1, 2022, indicated the licensee would follow the proper procedures for terminating an assisted living contract with a resident. A pre termination notice would be issued in writing to the resident and the resident's representatives at least five (5) business days in advance of the scheduled meeting. The written notice would include: a proposed time, date, and location of the meeting, a detailed explanation of the reason or reasons for the proposed termination, a list of facility individuals who will attend the meeting, an explanation that the resident may invite family members, representatives, relevant health professionals, a representative from the Office of Ombudsman for Long-Term Care, and other individuals of the resident's choosing to participate in the pre-termination meeting, contact information for the Office of Ombudsman for Long-Term Care and the Office for Ombudsman for Mental Health and Developmental Disabilities and a statement that the ombudsman offices provide advocacy services to residents, the name and contact information of an individual at the facility whom the resident may contact about the meeting or to request an accommodation notice that attendees may request reasonable accommodations for a communication disability or if they speak a	01070		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36148	A. BUILDING: _____ B. WING _____	C 07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOBLE CARES LLC	3240 SPRAGUE AVENUE ANOKA, MN 55303

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01070	Continued From page 60 language other than English; and notice that if the resident's housing or services are terminated, the resident has the right to appeal under Minnesota Statutes, section 144G.54 and Rule 4659.0210 The facility would schedule and participate in the pre-termination meeting and make reasonable efforts to ensure that the resident and the resident's representatives are able to attend the meeting. In addition, if a pre-termination meeting was held after an emergency relocation, the licensee would issue a notice to the resident, the resident's representatives, and the resident's case manager, if applicable, containing the information above at least 24 hours in advance of the pre-termination meeting. The policy further indicated the licensee would not terminate the assisted living contract if the underlying reason for termination may be resolved by the resident obtaining services from another provider of the resident's choosing and the resident obtains those services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01070		
02290 SS=F	144G.91 Subd. 2 Legislative intent The rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or require that any resident waive any of these rights at any time for any reason, including as a condition of admission to the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the	02290		

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02290	Continued From page 61 licensee included within the service plan and residency agreement contract language which limited the rights of one of one residents (R1). This had the potential to affect all residents and visitors. 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: R1's record contained a Resident Contract for Assisted Living signed and dated August 5, 2022. Page eight of the Resident Contract for Assisted Living included a section titled Visitors that indicated "you are free to receive visitors, but with limitations and space occupancy due to Noble Cares policy regarding health and safety. Noble Cares limits visiting hours to 10pm. You are responsible for the behavior of your guests while at Noble Cares. Visitors may not visit residents in their rooms during Covid-19 pandemic." R1's service agreement, signed and dated August 5, 2022, contained a section titled House Rules which read, "...Our staff are required to perform daily safety checks in the rooms. Knives and sharp objects are not allowed to be kept in the room. We lock them up until they are ready to be used. So are chemicals and any material that may be considered hazardous. Staff will remove any dangerous/hazardous material from your room if found. This will be reported to the manager/director, who in turn will document the	02290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02290	Continued From page 62 action in your personal records. We will also let you know at the same time why we removed any material from your room. The manager/director will have a personal discussion with you/legal representative if you disagree with such action." On August 1, 2023, at 11:50 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the facility had house rules to keep the residents safe and he was not aware they could not limit visitors or determine what residents keep in their rooms. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02290		
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: The facility failed to ensure one of one residents reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No plan of correction is required for this tag.	