

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL36221001M Date Concluded: June 21, 2022

Compliance #: HL36221002C

Name, Address, and County of Licensee

Investigated:

Eagancare Behavioral Health 1766 Gabbro Trail Eagan, MN 55327 Dakota County

Facility Type: Assisted Living Facility (ALF) Evaluator's Name: Michele R. Larson, RN

Special Investigator

Finding: Substantiated, facility responsibility

Nature of Visit:

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

Allegation(s):

It is alleged: The facility neglected to supervise resident 1 and resident 2 when resident 2 physically assaulted resident 1 during two separate incidents three months apart. Resident 1 sustained significant injuries from the assaults, including a fractured skull, torn leg ligament, concussion, broken toe, and thumb injury that required ongoing physical therapy.

Investigative Findings and Conclusion:

Neglect was substantiated. The facility was responsible for the maltreatment. Resident 1 and resident 2 occupied the only two rooms in the lower level of the facility and continued to live across the hall from each other after the first assault. The facility did not increase resident 1's safety checks and monitoring. Resident 1's record indicated she did not receive 24/7 (24 hours a day, seven days a week) safety monitoring and safety checks she was supposed to receive as indicated in resident one's record. The facility did not report the two assaults to the Minnesota Adult Abuse Reporting Center (MAARC).

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. In addition, the investigator spoke with a health professional involved in resident 1's care. The investigator reviewed the law enforcement report and photos. The facility's video footage was reviewed. The investigation included a tour of the facility, review of resident 1 and resident 2's medical records, incident reports, employee training records, and the facility's policies and procedures.

Resident 1 resided in a small, assisted living. Resident 1's diagnoses included schizoaffective disorder, bipolar disorder, borderline personality disorder, and post-traumatic stress disorder (PTSD). Resident 1 walked independently. Resident 1's service plan indicated she required assistance with medication management, personal cares, nightly oxygen therapy, and her continuous positive airway pressure (CPAP) machine. Resident 1's medical record indicated she was susceptible to being abused due to her mental instability and reported chronic suicidal ideations. Resident 1's medical record indicated she would receive 24/7 safety monitoring and safety checks.

Resident 2's diagnoses included bipolar 2, borderline personality disorder, PTSD. used a quad cane and a wheelchair for long distances. Resident 2's service plan indicated she received assistance with medication management. Resident 2's assessment indicated she had a history of unprovoked outbursts of verbal aggression that quickly escalated to physical aggression. Staff were to encourage resident 2 to take deep breaths and express frustration as needed. Resident 2 had a history of physically assaulting a staff and resident at a previous facility. Staff were educated on resident 2's behaviors (packing, verbal aggressions, throwing items, swearing). Resident 2 had poor coping skills resulting in violent actions. Resident 2 required scheduled safety checks per her abuse prevention plan.

A facility incident report indicated one day resident 1 and resident 2 argued in the hallway outside of their rooms. Resident 1 accused resident 2 of stealing items out of her room. An unlicensed personnel (ULP 1) went downstairs break up the argument. ULP 1 reported resident 2 stated, "resident 1 needs to be kicked in the ass." Resident 2 walked up the flight of stairs to the main level. Resident 1 and ULP 1 followed resident 2 up the stairs. Resident 2 stopped at the top of the stairs, preventing resident 1 and ULP 1 from entering the main level. Resident 2 turned to face resident 1 and pushed resident 1, causing resident 1 to fall backwards down the flight of stairs. Resident 1 fell into ULP 1, and continued to fall down the stairs, landing on ceramic tile. ULP 1 called 911. Emergency medical services (EMS) arrived and transported resident 1 to the hospital where she was diagnosed with head, leg, and neck injuries.

The facility failed to reassess resident 1 after she was assaulted by resident 2. In addition, resident 1's record lacked documentation the facility updated her service plan and individual abuse prevention plan (IAPP) after the assault.

The facility failed to reassess resident 2 after she assaulted resident 1. Resident 2's record lacked documentation her service plan was revised and IAPP updated to include specific interventions regarding the assault.

Resident 1's record indicated three months later, resident 1 and resident 2 argued outside of their rooms. Resident 1 asked resident 2 if she took a bottle of juice that was supposed to be shared between all the residents. Resident 2 responded by spitting in resident 1's face. Resident 2 walked to her room, grabbed the empty glass bottle of fruit juice, and struck resident 1 on her head multiple times. ULP 2 attempted to intervene. Law enforcement and 911 were called.

Law enforcement report indicated resident 2 stated she would kill resident 1 while she slept. Law enforcement reviewed the facility's video and audio footage of the assault which showed resident 2 striking resident 1 on the head with a glass bottle. Law enforcement filed a fifth-degree assault report for the incident.

During an interview, a nurse stated the facility asked resident 1 if she wanted to move to another facility they owned but stated resident 1 did not want to move. Resident 1 told the nurse resident 2 should move to the other facility. The nurse stated did not think it was safe for resident 1 to continue living downstairs with resident 2 and stated resident 1 told them she did not feel safe downstairs. The nurse stated to avoid another altercation, he had resident 1 sleep upstairs on the main floor sofa stating, "I felt it was safer for resident 1 to sleep upstairs because staff were close by." The facility moved resident 1 upstairs a few days after the second assault.

During an interview, ULP 1 stated resident 1 told him she was afraid of resident 2 and became more fearful after the first assault. ULP 1 stated staff tried to keep a close proximity to resident 1 and told resident 1 to stay away from resident 2. ULP 1 stated resident 2 previously assaulted staff members. ULP 1 stated resident 2 repeatedly punched a female staff member and threw a computer at them.

During an interview, ULP 2 stated resident 1 and resident 2's rooms were not immediately changed after the second assault. ULP 2 stated the facility discharged resident 2 a few days after the second assault.

During an interview, resident 1 stated she struggled emotionally after the assaults. Resident 1 stated she cried often and experienced PTSD. Resident 1 stated the facility installed a lock on her door after the first assault and told her and resident 2 to stay apart, stating, "that was all that they did."

During an interview, resident 1's health professional stated resident 1 told them she did not feel safe living in the facility.

In conclusion, neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.

"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17

"Neglect" means:

- (a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
- (1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
- (2) which is not the result of an accident or therapeutic conduct.
- (b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Vulnerable Adult interviewed: Yes.

Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:

Resident 2 was discharged from the facility after the second assault. The facility installed a lock on resident 1's door after the first assault.

Action taken by the Minnesota Department of Health:

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

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

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

cc:

The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Dakota County Attorney
Eagan City Attorney
Eagan Police Department

Minnesota Department of Health

AND DIAN OF CORRECTION INTERPRETATION NUMBERS		l `´	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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		36221	B. WING		C 04/14/2022	
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	In accordance with 144G.08 to 144G.9 issued pursuant to a Determination of where the state of th	PROVIDER LICENSING DER Minnesota Statutes, section 5, these correction orders are a complaint investigation. The ther a violation is corrected to with all requirements are number indicated below. Statute contains several analy with any of the items will of compliance. TS: L36221001M The Minnesota Department of a complaint investigation at the did the following correction at the time of the complaint were four residents receiving provider's Assisted Living ction orders are issued for		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal so Tag numbers have been assigned Minnesota State Statutes for Assis Living Facilities. The assigned tag number appears in the far left coluentitled "ID Prefix Tag." The state number and the corresponding text state Statute out of compliance is the "Summary Statement of Deficicolumn. This column also includes findings which are in violation of the requirement after the statement, "Minnesota requirement is not met evidenced by." Following the evaluation findings is the Time Period for Corplease DISREGARD THE HEAD THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION STATUTES. THE LETTER IN THE LEFT COLUMN THE LETTER IN THE LEFT COLUMN THE LEFT COLUMN STATUTES.	oftware. to sted Jumn Statute st of the listed in encies" s the le state This as lators' rection. DING OF THIS ON FOR TATE JMN IS	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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	for reporting maltrea abuse prevention p (a) The assisted living the requirements for maltreatment of vul 626.557. The facility implement a written cases of suspected. This MN Requirement by: Based on interview failed to comply with reporting suspected adults for three of the with reportable incident that has practice results violation that has reconstructed at a widesprease pervasive or rephase affected or has portion or all of the Findings Include: R1 R1's medical record admitted to the facility under the comprehence began receiving assistant as a company to the facility of the comprehence and	ing facility must comply with or the reporting of nerable adults in section y must establish and procedure to ensure that all maltreatment are reported. ent is not met as evidenced and record review, the facility has the requirements for maltreatment of vulnerable have residents (R1, R2, R5) dents. ed in a level three violation (and a resident's health or safety, as injury, impairment, or death, as the potential to lead to hirment, or death) and was read scope (when problems oresent a systemic failure that potential to affect a large					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	ECONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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0 620	indicated R1 receive management, R1's registered nursoctober 26, 2021, is reminders, and assocares. R1 required and medication due pressure (hypotens generalized body particular and medication to abuse were trained to receive had no history of at thoughts but did registed and report was assessed as in however, her IAPP to self-abuse due to needed intervention monitoring. R1 was cares and taking he intervention of staff wellness activities. hallucinations during	ated February 26, 2021, ed assistance with medication se (RN) assessment dated ndicated R1 needed cueing, istance with her personal daily blood pressure checks to history of low blood ion). R1 reported continuous ain and migraines. See prevention plan (IAPP) 2021, indicated R1 was to due to mental instability. Staff or or or chronic thoughts of staff with needed intervention suicidal thoughts to staff. R1 or vulnerable to self-abuse, indicated she was vulnerable to mental instability with a more received 24-hour daily verbally aggressive, resisted or medication, with needed encouraged R1 to engage in	0 620			
	needed intervention medications and so R1's IAPP indicated safety checks. R2 R2's medical record	ons. R1 had depression with as of managed with sheduled wellness activities. R1 received scheduled was reviewed. R2 admitted tober 16, 2020, under the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
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0 620	receiving assisted I 2021. R2's diagnos borderline personal Type 2, and depres and a wheelchair for R2's service plan dindicated R2 received management. R2's RN assessme indicated R2 required transfers. R2 required staff suffacility. R2 had unpaggression that quiraggression. Staff we deep breaths and experience and resident at a preducated on R2's baggressions, throwing poor coping skills resupervision when or risk to abuse others staff supervision when or risk to abuse others.	ne care license, and began iving services on August 1, es included bipolar 2, ity disorder, PTSD, diabetes sion. R2 used a quad cane or long distances. ated October 18, 2020, ed assistance with medication of the distance with medication of the distance with personal stand-by assistance with red medication management. It is included the provoked outbursts of verbal ockly escalated to physical ere to encourage R2 to take express frustration as needed. It is physically assaulting a staff revious facility. Staff were ehaviors (packing, verballing items, swearing). R2 had esulting in violent actions.				

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0 620	in the lower level of taking items from her permission. The representation in the main unlicensed personned R2. R2 stopped at a turned, facing R1 at to prevent R1 and level. R2 shoved R causing R1 to fall be was unable to prevent umbled down the folloor. Staff called 9 with head and neck was filed for the Se R1's progress note 9:48 p.m., indicated by R2 after R1 knows he took a glass boson supposed to be share sidents. R2 resper R2 grabbed the emand struck R1 over ULP-D attempted to and law enforceme with head and hand incident R1 was more previously occupied R1's law enforceme with head and hand incident R1 was more previously occupied R1's law enforceme with head multiple times with head multiple times with head multiple times.	indicated R1 and R2 argued the facility. R1 accused R2 of er bedroom without port indicated R2 stated, "R1 d in the ass." R2 walked a level of the facility. R1 and sel (ULP)-C followed behind the top of the stairs and and ULP-C. R2 used her body JLP-C from entering the main 1 at the top of the stairs ackwards into ULP-C. ULP-C ent R1 from falling, and R1 light of stairs onto a ceramic light of stairs onto a ceramic light of stairs onto a ceramic linjuries. Red evidence a MAARC report ptember 11, 2021 assault. Red evidence a MAARC report ptember 11, 2021 assault. R1 was physically assaulted exed on R2's door asking R2 if of the onded by spitting in R1's face. Pty glass bottle of fruit juice the head multiple times. In intervene. Staff called 911 and sent R1 to the hospital linjuries. Following the eved upstairs to a vacant room				

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l `´	CONSTRUCTION	` ′	(X3) DATE SURVEY COMPLETED	
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		ked evidence a MAARC report cember 10, 2021 assault.					
	facility never moved assaulted her. R1 states across the hall from second physical assaulty moved her to stated she has been for her hand and let the assaults. R1 states the right thumb. R1 after the incidents, assault, the facility in the second physical assault.	at 11:55 a.m., R1 stated the d R2 after she physically stated R2's room was directly hers. R1 stated after the sault in December 2021, the o a vacant room upstairs. R1 in receiving physical therapy ated she could no longer use stated she developed PTSD R1 stated after the first installed a lock on her door to stay away from each other, ll they did."					
	facility filed MAARC assaults. RN-A state facility had R1 sleet upstairs level of the was safer for R1 to because staff were stated R2 was confived was a call pendant anything. RN-A state altercation from occurrence.	at 1:50 p.m., RN-A stated the reports for the two physical ed after the first assault the on the sofa located on the facility. RN-A stated he felt it sleep upstairs on the sofa upstairs and close by. RN-A fined to her room, stating there R2 used if she needed ted this was to prevent another curing. RN-A stated R2 ther room, stating, "it took a					
	• • •	at 8:15 a.m., RN-A confirmed le MAARC reports for R1's two					
	•	at 11:30 a.m., medical doctor expressed to her she did not					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	l \ '	(X3) DATE SURVEY COMPLETED		
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0 620	was afraid of R2 afrairs. ULP-C state R1 after the first income near R1. ULF physically assaulted ULP and throwing a Con April 29, 2022, a R1 was afraid of R2 installed on her doc ULP-D stated on DR1, "I'm going to kill R2's room location after the the second were required to che hours during the night during the day."	ncidents. at 2:00 p.m., ULP-C stated R1 ter R2 pushed her down the ed staff tried to remain close to cident, to make sure R2 did not P-C stated one time R2 d another ULP, beating the a computer at her. at 10:00 a.m., ULP-D stated 2 and requested a lock be or after the first incident. ecember 10, 2021 R2 said to Il you." ULP-D stated R1 and was not changed right away d assault. ULP-D stated staff leck on residents every two ght and every four hours				
	to the facility on Jar comprehensive hor receiving assisted I 2021. R5's diagnos Schizoaffective disc anxiety. R5 walked R5's service plan dindicated R5 receive management R5's incident report 12:45 p.m., indicate penis using a pair of staff he did not like vagina, and told sta	d was reviewed. R5 admitted huary 23, 2021, under the me care license, and began iving services on August 1, les included suicidal ideation, order, substance abuse, and independently. ated January 23, 2021, led assistance with medication of scissors he found. R5 told his penis and wanted a left he would use any means to "I have been trying to cut it off,				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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0 620	observed a one-inc cut at the base of R to the hospital for a treatment. A safety include continuous the facility. A staff p on outings to the staperform a daily roomafter outings. R5's RN assessme indicated R5 tried to history of eloping and Staff were to monitorelopement. R5 had verbal aggression with drugs. Staff would redrugs. Staff would redrugs. Staff would redrugs. R5 constants facility to shop and facility staff. Staff won scheduled shop up items for R5. R5's progress note 6:28 p.m., indicated 5:22 p.m., R5's fam stating R5 left a voi wanted to kill himse stating R5 left a voi wanted to kill himse stating R5 left a voi wanted to kill himse R5's progress note 5:41 p.m., indicated seizure-like activity to a hospital for evaluation of the bought the bottle of bought the bottle of the staff recording the seizure of the bought the bottle of the bottle of the bought the bottle of the bought the bottle of the bottle of the bought the bottle of the bought the bottle of the bott	ong, and it is painful." A RN h long horizontal, superficial as spenis. R5 was transported psychiatric evaluation and plan was implemented to monitoring inside and outside erson would accompany R5 ore. In addition, staff would m checks, and bag searches and wandering from facilities. Or R5's safety and incidents of a history of physical and when under the influence of monitor his safety and use of ly requested to leave the often left the facility without ere to encourage R5 to shop ping days or ask staff to pick dated November 8, 2021, at all on November 20, 2021, at all on November 20, 2021, at all on November 20, 2021, at all R5 was found having Staff called 911 and sent R5	0 620				

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	-	nd self-injurious behaviors. R5 the intensive care unit for a					
	November 25, 2021	te indicated R5 died on 1, at 5:45 p.m., from liver acetaminophen (Tylenol)					
	R5 was vulnerable mental illness and used trained in reporting a timely manner. Reabused. Staff were was vulnerable to a	to self-abuse due to his unawareness of surroundings. for R5's safety and were suspected or actual abuse in 5 was vulnerable to being to monitor R5's safety. R5 abuse other vulnerable adults. or and report and suspected or					
	R5's record lacked MAARC reports for	evidence the facility filed a R5's two incidents.					
	believed R5 went to	9:13 a.m., RN-A stated he the the hospital due to not due to an overdose.					
	August 1,2021, indiwas discovered, the to remove the residual as needed and if indicated. When a toward a vulnerable employee would imployee would imployee would imployee or neglect will determine if the incidetermine if the incidenter would review the incidenter would revie	titled, Vulnerable Adult, dated cated when abuse or neglect employee's first action was lent from danger, provide first contact local law enforcement abuse or neglect directed was discovered, the mediately make an oral report plete a written report of the ithin 24 hours. The RN or and investigate to ident was reportable, and if so ald then be reported to					

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		COMPLETED		
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	copy of the report waretained in the residence policy indicated failured misdemeanor and of to potential civil dans	could expose the non-reporter				
	144G.42 Subd. 6 (b	,	0 630			
	individual abuse prevulnerable adult. The individualized review person's susceptibilized individual, including person's risk of abuse and statements of the taken to minimize the individual including and statements of the taken to minimize the individual including and statements of the individual including and statements of the individual including and statements of the individual including and including and statements of the individual including and including	t develop and implement an evention plan for each le plan shall contain an w or assessment of the lity to abuse by another other vulnerable adults; the sing other vulnerable adults; he specific measures to be ne risk of abuse to that person le adults. For purposes of the lan, abuse includes				
	Based on interview, licensee failed to en prevention plan (IAF three residents (R1 reviewed after R1 witimes by R2. R2's IAF she assaulted R1 to was not updated after the violation that harmed	and record review, the sure an individualized abuse PP) was updated for three of R2, R5) with records as physically assaulted two APP was not updated after to separate times. R5's IAPP ter he tried to sever his penis. The did a resident's health or safety, injury, impairment, or death,				

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		36221	B. WING	_	04/1) 4/2022
	PROVIDER OR SUPPLIER	EALTH 1766 GAE	DRESS, CITY, S BRO TRAIL MN 55122	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 630	serious injury, imparissued at a widesprare pervasive or rephas affected or has portion or all of the The findings include R1 R1's medical record to the licensee on Form comprehensive hor receiving assisted licensee plan daindicated R1 receiving and panic disorder. R1's service plan daindicated R1 receiving assisted licensee plan daindicated R1 receiving and panic disorder. R1's registered nurs cares. R1's medical administered by star pressure checks and low blood pressure continuous generaling R1's individual abust dated October 26, 2021, in reminders, and assisted licensee plan dated october 26, 2021, in reminders, and assisted licensee plan dated october 26, 2021, in reminders, and assisted licensee plan dated lic	as the potential to lead to irment, or death), and was ead scope (when problems present a systemic failure that potential to affect a large residents).				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		36221	B. WING			C 14/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	STATE, ZIP CODE		
FAGANO	CARE BEHAVIORAL H	IFALTH 1766 GA	BBRO TRAIL			
		EAGAN,	MN 55122			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
0 630	to self-abuse due to needed intervention monitoring. R1 was cares and taking he intervention of staff wellness activities. hallucinations durin needed intervention and cleaning solution needed intervention medications and so R1's IAPP indicated safety checks. R1's progress note 9:48 p.m., indicated by R2 after R1 knows she took the facility beverage from the spitting in R1's face bottle and struck R1 Unlicensed personnintervene. Staff call R1 emergency medications and struck R2 Unlicensed personnintervene. Staff call R1 emergency medications are room personnintervene. Staff call R1 emergency medications are room personnintervene. Following the upstairs to a room personnintervene are reported R1 to a injuries. Following the facility and revised the facility and revised multiple times are degree assault characteristics.	indicated she was vulnerable mental instability with a of received 24-hour daily verbally aggressive, resisted er medication, with needed encouraged R1 to engage in R1 had a history of g psychotic episodes with of staff locked sharp objects ons. R1 had depression with				
	R2					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	E CONSTRUCTION	(X3) DATE	SURVEY	
		36221	B. WING	_		C 14/2022
	PROVIDER OR SUPPLIER	IEALTH 1766 GAE	DRESS, CITY, S BRO TRAIL MN 55122	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
0 630	to the facility on Occomprehensive hor receiving assisted I 2021. R2's diagnos borderline personal Type 2, and depresand a wheelchair for R2's RN assessme indicated R2 had unaggression. Staff with deep breaths and eneeded. R2 had a hastaff and resident were educated on Fiverbal aggressions. R2 had poor coping actions. R2's incident report 6:10 p.m., indicated hallway located in the R1 accused R2 of the without permission. Stated, "R1 needed walked upstairs to the R1 and ULP-C following the top of the stairs ULP-C. R2 used held upstairs to the top of the stairs ULP-C. R2 used held upstairs to the top of the stairs ULP-C. R2 used held upstairs to the top of the stairs upper the stairs upper the stairs upper the stairs of the backwards into ULF prevent R1 from fall flight of stairs onto a stair of the stairs onto a stair of the stairs of the backwards into ULF prevent R1 from fall flight of stairs onto a stair of the stairs of the backwards into ULF prevent R1 from fall flight of stairs onto a stair of the stairs of the backwards into ULF prevent R1 from fall flight of stairs onto a stair of the stair of the backwards into ULF prevent R1 from fall flight of stairs onto a stair of the stair of the stair of the backwards into ULF prevent R1 from fall flight of stairs onto a stair of the s	d was reviewed. R2 admitted tober 16, 2020, under the ne care license, and began iving services on August 1, es included bipolar 2, ity disorder, PTSD, diabetes sion. R2 used a quad cane				

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	I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	E CONSTRUCTION	COMP	SURVEY
	36221		B. WING		04/4	
		36221	D. WING		04/1	4/2022
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET			STATE, ZIP CODE		
EAGANCARE BEHAVIORAL HEALTH			BBRO TRAIL MN 55122			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
0 630	Continued From pa updated after she p	ge 13 hysically assaulted R1 on	0 630			
	R2's IAPP dated De R2 was vulnerable a needed intervention when or risk to abuse others staff supervision who a history of attempt thoughts with a needed and locked at thoughts to staff. R2 abusing herself, and suicide or suicidal the suicidal ideation's. R2 had scheduled staff.	ecember 14, 2021, indicated to being abused by others with on of constant staff utside the facility. R2 was at with needed intervention of nen outside the facility. R2 had ed suicide and suicidal eded intervention of R2 was ed by staff. Sharp objects were away. R2 was to report suicidal was not vulnerable to d had no history of attempted houghts but did report chronic Staff were trained to call 911. Safety checks.				
	to the facility on Jar comprehensive hor receiving assisted li 2021. R5's diagnost Schizoaffective disc anxiety. R5 walked R5's service plan daindicated R5 received	d was reviewed. R5 admitted nuary 23, 2021, under the ne care license, and began living services on August 1, es included suicidal ideation, order, substance abuse, and independently. ated January 23, 2021, ed assistance with medication ner unknown scheduled				
	12:45 p.m., R5 atte	dated February 19, 2021, at mpted to sever penis using a found. R5 told staff he did not				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	36221	B. WING		04/1) 4/2022
NAME OF PROVIDER OR SUPPLIE	HEALTH 1766 GAE	DRESS, CITY, S' BRO TRAIL MN 55122	TATE, ZIP CODE		
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
he would use any have been trying long and it is pair (RN) observed a superficial cut at transported to the evaluation and tre implemented to in while inside the fa accompany R5 or would perform a searches after out. R5's IAPP was not interventions to possible to prove R5's RN assessmandicated R5 prevents had a history facilities she lived safety and incided history of physical under the influence his safety and use reported ongoing constantly reques R5 would take a factor being asked to we staff were to encoshopping days or he needs. On April 14, 2022 IAPP's were updated and the eds. The licensee polications are possible to the licensee polications and the resident needs.	wanted a vagina, and told staff means to sever it. R5 stated, "I to cut it off but it is taking too ful." The facility registered nurse one-inch long horizontal, the base of R5's penis. R5 was a hospital for a psychiatric eatment. A safety plan was aclude continuous monitoring acility and staff person to all outings. In addition, staff daily room checks, and bag				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
				С		
		36221	B. WING	_	04/1	14/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
EAGANG	CARE BEHAVIORAL H	IEALTH	BBRO TRAIL MN 55122			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
0 630	Continued From pa	ge 15	0 630			
	frequently, if neces	sary.				
	TIME PERIOD TO	CORRECT: Seven (7) days.				
01620 SS=I	(1)		01620			
	be conducted no mafter initiation of se reassessment and as needed based or resident and cannot from the last date of (d) For residents or services specified in 9, clauses (1) to (5) individualized initial and preferences. To completed within 30 services. Resident be conducted as not the needs of the recalendar days from (e) A facility must in of the availability of long-term care consection 256B.0911, prospective resident facility or the date of resident moves in, and the date of the availability of long-term care consection 256B.0911, prospective resident moves in, and the date of the	essment and monitoring must ore than 14 calendar days rvices. Ongoing resident monitoring must be conducted n changes in the needs of the t exceed 90 calendar days of the assessment. The receiving assisted living n section 144G.08, subdivision of the facility shall complete an review of the resident's needs the initial review must be concluded and review must be concluded and review must be concluded and review must be deded based on changes in sident and cannot exceed 90 the date of the last review. Inform the prospective resident and contact information for sultation services under prior to the date on which a not executes a contract with a contact in the prospective which a registered nurse (RN) sments for three of three R5) with records reviewed				

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′	CONSTRUCTION	(X3) DATE COMP	LETED
	36221			04/1) 4/2022
NAME OF PROVIDER OR SUPPLIE	HEALTH 1766 GA	DDRESS, CITY, ST BBRO TRAIL MN 55122	TATE, ZIP CODE		
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDEFICIENCY)	D BE	(X5) COMPLETE DATE
separate incidents the RN reassesse assaulted R1. R5 another incident, to a family member This practice result violation that harm not including serior or a violation that serious injury, implies ued at a wides are pervasive or management and receiving assisted 2021. R1's medical receiving assisted 2021. R1's diagnor disorder, Post-Tradisorder, Post-Tradisorder, Post-Tradisorder R1 walked independent and R2's medical receiving assisted and R2's diagnor limited to bipolar 2021. R2's diagnor limited to bipolar 2021. R2's diagnor limited to bipolar 2021.	assaulted by R2 in two s. R2's record lacked evidence ed R2 after she physically tried to cut off his penis, and in stated he wanted to kill himself er. Itted in a level three violation (a ned a resident's health or safety, bus injury, impairment, or death, has the potential to lead to pairment, or death), and was pread scope (when problems epresent a systemic failure that as potential to affect a large e residents). It de: Ord was reviewed. R1 admitted as potential to affect a large e residents). It is a level three violation (a ned a resident's health or safety) and was pread scope (when problems epresent a systemic failure that as potential to affect a large e residents). It is a level three violation (a ned a resident's health or safety) and was pread scope (when problems epresent a systemic failure that as potential to affect a large e residents). It is a level three violation (a ned a resident's health or safety) and was pread to lead to pair the problems expressive and was reviewed. R1 admitted a resident so affect a large e residents).				

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	COMPLETED COMPLETED
36221 B. WING	
NAME OF PROVIDER OR SUPPLIER EAGANCARE BEHAVIORAL HEALTH STREET ADDRESS, CITY, STATE 1766 GABBRO TRAIL EAGAN, MN 55122	E, ZIP CODE
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETE DATE
depression. R2 used a quad cane and a wheelchair for long distances. R2's service plan dated October 18, 2020, indicated R2 received assistance with medication management and other unknown services. R2's incident report dated September 11, 2021, at 6:10 p.m., indicated R1 and R2 argued in a hallway located in the lower level of the facility. R1 accused R2 of taking items from her bedroom without permission. The report indicated R2 stated, "R1 needed to be kicked in the ass." R2 walked upstairs to the main level of the facility. R1 and ULP-C followed behind R2. R2 stopped at the top of the stairs and turned, facing R1 and ULP-C. R2 used her body to prevent R1 and ULP-C. From entering the main level. R2 shoved R1 at the top of the stairs causing R1 to fall backwards into ULP-C. ULP-C was unable to prevent R1 from falling, and R1 tumbled down the flight of stairs onto a ceramic floor. 911 was called. R1 was taken to the hospital with head and neck injuries. R1 and R2's record both lacked an assessment after the incident on September 11, 2021, that would included assessing R1's injuries and preventions of abuse and R2's agressive behaviors and interventions to prevent R2 from injuring others. R1's RN assessment dated October 26, 2021, indicated R1 needed cueing, reminders, and assistance with her personal cares. R1 required set-up with her nebulizer treatment, and assistance with her plelvel positive airway pressure (BiPap) face mask. R1's medications were stored and administered by staff. R1 required set to grant and administered by staff. R1 required set to grant and administered by staff. R1 required set to grant and administered by staff. R1 required set to grant and administered by staff. R1 required set to grant and gran	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	CONSTRUCTION	l \ '	E SURVEY PLETED	
		36221	B. WING			C 14/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, S	TATE, ZIP CODE		
EAGANC	ARE BEHAVIORAL H	EALTH	BBRO TRAIL MN 55122			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
01620	(hypotension). R1 r generalized body particles of R2's RN assessme indicated R2 had un aggression that quiraggression. Staff wideep breaths and eneeded. R2 had a resident facility provided 24/on R1's behaviors (throwing items, swe skills resulting in violated by R2 after R1 knows he took the facility beverage from the spitting in R1's face bottle and struck R1 Unlicensed personnintervene. 911 and R1 was taken to the injuries. Following the upstairs to a vacant R5. R1 and R2's record after the incident or would included assepreventions of abust behaviors and intervinjuring others.	nistory of low blood pressure eported continuous ain and migraines. Int dated October 26, 2021, aprovoked outbursts of verbal ckly would escalate to physical ere to encourage R2 to take express her frustration as history of physically assaulting at a previous facility. The 7 staffing. Staff were educated packing, verbal aggressions, earing). R2 had poor coping				
		anuary 23, 2021, under the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	CONSTRUCTION	` '	E SURVEY PLETED	
		36221	B. WING			C 14/2022
	PROVIDER OR SUPPLIER	IEALTH 1766 GA	DDRESS, CITY, ST BBRO TRAIL MN 55122	TATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
01620	receiving assisted I 2021. R5's diagnos Schizoaffective disc anxiety. R5 walked R5's incident report 12:45 p.m., R5 atteusing a pair of sciss did not like his penit told staff he would penis. R5 stated, "I but it is taking too le RN observed a one superficial cut at the transported to the hevaluation and treatimplemented to include inside the fact accompany R5 on a would perform a dasearches after outin R5's record lacked incident on Februar mental health. R5's RN assessment indicated R5 tried to history of eloping at Staff were to monite elopement. R5 had verbal aggression of drugs. Staff would in drugs. R2 was para auditory hallucination to leave the facility facility without facility facility without facility	me care license, and began iving services on August 1, es included suicidal ideation, order, substance abuse, and independently. I dated February 19, 2021, at impted to cut off his penis sors he found. R5 told staff he is and wanted a vagina, and use any means to sever his have been trying to cut it off ong and it is painful." A facility e-inch long horizontal, e base of R5's penis. R5 was nospital for a psychiatric timent. A safety plan was lude continuous monitoring ility and staff person to all outings. In addition, staff tily room checks, and bag				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		36221	B. WING		04/1) 4/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
EAGANO	CARE BEHAVIORAL H	EALTH	BBRO TRAIL			
		EAGAN,	MN 55122			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01620	Continued From pa	ge 20	01620			
	6:28 p.m., indicated 5:22 p.m., R5's fam	dated November 8, 2021, at on November 8, 2021, at lily member called the facility ce message indicating he R5 elf with a knife.				
	R5's record lacked an RN assessment for suicidal ideation.					
	R5's progress note dated November 20, 2021, at 5:41 p.m., indicated R5 was found having seizure-like activity. 911 was called and transported R5 to a hospital for evaluation.					
	indicated R5 reported at an unknown time suicide five previous	d dated November 21, 2021, ed he took 500 pills of Tylenol, and stated he attempted s times. R5 was transferred to init for a higher level of care.				
	November 25, 2021	te indicated R5 died on I, at 5:45 p.m., from liver acetaminophen (Tylenol)				
	performed follow-up were needed. RN-A	at 1:50 p.m., RN-A stated he assessments if adjustments stated he was unsure if he sments on R1 and R2 after the ts.				
	Reassessment, dat ongoing resident m	titled Assessment and ed August 1, 2021, indicated onitoring must be conducted n changes in the needs of the				
	TIME PERIOD TO	CORRECT: Seven (7) days.				

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AND DIAN OF CORRECTION INTERPRETATION NUMBERS		1 ` '		` ′	OATE SURVEY OMPLETED	
	36221	B. WING		04/1	; 4/2022	
NAME OF PROVIDER OR SUPPLIER EAGANCARE BEHAVIORAL H	IEALTH 1766 GAE	DRESS, CITY, S BRO TRAIL IN 55122	STATE, ZIP CODE			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
01640 Continued From pa	ge 21	01640				
01640 144G.70 Subd. 4 (a SS=I implementation and	,	01640				
that services are fire facility shall finalize (b) The service plant include a signature facility and by the reaspeament on the service plan must be resident reassessmant facility must provide about changes to the and how to contact Long-Term Care. (c) The facility must service required by (d) The service plant must be entered into including notice of a when applicable.	calendar days after the date st provided, an assisted living a current written service plan. In and any revisions must or other authentication by the esident documenting services to be provided. The se revised, if needed, based on sent under subdivision 2. The existence information to the resident se facility's fee for services the Office of Ombudsman for the current service plan. In and the revised service plan to the resident record, a change in a resident's fees services must be informed of service plan.					
by: Based on interview licensee failed to residents (R1, Rafter incidents with failed to ensure services to be provincesidents (R1, R2, I reviewed.	and record review, the vise service plans for three of (2, R5) with records reviewed injury. In addition, the licensee vice plans included all the (ded as indicated for five of six R4, R5, R6) with records					
This practice result	ed in a level three violation (a					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36221		1 ` ′	CONSTRUCTION	(X3) DATE	SURVEY PLETED	
		36221	B. WING			C 14/2022
	PROVIDER OR SUPPLIER	IEALTH 1766 GAE	DRESS, CITY, ST BRO TRAIL IN 55122	TATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
01640	not including serious or a violation that he serious injury, impairs and at a widesprare pervasive or rephas affected or has portion or all of the Findings Include: R1 R1's medical record to the license on Fecomprehensive hor receiving assisted I 2021. R1's diagnos disorder, Post-Trau Dissociative identity R1 walked independed in the license on Fecomprehensive hor receiving assisted I 2021. R1's diagnos disorder, Post-Trau Dissociative identity R1 walked independed in the license of the license on Fecomprehensive hor receiving assistance with bloor required nightly assistance with bloor required nightly assistance with bloor required nightly assistance with bloor required R1 receiving unknown services for (ULP). R1's service plan facoxygen management assistance with her A facility incident receiving management as	ed a resident's health or safety, is injury, impairment, or death, as the potential to lead to airment, or death) and was read scope (when problems bresent a systemic failure that potential to affect a large residents). It was reviewed. R1 admitted abruary 26, 2021 under the me care license, and began iving services on August 1, es included major depressive matic Stress Disorder (PTSD), and disorder, and panic disorder. It dently. Itherapy plan dated February R1 required assistance with an therapy delivered at 2 Liters al cannula. R1 required daily and glucose checks. R1 sistance with her continuous assure (CPAP) machine. Itated February 26, 2021, ed daily assistance and other from unlicensed personnel ailed to include services for ant, blood glucose checks and				

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PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) O1640 Continued From page 23 in a hallway located in the lower level of the facility. R1 accused R2 of taking items from her bedroom without permission. The report indicated R2 stated, "R1 needed to be kicked in the ass." R2 walked upstairs to the main level of the facility. R1 and ULP-C followed behind R2. R2 stopped at the top of the stairs and turned, facing	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		` ′	(X3) DATE SURVEY COMPLETED	
EAGANCARE BEHAVIORAL HEALTH (X4) ID PREFIX TAG (CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Description of the facility. R1 accused R2 of taking items from her bedroom without permission. The report indicated R2 stated, "R1 needed to be kicked in the ass." R2 walked upstairs to the main level of the facility. R1 and ULP-C followed behind R2. R2 stopped at the top of the stairs and turned, facing		36221	B. WING				
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) O1640 Continued From page 23 in a hallway located in the lower level of the facility. R1 accused R2 of taking items from her bedroom without permission. The report indicated R2 stated, "R1 needed to be kicked in the ass." R2 walked upstairs to the main level of the facility. R1 and ULP-C followed behind R2. R2 stopped at the top of the stairs and turned, facing SUMMARY STATEMENT OF CORRECTION (X5) COMPLICATION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF CROSS-REFERENCED TO		EALTH 1766 GAB	BRO TRAIL	TATE, ZIP CODE			
in a hallway located in the lower level of the facility. R1 accused R2 of taking items from her bedroom without permission. The report indicated R2 stated, "R1 needed to be kicked in the ass." R2 walked upstairs to the main level of the facility. R1 and ULP-C followed behind R2. R2 stopped at the top of the stairs and turned, facing	PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	LD BE	(X5) COMPLETE DATE	
R1 and ULP-C. R2 used her body to prevent R1 and ULP-C from entering the main level. R2 shoved R1 at the top of the stairs causing R1 to fall backwards into ULP-C. ULP-C was unable to prevent R1 from falling, and R1 tumbled down the flight of stairs onto a ceramic floor. 911 was called. R1 was taken to the hospital with head and neck injuries. R1's service plan lacked evidence it was revised after R1 was physically assaulted in September 2021. R1's registered nurse (RN) assessment dated October 26, 2021, indicated R1 needed cueing, reminders, and assistance with her personal cares. R1 required set-up with her nebulizer treatment, and assistance with her bilevel positive airway pressure (BiPap) face mask. R1's medications were stored and administered by staff. R1 required daily blood pressure checks and medication due to history of low blood pressure (hypotension). R1 reported continuous generalized body pain and migraines. R1's individual abuse prevention plan (IAPP) dated October 26, 2021, indicated R1 received 24/7 safety monitoring and scheduled safety checks. R1's service plan was not updated to reflect the required services R1 needed based on her	in a hallway located facility. R1 accused bedroom without per R2 stated, "R1 need R2 walked upstairs facility. R1 and ULP stopped at the top of R1 and ULP-C. R2 and ULP-C from en shoved R1 at the tof fall backwards into prevent R1 from fall flight of stairs onto a called. R1 was take and neck injuries. R1's service plan la after R1 was physica 2021. R1's registered nursoctober 26, 2021, in reminders, and assicares. R1 required streatment, and assicariway pressure (Bill medications were staff. R1 required dand medication due pressure (hypotens generalized body par R1's individual abust dated October 26, 224/7 safety monitoric checks. R1's service plan was physical stated of the pressure of t	in the lower level of the R2 of taking items from her emission. The report indicated ded to be kicked in the ass." to the main level of the C followed behind R2. R2 of the stairs and turned, facing used her body to prevent R1 tering the main level. R2 p of the stairs causing R1 to ULP-C. ULP-C was unable to ling, and R1 tumbled down the a ceramic floor. 911 was in to the hospital with head cked evidence it was revised ally assaulted in September as (RN) assessment dated andicated R1 needed cueing, istance with her personal set-up with her nebulizer stance with her bilevel positive Pap) face mask. R1's tored and administered by aily blood pressure checks to history of low blood ion). R1 reported continuous ain and migraines. See prevention plan (IAPP) 2021, indicated R1 received and achieved safety					

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		36221	B. WING		04/1) 4/2022
EAGANCARE BEHAVIORAL HEALTH			DRESS, CITY, S BRO TRAIL IN 55122	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
01640	Continued From pa	ge 24	01640			
	9:48 p.m., indicated by R2 after R1 knows she took the facility beverage from the respitting in R1's face bottle and struck R2 Unlicensed personn intervene. 911 and R1 was taken to the injuries. Following the	dated December 10, 2021, at R1 was physically assaulted ked on R2's door asking R2 if s bottle of non-alcoholic refrigerator. R2 responded by R2 grabbed an empty glass over the head multiple times hel (ULP)-D attempted to law enforcement were called hospital with head and hand he incident R1 was moved to room previously occupied by				
	R1's service plan lacked evidence it was revised after R1 was physically assaulted in December 2021.					
	2021 through April 2 daily assistance with assistance with her housekeeping, two	y record dated September 2022, indicated R1 received h behaviors, bathing, CPAP machine, hour nightly oxygen and safety OVID-19 screening.				
	and 24/7 safety mother service plan alo	cked evidence safety checks nitoring were implemented in ng with instruction for ULP on scheduled services.				
		y records lacked received all of her services rided as indicated in her				
		d was reviewed. R2 admitted October 16, 2020, under the				

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AND PLAN OF CO	DEFICIENCIES DRRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		36221	B. WING		04/1	C 4/2022
EAGANCARE BEHAVIORAL HEALTH			DDRESS, CITY, S BBRO TRAIL MN 55122	STATE, ZIP CODE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
commede 202 limit discondent disc	eiving assisted lands and to bipolar 2, order, PTSD, diagnost electron. R2 use electron magement services treatment and 2020, indicated and glucose checks, and other electron	me care license, and began living services on August 1, ses included, but were not borderline personality abetes Type 2, and ed a quad cane and a distances. anagement plan dated October R2 received medication ces. I therapy plan dated October R2 received three times daily cks. ated October 18, 2020, red assistance with medication et times per day blood glucose unknown scheduled services. Ty record dated September ember 2021, indicated R2 stance with behaviors, adry, meals, toileting, daily istance with activites, and e with walking. Ty records lacked received all of her services vided as indicated in her ecember 14, 2021, indicated afety monitoring and				

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE	E SURVEY PLETED
		36221	B. WING	_		C 14/2022
	PROVIDER OR SUPPLIER	IEALTH 1766 GAI	DRESS, CITY, S BRO TRAIL MN 55122	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
01640	Continued From pa	ge 26	01640			
	to the licensee on Nadiagnoses included generalized anxiety cane for walking. R4's service plan daindicated R4 receivement, persentant stand-by assist with R4's service deliver lacked documentation.	d was reviewed. R4 admitted March 28, 2022. R4's bipolar affective disorder and disorder (GAD). R4 used a ated March 28, 2022, ed assistance with medication onal cares, toileting, and a transfers. By record dated April 2022, ion R2 received all of her to be provided as indicated in				
	to the licensee on Journal comprehensive hor receiving assisted I 2021. R5's diagnos	d was reviewed. R5 admitted anuary 23, 2021, under the ne care license, and began iving services on August 1, es included suicidal ideation, order, substance abuse, and independently.				
	2021, indicated R5	ry record dated January 23, received daily assistance with and temperature checks, and				
		anagement plan dated January R5 received assistance with ement.				
	R5's IAPP dated Ja received 24/7 moni	nuary 23, 2021, indicated R5 toring.				
	R5's service plan da	ated January 23, 2021,				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		36221	B. WING			C 14/2022	
	PROVIDER OR SUPPLIER	IEALTH 1766 GAI	DDRESS, CITY, S BBRO TRAIL MN 55122	STATE, ZIP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
01640	scheduled services include services for oxygen and temper behaviors and mon R5's incident report 12:45 p.m., R5 atte a pair of scissors he not like his penis ar staff he would use a stated, "I have been taking too long and registered nurse (R horizontal, superfici penis. R5 was transpsychiatric evaluation plan was implement monitoring while insperson to accompate addition, staff would and bag searches and staff outings. R5's record lacked was revised to incluce the continuous monitor searches, and staff outings. R5's service record 3:50 p.m., and documentation and outlings.	ed assistance with unknown. R5's service plan failed to medication management, rature checks, assistance with itoring. I dated February 19, 2021, at mpted to sever his penis using e found. R5 told staff he did and wanted a vagina, and told any means to sever it. R5 it is painful." The facility N) observed a one-inch long fal cut at the base of R5's sported to the hospital for a on and treatment. A safety ted to include continuous side the facility and staff ny R5 on all outings. In the perform a daily room checks,					

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	CONSTRUCTION	· /	E SURVEY PLETED
		36221	B. WING			C 14/2022
	PROVIDER OR SUPPLIER	1766 GAE	DRESS, CITY, ST	TATE, ZIP CODE		
LAGAN	SANL BLIIAVIONAL II	EAGAN, I	MN 55122			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO TO DEFICIENCE)	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
01640	Continued From pa	ige 28	01640			
	to the licensee on A	d was reviewed. R6 admitted April 12, 2022. R6's diagnoses disorder, schizophrenia, and independently.				
	indicated R6 receiv	ry record dated April 2022, ed the following daily services: behavior managment, and				
		ry record lacked received all of his services that as indicated in R6's service				
	received assistance management and not to included services	ated April 2022, indicated R6 with medication neals. R6's service plan failed for bathing reminders, ent and housekeeping.				
	service plans were	at 1:50 p.m., RN-A stated updated when a resident nge in condition. RN-A stated ident's service plan.				
	August 1, 2021, indideveloped based of or responsible party identified in the conservice plans would description of the service description resident's care plans frequency of each service ategories of staff vertices of staff vertices.	titled Service Plan, dated licated service plans were in agreement with the resident of and on the assessed needs include the following: (a) a services to be provided; the may be in the form of the include according to the service according to the eview or assessment and es; identification of staff or who provided the services; od of monitoring reviews or				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l `´	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			7. 50.25.110.		C	
		36221	B. WING		04/1	4/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
EAGANCARE BEHAVIORAL HEALTH			BRO TRAIL IN 55122			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETE DATE
01640	Continued From pa	age 29	01640			
	assessments of the	e resident.				
	TIME PERIOD TO	CORRECT: Seven (7) days.				
01650 SS=F	•	Service plan, implementation	01650			
	the fees for service service, according assessment and re (2) the identification who will provide the (3) the schedule arransessments of the (4) the schedule arransessments of the (4) the schedule arransessments of the (5) a contingency p (i) the action to be cannot be provided (ii) information and facility; (iii) the names and the resident wishes emergency or if the change in the resididentification of and authority to sign for and (iv) the circumstant medical services arconsistent with change chapters. This MN Requirem by:	the services to be provided, es, and the frequency of each to the resident's current esident preferences; nof staff or categories of staff e services; nd methods of monitoring e resident; nd methods of monitoring staff and plan that includes: taken if the scheduled service				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		36221	B. WING		04/1	; 4/2022
	NAME OF PROVIDER OR SUPPLIER EAGANCARE BEHAVIORAL HEALTH STREET AD 1766 GAI EAGAN,			STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
01650	the required content R2, R4, R5, R6) with This practice results violation that did not safety but had the president's health or widespread scope (or represent a system or has the potential of the residents). Findings Include: R1 R1's medical record to the licensee on From the comprehensive hor receiving assisted literated R1's diagnost disorder, Post-Trau Dissociative identity with agoraphobia. Findicated R1 received unknown services for (ULP). R1's service plan, dindicated R1 received unknown services for (ULP). R1's service plan last services to be provising an emergency or change in R1's content of and information and an emergency or change in R1's content of and information and emergency or change in R1's content of and information and emergency or change in R1's content of and information and emergency or change in R1's content of and information and emergency or change in R1's content of and information and emergency or change in R1's content of and information and emergency or change in R1's content of and information and emergency or change in R1's content of and information and emergency or change in R1's content of and information and emergency or change in R1's content of and information and emergency or change in R1's content of and information and emergency or change in R1's content of an emerg	sure service plans contained t for five of six residents (R1,	01650			

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	AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		36221	B. WING		04/1) 4/2022
EAGANCARE BEHAVIORAL HEALTH			DDRESS, CITY, S BBRO TRAIL MN 55122	TATE, ZIP CODE	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01650	to the licensee on Comprehensive hor receiving assisted I 2021. R2's diagnos borderline personal Type 2, and depress and a wheelchair for R2's service plan dindicated R2 receives management, three checks, and other to R2's service plan laservices to be provided generalized anxiety cane for walking. R4's medical record to the licensee on Madiagnoses included generalized anxiety cane for walking. R4's service plan daindicated R4 receives management, personal stand-by assist with R4's service plan laser action to be taken in not be provided; information of personal information of personal information of personal information of and information assign for R1 in an entire receiving the provided information assign for R1 in an entire receiving the provided information assign for R1 in an entire receiving the provided information assign for R1 in an entire receiving the provided information assign for R1 in an entire receiving the personal receiving the per	d was reviewed. R2 admitted October 16, 2020, under the me care license, and began iving services on August 1, es included bipolar 2, lity disorder, PTSD, diabetes sion. R2 used a quad cane or long distances. ated October 18, 2020, ed assistance with medication et times per day blood glucose unknown scheduled services. acked a description of the ided. d was reviewed. R4 admitted March 28, 2022. R4's bipolar affective disorder and disorder (GAD). R4 used a lated March 28, 2022, ed assistance with medication onal cares, toileting, and a transfers. acked a contingency plan; f the scheduled services could formation and method to the names and contact ons R1 wished to have notified if there was a significant dition, including identification as to who had the authority to				

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		36221	B. WING		04/1) 4/2022
	PROVIDER OR SUPPLIER	1766 GAB	BRO TRAIL	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
01650	and a method to constatus, and acknown of the assisted living of personal health is and grievance productives and amenical understanding of the notice. R5 R5's medical record to the facility on Jarcomprehensive hor receiving assisted if 2021. R5's diagnostical Schizoaffective discussives anxiety. R5 walked R5's service plan daindicated R5 receives scheduled services. R5's service plan last services to be provided schizophrenia, and independently. R6's medical record diagnoses included schizophrenia, and independently. R6's service plan dareceived assistance management and methods of monitor when to notify a region of the service plan last methods of monitor when to notify a region of the service plan last methods of monitor when to notify a region of the service plan last methods of monitor when to notify a region of the service plan last methods of monitor when to notify a region of the service plan last methods of monitor when to notify a region of the service plan last methods of monitor when to notify a region of the service plan last methods of monitor when to notify a region of the service plan last methods of monitor when to notify a region of the service plan last methods of monitor when to notify a region of the service plan last methods of monitor when to notify a region of the service plan last methods of monitor when to notify a region of the service plan last methods of monitor when to notify a region of the service plan last methods of monitor when to notify a region of the service plan last methods of monitor when to notify a region of the service plan last methods of monitor when to notify a region of the service plan last methods of monitor when to notify a region of the service plan last methods of monitor when to notify a region of the service plan last methods of monitor when to notify a region of the service plan last methods of monitor when the service plan last methods of monitor when the service plan last methods of monitor when the service plan last methods of the service plan last	be summoned, information intact the facilit, R4's code eledgement R4 received copies g bill of rights (ALBOR), notice information privacy, complaint ess, uniform disclosure of ALities, evacuation plan, and e availability of a dementia discovered was reviewed. R5 admitted many 23, 2021, under the me care license, and began iving services on August 1, es included suicidal ideation, order, substance abuse, and independently. The dead and a description of the ided. It was reviewed. R6's delusional disorder, anxiety. R6 walked The dead and the description of the ided attended and the description of the ided.	01650			

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	ID PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		COMPLETED	
		36221	B. WING		O4/1	; 4/2022
			_I		1 0-7/1	TILULL
NAME OF I	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
EAGANC	CARE BEHAVIORAL H	EALTH	BBRO TRAIL MN 55122			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
01650	Continued From pa	ge 33	01650			
	(ALBOR), notice of privacy, complaint a uniform disclosure of evacuation plan, an availability of a dem					
	· '	at 1:50 p.m., RN-A stated he re resposible for developing ns.				
	August 1, 2021, ind include the following services to be proving the form fees for services and service according to or assessment and identification of staff provided the services.	titled Service Plan, dated icated service plans would g: (a) a description of the ided; the service description of the resident's care plan; (b) id the frequency of each of the resident's current review resident preferences; if or categories of staff who es; schedule and method of or assessments of the				
	TIME PERIOD TO	CORRECT: Seven (7) days.				
01730 SS=D		dividualized medication	01730			
	management services must prepare and in written statement of services that will be facility must developed individualized medical each resident bases	nt receiving medication ces, the assisted living facility nclude in the service plan a f the medication management provided to the resident. The p and maintain a current cation management record for d on the resident's ust contain the following:				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		36221	B. WING		04/1	; 4/2022
NAME OF PR	OVIDER OR SUPPLIER		,	STATE, ZIP CODE		
EAGANCA	RE BEHAVIORAL H	EALTH	BBRO TRAIL MN 55122			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETE DATE
01730 () () () () () () () () () () () () () (Continued From part 1) a statement desmanagement service 2) a description of son the resident's new diversion, and considerations; 3) documentation of part of the admiration of the admir	ge 34 cribing the medication ces that will be provided; storage of medications based reds and preferences, risk of istent with the manufacturer's of specific resident instructions nistration of medications; persons responsible for ion supplies and ensuring that re ordered on a timely basis; medication management relegated to unlicensed staff notifying a registered re licensed health professional ses with medication res; and recific requirements relating to reation administration, medications are administered monitoring of medication use complications or adverse management record must be d when there are any nciliation must be completed rese, licensed health horized prescriber is providing	01730			
t E li r	by: Based on interview icensee failed to co nedication manage	ent is not met as evidenced and record review, the emplete an individualized ement services plan with one of six residents (R4) with				

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	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	CONSTRUCTION	(X3) DATE	LETED
		26224	B. WING		04/4	
		36221	D. W		04/1	4/2022
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, ST BBRO TRAIL	TATE, ZIP CODE		
EAGANC	CARE BEHAVIORAL H	IEALTH	MN 55122			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01730	Continued From pa	ge 35	01730			
	violation that did no safety but had the president's health or widespread scope (or represent a system)	ed in a level two violation (a tharm a resident's health or otential to have harmed a safety) and was issued at a (when problems are pervasive emic failure that has affected to affect a large portion or all e:				
	to the licensee on N diagnoses included	d was reviewed. R4 admitted March 28, 2022. R4's bipolar affective disorder and disorder (GAD). R4 used a				
	indicated R4 receive	ated March 28, 2022, ed assistance with medication onal cares, toileting, and transfers.				
		a medication management following required content:				
	the resident's needs diversion, and cons directions; *Documentation of relating to the admi *Resident-specific re documenting medic verification all medic prescribed; *Monitoring of medic	age of medications based on a sand preferences, risk of sistent with manufacturer's specific resident instructions nistration of medications; requirements relating to cation administration, cations were administered as ication used to prevent ons or adverse reactions.				
	On April 26, 2022, a	at 2:00 p.m., unlicensed				

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	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	E CONSTRUCTION	COMP	
		36221	B. WING		04/1) 4/2022
			<u> </u>		1 0-1/1	TILULL
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S BRO TRAIL	STATE, ZIP CODE		
EAGANC	ARE BEHAVIORAL H	EALTH	IN 55122			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
01730	Continued From pa	ge 36	01730			
	•	stated he administered				
	August 1, 2021, ind would be maintaine	titled, Clinical Records, dated icated a legible, clinical record d for all residents that nited to medications, treatment				
	TIME PERIOD TO days.	CORRECT: Fourteen (14)				
02360	144G.91 Subd. 8 Fi	reedom from maltreatment	02360			
	sexual, and emotion exploitation; and all	right to be free from physical, nal abuse; neglect; financial forms of maltreatment /ulnerable Adults Act.				
	by: Based on observation review, the facility fa	ent is not met as evidenced ons, interviews, and document ailed to ensure two of four (R1, R2) were free from nd R2 were neglected.				
	Findings include:					
	Health (MDH) issue occurred, and that the maltreatment, in which occurred at the	the Minnesota Department of ed a determination that neglect the facility was responsible for a connection with incidents he facility. The MDH is a preponderance of eatment occurred.				
03000 SS=I	626.557 Subd. 3 Tir	ming of report	03000			
	(a) A mandated rep	orter who has reason to				

Minnesota Department of Health

	AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		COMPLETED	
			D WING		С	
		36221	B. WING		04/1	4/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
EAGAN	CARE BEHAVIORAL H	EALTH	BBRO TRAIL VIN 55122			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE COM		(X5) COMPLETE DATE
03000	been maltreated, or vulnerable adult has which is not reason immediately report common entry poin vulnerable adult soladmitted to a facility required to report s individual that occurred unless: (1) the individual was another facility and believe the vulneral previous facility; or (2) the reporter known that the individual is in section 626.5572 (a), clause (4). (b) A person not recording in this section of this section of the section of the control	rable adult is being or has who has knowledge that a sustained a physical injury ably explained shall the information to the t. If an individual is a ely because the individual is a, a mandated reporter is not uspected maltreatment of the red prior to admission, as admitted to the facility from the reporter has reason to be adult was maltreated in the ws or has reason to believe a vulnerable adult as defined a vulnerable adult as defined a subdivision 21, paragraph quired to report under the ection may voluntarily report as ection requires a report of a maltreatment, if the reporter on to know that a report has ommon entry point. ection shall preclude a eporting to a law enforcement orter who knows or has not an error under section on 17, paragraph (c), clause make a report under this eporter or a facility, at any time estigation by a lead y will determine or should reported error was not neglect teria under section 626.5572, agraph (c), clause (5), the				

Minnesota Department of Health

	ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		36221	B. WING		04/1	2 4/2022	
	PROVIDER OR SUPPLIER	IEALTH 1766 GA	DDRESS, CITY, S BBRO TRAIL MN 55122	STATE, ZIP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
03000	entry point or direct agency information meets the criteria usubdivision 17, paralead investigative as information when meets the report under sufficient to comply with reporting suspected adults for three of serecords reviewed. This practice results violation that harmen not including serious or a violation that harmen not including serious or a violation that has serious injury, impairs and at a widesprare pervasive or rephase affected or has portion or all of the Findings Include: R1 R1's medical record admitted to the facility under the comprehendation of the properties of th	nay provide to the common ly to the lead investigative explaining how the event nder section 626.5572, agraph (c), clause (5). The gency shall consider this naking an initial disposition of bdivision 9c. ent is not met as evidenced and record review, the facility has the requirements for a maltreatment of vulnerable fix residents (R1, R2, R5) with ed in a level three violation (and a resident's health or safety, as the potential to lead to a sinjury, impairment, or death, as the potential to lead to a seed scope (when problems oresent a systemic failure that potential to affect a large					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ` '	1 ` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			, 20.22)
		36221	B. WING		04/1	4/2022
NAME OF	PROVIDER OR SUPPLIER		,	STATE, ZIP CODE		
EAGAN	CARE BEHAVIORAL H	IEALTH	BBRO TRAIL IN 55122			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
03000	Continued From pa	ge 39	03000			
	indicated R1 received assistance with medication management,					
	October 26, 2021, is reminders, and assistances. R1 required and medication due pressure (hypotens generalized body particles individual abust dated October 26, 2 vulnerable to abuse were trained to receive had no history of at thoughts but did repsuicidal ideation to of R1 would report was assessed as no however, her IAPP to self-abuse due to needed intervention monitoring. R1 was cares and taking he intervention of staff wellness activities. hallucinations during needed intervention and cleaning solution needed intervention and cleaning solution needed intervention and cleaning solution and cleaning solution needed intervention needed int	se prevention plan (IAPP) 2021, indicated R1 was e due to mental instability. Staff ognize and report abuse. R1 tempted suicide or suicidal cort chronic thoughts of staff with needed intervention suicidal thoughts to staff. R1 ot vulnerable to self-abuse, indicated she was vulnerable of mental instability with a n of received 24-hour daily everbally aggressive, resisted er medication, with needed encouraged R1 to engage in R1 had a history of g psychotic episodes with n of staff locked sharp objects ons. R1 had depression with				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	CONSTRUCTION	(X3) DATE	E SURVEY PLETED	
		36221	B. WING			C 14/2022
	PROVIDER OR SUPPLIER	1766 GAI	DRESS, CITY, S	TATE, ZIP CODE		
EAGAN	CARE BEHAVIORAL H	IEALTH	MN 55122			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOOD CROSS-REFERENCED TO THE APPORT (CORRECTIVE ACTION SHOOD)	OULD BE	(X5) COMPLETE DATE
03000	Continued From pa	ge 40	03000			
	borderline personal Type 2, and depres and a wheelchair for					
	R2's service plan dated October 18, 2020, indicated R2 received assistance with medication management.					
	indicated R2 required transfers. R2 required staff su facility. R2 had unpaggression that qui aggression. Staff we deep breaths and expendicated on R1's baggressions, throw	ed assistance with personal stand-by assistance with red medication management. Upervision when outside the rovoked outbursts of verbal ckly escalated to physical rere to encourage R2 to take express frustration as needed. Physically assaulting a staff revious facility. Staff were behaviors (packing, verbal ing items, swearing). R2 had esulting in violent actions.				
	R2 was vulnerable a needed intervention supervision when or risk to abuse others staff supervision who a history of attempt thoughts with a needed constantly monitore stored and locked a	ecember 14, 2021, indicated to being abused by others with on of constant staff outside the facility. R2 was at swith needed intervention of nen outside the facility. R2 had sed suicide and suicidal eded intervention of R2 was ed by staff. Sharp objects were away. R2 was to report suicidal 2 had scheduled safety				
	2021, at 6:10 p.m.,	port dated September 11, indicated R1 and R2 argued the facility. R1 accused R2 of				

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1766 GABBRO TRAIL EAGAN, MN 55122 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 03000 Continued From page 41 taking items from her bedroom without permission. The report indicated R2 stated, "R1 needed to be kicked in the ass." R2 walked upstairs to the main level of the facility. R1 and unlicensed personnel (ULP)-C followed behind R2. R2 stopped at the top of the stairs and turned, facing R1 and ULP-C. R2 used her body to prevent R1 and ULP-C from entering the main	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SU COMPLE	
NAME OF PROVIDER OR SUPPLIER EAGANCARE BEHAVIORAL HEALTH (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) DO Continued From page 41 taking items from her bedroom without permission. The report indicated R2 stated, "R1 needed to be kicked in the ass." R2 walked upstairs to the main level of the stairs and turned, facing R1 and ULP-C. R2 used her body STREET ADDRESS, CITY, STATE, ZIP CODE 1766 GABBRO TRAIL EAGAN, MN 55122 DROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) O3000 O3000 Continued From page 41 03000 O3000 O	36221		2022
EAGANCARE BEHAVIORAL HEALTH EAGAN, MN 55122 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) O3000 Continued From page 41 taking items from her bedroom without permission. The report indicated R2 stated, "R1 needed to be kicked in the ass." R2 walked upstairs to the main level of the facility. R1 and unlicensed personnel (ULP)-C followed behind R2. R2 stopped at the top of the stairs and turned, facing R1 and ULP-C. R2 used her body		•	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) O3000 Continued From page 41 taking items from her bedroom without permission. The report indicated R2 stated, "R1 needed to be kicked in the ass." R2 walked upstairs to the main level of the facility. R1 and unlicensed personnel (ULP)-C followed behind R2. R2 stopped at the top of the stairs and turned, facing R1 and ULP-C. R2 used her body	AGANCARE BEHAVIORAL HEALTH		
taking items from her bedroom without permission. The report indicated R2 stated, "R1 needed to be kicked in the ass." R2 walked upstairs to the main level of the facility. R1 and unlicensed personnel (ULP)-C followed behind R2. R2 stopped at the top of the stairs and turned, facing R1 and ULP-C. R2 used her body	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL	IVE ACTION SHOULD BE CED TO THE APPROPRIATE	COMPLETE
level. R2 shoved R1 at the top of the stairs causing R1 to fall backwards into ULP-C. ULP-C was unable to prevent R1 from falling, and R1 tumbled down the flight of stairs onto a ceramic floor. Staff called 911 and sent R1 to the hospital with head and neck injuries. Facility records lacked evidence a MAARC report was filed for the September 11, 2021 assault. R1's progress note dated December 10, 2021, at 9:48 p.m., indicated R1 was physically assaulted by R2 after R1 knocked on R2's door asking R2 if she took a glass bottle of fruit juice that was supposed to be shared between all of the residents. R2 responded by spitting in R1's face. R2 grabbed the empty glass bottle of fruit juice and struck R1 over the head multiple times. ULP-D attempted to intervene. Staff called 911 and law enforcement and sent R1 to the hospital with head and hand injuries. Following the incident R1 was moved upstairs to a vacant room previously occupied by R5. R1's law enforcement report dated December 10, 2021, at 7:54 p.m., indicated law enforcement reviewed the facility's audio and video footage. The video footage showed R2 striking R1 over the head multiple times with a glass bottle. R2 told law enforcement she would kill R1 while R1 slept.	taking items from her bedroom without permission. The report indicated R2 stated, "R needed to be kicked in the ass." R2 walked upstairs to the main level of the facility. R1 and unlicensed personnel (ULP)-C followed behind R2. R2 stopped at the top of the stairs and turned, facing R1 and ULP-C. R2 used her bot to prevent R1 and ULP-C from entering the malevel. R2 shoved R1 at the top of the stairs causing R1 to fall backwards into ULP-C. ULP was unable to prevent R1 from falling, and R1 tumbled down the flight of stairs onto a cerami floor. Staff called 911 and sent R1 to the hospi with head and neck injuries. Facility records lacked evidence a MAARC repwas filed for the September 11, 2021 assault. R1's progress note dated December 10, 2021, 9:48 p.m., indicated R1 was physically assault by R2 after R1 knocked on R2's door asking R she took a glass bottle of fruit juice that was supposed to be shared between all of the residents. R2 responded by spitting in R1's fare R2 grabbed the empty glass bottle of fruit juice and struck R1 over the head multiple times. ULP-D attempted to intervene. Staff called 911 and law enforcement and sent R1 to the hospi with head and hand injuries. Following the incident R1 was moved upstairs to a vacant ropreviously occupied by R5. R1's law enforcement report dated December 2021, at 7:54 p.m., indicated law enforcement reviewed the facility's audio and video footage. The video footage showed R2 striking R1 over the head multiple times with a glass bottle. R2 told law enforcement she would kill R1 while R		

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				` ′	DATE SURVEY COMPLETED	
		36221	B. WING		04/1) 4/2022	
	PROVIDER OR SUPPLIER	1766 GAB	BRO TRAIL	STATE, ZIP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
03000	On April 14, 2022, a facility never moved assaulted her. R1 s across the hall from second physical assaulty moved her to stated she has been for her hand and left the assaults. R1 stated the incidents. assault, the facility in the facilit	ted evidence a MAARC report cember 10, 2021 assault. at 11:55 a.m., R1 stated the R2 after she physically tated R2's room was directly hers. R1 stated after the sault in December 2021, the a vacant room upstairs. R1 in receiving physical therapy it leg that were injured during ated she could no longer use stated she developed PTSD R1 stated after the first installed a lock on her door to stay away from each other,	03000				
	facility filed MAARC assaults. RN-A state facility had R1 sleep upstairs level of the was safer for R1 to because staff were stated R2 was confiwas a call pendant anything. RN-A state altercation from occeventually came outwhile." On April 15, 2022, a the facility did not fit physical assaults. On April 25, 2022, a confirmation of the facility did not fit physical assaults.	at 1:50 p.m., RN-A stated the reports for the two physical ed after the first assault the o on the sofa located on the facility. RN-A stated he felt it sleep upstairs on the sofa upstairs and close by. RN-A ined to her room, stating there R2 used if she needed ed this was to prevent another curing. RN-A stated R2 ther room, stating, "it took a state of the took and t					

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	, ,	E SURVEY PLETED
		36221	B. WING		04/	C 14/2022
NAME OF	PROVIDER OR SUPPLIER		,	TATE, ZIP CODE		
EAGAN	CARE BEHAVIORAL H	IEALTH EAGAN, N	BRO TRAIL IN 55122			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
03000	Continued From pa	ge 43	03000			
	was afraid of R2 afrairs. ULP-C state R1 after the first income near R1. ULF physically assaulted ULP and throwing a R1 was afraid of R2 installed on her documentally ulperstands on the R1, "I'm going to kill R2's room location after the the second were required to che	at 2:00 p.m., ULP-C stated R1 ter R2 pushed her down the ed staff tried to remain close to cident, to make sure R2 did not P-C stated one time R2 d another ULP, beating the a computer at her. at 10:00 a.m., ULP-D stated 2 and requested a lock be or after the first incident. ecember 10, 2021 R2 said to Il you." ULP-D stated R1 and was not changed right away d assault. ULP-D stated staff leck on residents every two ght and every four hours				
	to the facility on Jar comprehensive hor receiving assisted I 2021. R5's diagnos Schizoaffective disc anxiety. R5 walked	d was reviewed. R5 admitted nuary 23, 2021, under the ne care license, and began iving services on August 1, es included suicidal ideation, order, substance abuse, and independently. ated January 23, 2021, ed assistance with medication				
	R5's incident report 12:45 p.m., indicate penis using a pair of staff he did not like vagina, and told stated, but it is taking too look	dated February 19, 2021, at ed R5 attempted to cut off his of scissors he found. R5 told his penis and wanted a eff he would use any means to "I have been trying to cut it off, ong, and it is painful." A RN h long horizontal, superficial				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		` ′	(X3) DATE SURVEY COMPLETED	
		36221	B. WING		C 04/14/2022		
	PROVIDER OR SUPPLIER	1766 GAB	BRO TRAIL	TATE, ZIP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOOT CROSS-REFERENCED TO THE APPIDEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
03000	to the hospital for a treatment. A safety include continuous the facility. A staff pon outings to the st perform a daily roof after outings. R5's RN assessme indicated R5 tried to history of eloping as Staff were to monite elopement. R5 had verbal aggression of drugs. Staff would a drugs. Staff would a drugs. R5 constant facility to shop and facility staff. Staff won scheduled shop up items for R5. R5's progress note 6:28 p.m., indicated 5:22 p.m., R5's fam stating R5 left a voi wanted to kill himse seizure-like activity to a hospital for evaluation of the seizure of hospital record indicated R5 told he soon the sound of the seizure of hospital record indicated R5 told he soon the seizure of hospital record indicated R5 tol	R5's penis. R5 was transported psychiatric evaluation and plan was implemented to monitoring inside and outside person would accompany R5 ore. In addition, staff would make checks, and bag searches and wandering from facilities. From the influence of a history of physical and when under the influence of monitor his safety and use of ly requested to leave the often left the facility without were to encourage R5 to shop ping days or ask staff to pick dated November 8, 2021, at a did not	03000				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		' '	(X3) DATE SURVEY COMPLETED	
		36221	B. WING		O4/14/2022		
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE			
		1766 GA	BBRO TRAIL				
EAGANG	CARE BEHAVIORAL H	EAGAN,	MN 55122				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
03000	Continued From pa	ge 45	03000				
	higher level of care. R5's death certificate indicated R5 died on November 25, 2021, at 5:45 p.m., from liver failure due to acute acetaminophen (Tylenol) toxicity.						
	R5 was vulnerable mental illness and used trained in reporting a timely manner. Reabused. Staff were was vulnerable to a	to self-abuse due to his unawareness of surroundings. for R5's safety and were suspected or actual abuse in 5 was vulnerable to being to monitor R5's safety. R5 abuse other vulnerable adults. or and report and suspected or					
	R5's record lacked MAARC reports for	evidence the facility filed a R5's two incidents.					
	believed R5 went to	9:13 a.m., RN-A stated he the the hospital due to not due to an overdose.					
	August 1,2021, indivas discovered, the to remove the residual as needed and if indicated. When a toward a vulnerable employee would imployee would imployee would imployee or neglect will determine if the incomplete the information would make the information would	titled, Vulnerable Adult, dated cated when abuse or neglect employee's first action was lent from danger, provide first contact local law enforcement abuse or neglect directed was discovered, the mediately make an oral report plete a written report of the ithin 24 hours. The RN or aw and investigate to ident was reportable, and if so ald then be reported to by, or as soon as possible. A would be sent to MAARC and					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED				
		7. DOILDING.			}			
	36221	B. WING			4/2022			
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE					
EAGANCARE BEHAVIORAL HEALTH EAGAN, MN 55122								
PREFIX (EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE			
03000 Continued From pa	ge 46	03000						
retained in the residence policy indicated fails misdemeanor and to potential civil darks	dent's record. The licensee ure to report was a could expose the non-reporter	03000						