Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL36221001M
Compliance #: HL36221002C

Date Concluded: June 21, 2022

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36221	A. BUILDING: _____ B. WING _____	C 04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGANCARE BEHAVIORAL HEALTH	1766 GABBRO TRAIL EAGAN, MN 55122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL36221002C/#HL36221001M On April 14, 2022, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were four residents receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL36221002C/#HL36221001M, tag identification 620, 630, 1620, 1640, 1650, 1730, 2360, 3000.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 620 SS=I	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36221	A. BUILDING: _____ B. WING _____	C 04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGANCARE BEHAVIORAL HEALTH	1766 GABBRO TRAIL EAGAN, MN 55122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 620	Continued From page 1 144G.42 Subd. 6. Compliance with requirements for reporting maltreatment of vulnerable adults; abuse prevention plan. (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to comply with the requirements for reporting suspected maltreatment of vulnerable adults for three of three residents (R1, R2, R5) with reportable incidents. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings Include: R1 R1's medical record was reviewed. R1 was admitted to the facility on February 26, 2021, under the comprehensive home care license and began receiving assisted living services on August 1, 2021. R1's diagnoses included depressive disorder, Post-Traumatic Stress Disorder (PTSD), and panic disorder. R1 walked independently.	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36221	A. BUILDING: _____ B. WING _____	C 04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGANCARE BEHAVIORAL HEALTH	1766 GABBRO TRAIL EAGAN, MN 55122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 620	Continued From page 2 R1's service plan dated February 26, 2021, indicated R1 received assistance with medication management, R1's registered nurse (RN) assessment dated October 26, 2021, indicated R1 needed cueing, reminders, and assistance with her personal cares. 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 was vulnerable to abuse due to mental instability. Staff were trained to recognize and report abuse. R1 had no history of attempted suicide or suicidal thoughts but did report chronic thoughts of suicidal ideation to staff with needed intervention of R1 would report suicidal thoughts to staff. R1 was assessed as not vulnerable to self-abuse, however, her IAPP indicated she was vulnerable to self-abuse due to mental instability with a needed intervention of received 24-hour daily monitoring. R1 was verbally aggressive, resisted cares and taking her medication, with needed intervention of staff encouraged R1 to engage in wellness activities. R1 had a history of hallucinations during psychotic episodes with needed intervention of staff locked sharp objects and cleaning solutions. R1 had depression with needed interventions of managed with medications and scheduled wellness activities. R1's IAPP indicated R1 received scheduled safety checks. R2 R2's medical record was reviewed. R2 admitted to the facility on October 16, 2020, under the	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36221	A. BUILDING: _____ B. WING _____	C 04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGANCARE BEHAVIORAL HEALTH	1766 GABBRO TRAIL EAGAN, MN 55122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 620	Continued From page 3 comprehensive home care license, and began receiving assisted living services on August 1, 2021. R2's diagnoses included bipolar 2, borderline personality disorder, PTSD, diabetes Type 2, and 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. R2's RN assessment dated October 26, 2021, indicated R2 required assistance with personal cares. R2 required stand-by assistance with transfers. R2 required medication management. R2 required staff supervision when outside the facility. R2 had unprovoked outbursts of verbal aggression that quickly escalated to physical aggression. Staff were to encourage R2 to take deep breaths and express frustration as needed. R2 had a history of physically assaulting a staff and resident at a previous facility. Staff were educated on R2's behaviors (packing, verbal aggressions, throwing items, swearing). R2 had poor coping skills resulting in violent actions. R2's IAPP dated December 14, 2021, indicated R2 was vulnerable to being abused by others with a needed intervention of constant staff supervision when outside the facility. R2 was at risk to abuse others with needed intervention of staff supervision when outside the facility. R2 had a history of attempted suicide and suicidal thoughts with a needed intervention of R2 was constantly monitored by staff. Sharp objects were stored and locked away. R2 was to report suicidal thoughts to staff. R2 had scheduled safety checks. A facility incident report dated September 11,	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36221	A. BUILDING: _____ B. WING _____	C 04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGANCARE BEHAVIORAL HEALTH	1766 GABBRO TRAIL EAGAN, MN 55122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 620	Continued From page 4 2021, at 6:10 p.m., indicated R1 and R2 argued 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 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 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	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36221	A. BUILDING: _____ B. WING _____	C 04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGANCARE BEHAVIORAL HEALTH	1766 GABBRO TRAIL EAGAN, MN 55122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 620	Continued From page 5 slept. Facility records lacked evidence a MAARC report was filed for the December 10, 2021 assault. On April 14, 2022, at 11:55 a.m., R1 stated the facility never moved R2 after she physically assaulted her. R1 stated R2's room was directly across the hall from hers. R1 stated after the second physical assault in December 2021, the facility moved her to a vacant room upstairs. R1 stated she has been receiving physical therapy for her hand and left leg that were injured during the assaults. R1 stated she could no longer use her right thumb. R1 stated she developed PTSD after the incidents. R1 stated after the first assault, the facility installed a lock on her door and told R1 and R2 to stay away from each other, stating, "that was all they did." On April 14, 2022, at 1:50 p.m., RN-A stated the facility filed MAARC reports for the two physical assaults. RN-A stated after the first assault the facility had R1 sleep on the sofa located on the upstairs level of the facility. RN-A stated he felt it was safer for R1 to sleep upstairs on the sofa because staff were upstairs and close by. RN-A stated R2 was confined to her room, stating there was a call pendant R2 used if she needed anything. RN-A stated this was to prevent another altercation from occuring. RN-A stated R2 eventually came out her room, stating, "it took a while." On April 15, 2022, at 8:15 a.m., RN-A confirmed the facility did not file MAARC reports for R1's two physical assaults. On April 25, 2022, at 11:30 a.m., medical doctor (MD)-B stated R1 expressed to her she did not	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36221	A. BUILDING: _____ B. WING _____	C 04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGANCARE BEHAVIORAL HEALTH	1766 GABBRO TRAIL EAGAN, MN 55122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 620	Continued From page 6 feel safe after the incidents. On April 26, 2022, at 2:00 p.m., ULP-C stated R1 was afraid of R2 after R2 pushed her down the stairs. ULP-C stated staff tried to remain close to R1 after the first incident, to make sure R2 did not come near R1. ULP-C stated one time R2 physically assaulted another ULP, beating the ULP and throwing a computer at her. On April 29, 2022, at 10:00 a.m., ULP-D stated R1 was afraid of R2 and requested a lock be installed on her door after the first incident. ULP-D stated on December 10, 2021 R2 said to R1, "I'm going to kill you." ULP-D stated R1 and R2's room location was not changed right away after the the second assault. ULP-D stated staff were required to check on residents every two hours during the night and every four hours during the day. R5 R5's medical record was reviewed. R5 admitted to the facility on January 23, 2021, under the comprehensive home care license, and began receiving assisted living services on August 1, 2021. R5's diagnoses included suicidal ideation, Schizoaffective disorder, substance abuse, and anxiety. R5 walked independently. R5's service plan dated January 23, 2021, indicated R5 received assistance with medication management R5's incident report dated February 19, 2021, at 12:45 p.m., indicated R5 attempted to cut off his penis using a pair of scissors he found. R5 told staff he did not like his penis and wanted a vagina, and told staff he would use any means to sever it. R5 stated, "I have been trying to cut it off,	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36221	A. BUILDING: _____ B. WING _____	C 04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGANCARE BEHAVIORAL HEALTH	1766 GABBRO TRAIL EAGAN, MN 55122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 620	Continued From page 7 but it is taking too long, and it is painful." A RN observed a one-inch long horizontal, superficial cut at the base of R5's penis. R5 was transported to the hospital for a psychiatric evaluation and treatment. A safety plan was implemented to include continuous monitoring inside and outside the facility. A staff person would accompany R5 on outings to the store. In addition, staff would perform a daily room checks, and bag searches after outings. R5's RN assessment dated September 6, 2021, indicated R5 tried to cut off his penis. R5 had a history of eloping and wandering from facilities. Staff were to monitor R5's safety and incidents of elopement. R5 had a history of physical and verbal aggression when under the influence of drugs. Staff would monitor his safety and use of drugs. R5 constantly requested to leave the facility to shop and often left the facility without facility staff. Staff were to encourage R5 to shop on scheduled shopping days or ask staff to pick up items for R5. R5's progress note dated November 8, 2021, at 6:28 p.m., indicated on November 8, 2021, at 5:22 p.m., R5's family member called the facility stating R5 left a voice message indicating he R5 wanted to kill himself with a knife. R5's progress note dated November 20, 2021, at 5:41 p.m., indicated R5 was found having seizure-like activity. Staff called 911 and sent R5 to a hospital for evaluation. R5's hospital record dated November 21, 2021, indicated R5 told health professionals he ingested 500 Tylenol pills to commit suicide. R5 stated he bought the bottle of Tylenol at a store. R5's hospital record indicated R5 had a history of	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36221	A. BUILDING: _____ B. WING _____	C 04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGANCARE BEHAVIORAL HEALTH	1766 GABBRO TRAIL EAGAN, MN 55122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 620	Continued From page 8 suicide attempts and self-injurious behaviors. R5 was transferred to the intensive care unit for a 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's IAPP dated November 29, 2021, indicated R5 was vulnerable to self-abuse due to his mental illness and unawareness of surroundings. Staff were to monitor R5's safety and were trained in reporting suspected or actual abuse in a timely manner. R5 was vulnerable to being abused. Staff were to monitor R5's safety. R5 was vulnerable to abuse other vulnerable adults. Staff were to monitor and report and suspected or actual abuse. R5's record lacked evidence the facility filed a MAARC reports for R5's two incidents. On May 4, 2022, at 9:13 a.m., RN-A stated he believed R5 went to the hospital due to seizure-like activity, not due to an overdose. The licensee policy titled, Vulnerable Adult, dated August 1,2021, indicated when abuse or neglect was discovered, the employee's first action was to remove the resident from danger, provide first aid as needed and contact local law enforcement if indicated. When abuse or neglect directed toward a vulnerable was discovered, the employee would immediately make an oral report to the RN and complete a written report of the abuse or neglect within 24 hours. The RN or director would review and investigate to determine if the incident was reportable, and if so, the information would then be reported to	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36221	A. BUILDING: _____ B. WING _____	C 04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGANCARE BEHAVIORAL HEALTH	1766 GABBRO TRAIL EAGAN, MN 55122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 620	Continued From page 9 MAARC immediately, or as soon as possible. A copy of the report would be sent to MAARC and retained in the resident's record. The licensee policy indicated failure to report was a misdemeanor and could expose the non-reporter to potential civil damages. TIME PERIOD TO CORRECT: Seven (7) days.	0 620		
0 630 SS=I	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure an individualized abuse prevention plan (IAPP) was updated for three of three residents (R1, R2, R5) with records reviewed after R1 was physically assaulted two times by R2. R2's IAPP was not updated after she assaulted R1 two separate times. R5's IAPP was not updated after he tried to sever his penis. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death,	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36221	A. BUILDING: _____ B. WING _____	C 04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGANCARE BEHAVIORAL HEALTH	1766 GABBRO TRAIL EAGAN, MN 55122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 630	Continued From page 10 or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1's medical record was reviewed. R1 admitted to the licensee on February 26, 2021, under the comprehensive home care license, and began receiving assisted living services on August 1, 2021. R1's diagnoses included major depressive disorder, Post-Traumatic Stress Disorder (PTSD), and panic disorder. R1 walked independently. R1's service plan dated February 26, 2021, indicated R1 received assistance with medication managment, R1's registered nurse (RN) assessment dated October 26, 2021, indicated R1 needed cueing, reminders, and assistance with her personal cares. 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 was vulnerable to abuse due to mental instability. Staff were trained to recognize and report abuse. R1 had no history of attempted suicide or suicidal thoughts but did report chronic thoughts of suicidal ideation to staff with needed intervention of R1 would report suicidal thoughts to staff. R1 was assessed as not vulnerable to self-abuse,	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36221	A. BUILDING: _____ B. WING _____	C 04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGANCARE BEHAVIORAL HEALTH	1766 GABBRO TRAIL EAGAN, MN 55122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 630	Continued From page 11 however, her IAPP indicated she was vulnerable to self-abuse due to mental instability with a needed intervention of received 24-hour daily monitoring. R1 was verbally aggressive, resisted cares and taking her medication, with needed intervention of staff encouraged R1 to engage in wellness activities. R1 had a history of hallucinations during psychotic episodes with needed intervention of staff locked sharp objects and cleaning solutions. R1 had depression with needed interventions of managed with medications and scheduled wellness activities. R1's IAPP indicated R1 received scheduled safety checks. 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 the facility's bottle of non-alcoholic beverage from the refrigerator. R2 responded by spitting in R1's face. R2 grabbed an empty glass bottle and struck R1 over the head multiple times. Unlicensed personnel (ULP)-D attempted to intervene. Staff called 911 and law enforcement. R1 emergency medical services (EMS) transported R1 to a hospital with head and hand injuries. Following the incident, R1 was moved upstairs to a room previously occupied by R5. R1's police report dated December 10, 2021, at 7:54 p.m., indicated law enforcement arrived at the facility and reviewed audio and video footage of the assault showing R2 striking R1 over the head multiple times with a glass bottle. Fifth degree assault charges were filed against R2. R1's record lacked evidence her IAPP was updated after she was physically assaulted by R2. R2	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36221	A. BUILDING: _____ B. WING _____	C 04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGANCARE BEHAVIORAL HEALTH	1766 GABBRO TRAIL EAGAN, MN 55122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 630	Continued From page 12 R2's medical record was reviewed. R2 admitted to the facility on October 16, 2020, under the comprehensive home care license, and began receiving assisted living services on August 1, 2021. R2's diagnoses included bipolar 2, borderline personality disorder, PTSD, diabetes Type 2, and depression. R2 used a quad cane and a wheelchair for long distances. R2's RN assessment dated October 26, 2021, indicated R2 had unprovoked outbursts of verbal aggression that quickly would escalate to physical aggression. Staff were to encourage R2 to take deep breaths and express her frustration as needed. R2 had a history of physically assaulting a staff and resident at a previous facility. Staff were educated on R1's behaviors (packing, verbal aggressions, throwing items, swearing). R2 had poor coping skills resulting in violent actions. 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. Staff called 911 and sent R1 to the hospital with head and neck injuries. R2's record lacked evidence her IAPP was	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36221	A. BUILDING: _____ B. WING _____	C 04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGANCARE BEHAVIORAL HEALTH	1766 GABBRO TRAIL EAGAN, MN 55122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 630	Continued From page 13 updated after she physically assaulted R1 on September 11, 2021. R2's IAPP dated December 14, 2021, indicated R2 was vulnerable to being abused by others with a needed intervention of constant staff supervision when outside the facility. R2 was at risk to abuse others with needed intervention of staff supervision when outside the facility. R2 had a history of attempted suicide and suicidal thoughts with a needed intervention of R2 was constantly monitored by staff. Sharp objects were stored and locked away. R2 was to report suicidal thoughts to staff. R2 was not vulnerable to abusing herself, and had no history of attempted suicide or suicidal thoughts but did report chronic suicidal ideation's. Staff were trained to call 911. R2 had scheduled safety checks. R2's IAPP lacked specific interventions to prevent R2 from assaulting R1. R5 R5's medical record was reviewed. R5 admitted to the facility on January 23, 2021, under the comprehensive home care license, and began receiving assisted living services on August 1, 2021. R5's diagnoses included suicidal ideation, Schizoaffective disorder, substance abuse, and anxiety. R5 walked independently. R5's service plan dated January 23, 2021, indicated R5 received assistance with medication managment and other unknown scheduled services. R5's incident report dated February 19, 2021, at 12:45 p.m., R5 attempted to sever penis using a pair of scissors he found. R5 told staff he did not	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36221	A. BUILDING: _____ B. WING _____	C 04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGANCARE BEHAVIORAL HEALTH	1766 GABBRO TRAIL EAGAN, MN 55122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 630	Continued From page 14 like his penis and wanted a vagina, and told staff he would use any means to sever it. R5 stated, "I have been trying to cut it off but it is taking too long and it is painful." The facility registered nurse (RN) observed a one-inch long horizontal, superficial cut at the base of R5's penis. R5 was transported to the hospital for a psychiatric evaluation and treatment. A safety plan was implemented to include continuous monitoring while inside the facility and staff person to accompany R5 on all outings. In addition, staff would perform a daily room checks, and bag searches after outings. R5's IAPP was not updated with specific interventions to prevent R5 from self injury. R5's RN assessment dated September 6, 2021, indicated R5 previously tried to sever his penis. R5 had a history of eloping and wandering from facilities she lived in. Staff would monitor R5's safety and incidents of elopement. R5 had a history of physical and verbal aggression when under the influence of drugs. Staff would monitor his safety and use of drugs. R2 was paranoid and reported ongoing auditory hallucinations. R5 constantly requested to leave the facility to shop. R5 would take a taxi to a gas station despite being asked to wait for regular shopping days. Staff were to encourage R5 to shop on scheduled shopping days or have incoming staff buy what he needs. On April 14, 2022, at 1:50 p.m., RN-A stated IAPP's were updated as needed based on resident needs. The licensee policy titled, Vulnerable Adult, dated August 1, 2021, indicated the licensee would evaluate IAPPs at each supervisory visit or more	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36221	A. BUILDING: _____ B. WING _____	C 04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGANCARE BEHAVIORAL HEALTH	1766 GABBRO TRAIL EAGAN, MN 55122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 630	Continued From page 15 frequently, if necessary. TIME PERIOD TO CORRECT: Seven (7) days.	0 630		
01620 SS=I	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted reassessments for three of three residents (R1, R2, R5) with records reviewed whom required a change in needs assessment.	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36221	A. BUILDING: _____ B. WING _____	C 04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGANCARE BEHAVIORAL HEALTH	1766 GABBRO TRAIL EAGAN, MN 55122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 16 R1 was physically assaulted by R2 in two separate incidents. R2's record lacked evidence the RN reassessed R2 after she physically assaulted R1. R5 tried to cut off his penis, and in another incident, stated he wanted to kill himself to a family member. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 and R2 R1's medical record was reviewed. R1 admitted to the licensee on February 26, 2021 under the comprehensive home care license, and began receiving assisted living services on August 1, 2021. R1's diagnoses included major depressive disorder, Post-Traumatic Stress Disorder (PTSD), Dissociative identity disorder, and panic disorder. R1 walked independently. R1's service plan, dated February 26, 2021, indicated R1 received assistance with medication management and other unknown services. R2's medical record was reviewed. R2 admitted to the licensee on October 16, 2020, under the comprehensive home care license, and began receiving assisted living services on August 1, 2021. R2's diagnoses included, but were not limited to bipolar 2, borderline personality disorder, PTSD, diabetes Type 2, and	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36221	A. BUILDING: _____ B. WING _____	C 04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGANCARE BEHAVIORAL HEALTH	1766 GABBRO TRAIL EAGAN, MN 55122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 17 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 bilevel positive airway pressure (BiPap) face mask. R1's medications were stored and administered by staff. R1 required daily blood pressure checks and	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36221	A. BUILDING: _____ B. WING _____	C 04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGANCARE BEHAVIORAL HEALTH	1766 GABBRO TRAIL EAGAN, MN 55122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 18 medication due to history of low blood pressure (hypotension). R1 reported continuous generalized body pain and migraines. R2's RN assessment dated October 26, 2021, indicated R2 had unprovoked outbursts of verbal aggression that quickly would escalate to physical aggression. Staff were to encourage R2 to take deep breaths and express her frustration as needed. R2 had a history of physically assaulting a staff and resident at a previous facility. The facility provided 24/7 staffing. Staff were educated on R1's behaviors (packing, verbal aggressions, throwing items, swearing). R2 had poor coping skills resulting in violent actions. 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 the facility's bottle of non-alcoholic beverage from the refrigerator. R2 responded by spitting in R1's face. R2 grabbed an empty glass bottle and struck R1 over the head multiple times. Unlicensed personnel (ULP)-D attempted to intervene. 911 and law enforcement were called. R1 was taken to the hospital with head and hand injuries. Following the incident R1 was moved upstairs to a vacant room previously occupied by R5. R1 and R2's record both lacked an assessment after the incident on Decemeber 10, 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. R5 R5's medical record was reviewed. R5 admitted to the licensee on January 23, 2021, under the	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36221	A. BUILDING: _____ B. WING _____	C 04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGANCARE BEHAVIORAL HEALTH	1766 GABBRO TRAIL EAGAN, MN 55122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 19 comprehensive home care license, and began receiving assisted living services on August 1, 2021. R5's diagnoses included suicidal ideation, Schizoaffective disorder, substance abuse, and anxiety. R5 walked independently. R5's incident report dated February 19, 2021, at 12:45 p.m., R5 attempted to cut off his penis using a pair of scissors he found. R5 told staff he did not like his penis and wanted a vagina, and told staff he would use any means to sever his penis. R5 stated, "I have been trying to cut it off but it is taking too long and it is painful." A facility RN observed a one-inch long horizontal, superficial cut at the base of R5's penis. R5 was transported to the hospital for a psychiatric evaluation and treatment. A safety plan was implemented to include continuous monitoring while inside the facility and staff person to accompany R5 on all outings. In addition, staff would perform a daily room checks, and bag searches after outings. R5's record lacked an RN assessment after the incident on February 19, 2021 for a change in mental health. R5's RN assessment dated September 6, 2021, indicated R5 tried to cut off his penis. R5 had a history of eloping and wandering from facilities. Staff were to monitor R5's safety and incidents of elopement. R5 had a history of physical and verbal aggression when under the influence of drugs. Staff would monitor her safety and use of drugs. R2 was paranoid and reported ongoing auditory hallucinations. R5 constantly requested to leave the facility to shop and often left the facility without facility staff. Staff were to encourage R5 to shop on scheduled shopping days or ask staff to pick up items for R5.	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36221	A. BUILDING: _____ B. WING _____	C 04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGANCARE BEHAVIORAL HEALTH	1766 GABBRO TRAIL EAGAN, MN 55122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 20 R5's progress note dated November 8, 2021, at 6:28 p.m., indicated on November 8, 2021, at 5:22 p.m., R5's family member called the facility stating R5 left a voice message indicating he R5 wanted to kill himself 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. R5's hospital record dated November 21, 2021, indicated R5 reported he took 500 pills of Tylenol, at an unknown time and stated he attempted suicide five previous times. R5 was transferred to the intensive care unit for a 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. On April 14, 2022, at 1:50 p.m., RN-A stated he performed follow-up assessments if adjustments were needed. RN-A stated he was unsure if he performed reassessments on R1 and R2 after the two physical assaults. The licensee policy titled Assessment and Reassessment, dated August 1, 2021, indicated ongoing resident monitoring must be conducted as needed based on changes in the needs of the resident. TIME PERIOD TO CORRECT: Seven (7) days.	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36221	A. BUILDING: _____ B. WING _____	C 04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGANCARE BEHAVIORAL HEALTH	1766 GABBRO TRAIL EAGAN, MN 55122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01640	Continued From page 21	01640		
01640 SS=I	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to revise service plans for three of six residents (R1, R2, R5) with records reviewed after incidents with injury. In addition, the licensee failed to ensure service plans included all the services to be provided as indicated for five of six residents (R1, R2, R4, R5, R6) with records reviewed. This practice resulted in a level three violation (a	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36221	A. BUILDING: _____ B. WING _____	C 04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGANCARE BEHAVIORAL HEALTH	1766 GABBRO TRAIL EAGAN, MN 55122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01640	Continued From page 22 violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings Include: R1 R1's medical record was reviewed. R1 admitted to the license on February 26, 2021 under the comprehensive home care license, and began receiving assisted living services on August 1, 2021. R1's diagnoses included major depressive disorder, Post-Traumatic Stress Disorder (PTSD), Dissociative identity disorder, and panic disorder. R1 walked independently. R1's treatment and therapy plan dated February 26, 2021, indicated R1 required assistance with her bedtime oxygen therapy delivered at 2 Liters per minute via nasal cannula. R1 required daily assistance with blood glucose checks. R1 required nightly assistance with her continuous positive airway pressure (CPAP) machine. R1's service plan, dated February 26, 2021, indicated R1 received daily assistance and other unknown services from unlicensed personnel (ULP). R1's service plan failed to include services for oxygen management, blood glucose checks and assistance with her CPAP. A facility incident report dated September 11, 2021, at 6:10 p.m., indicated R1 and R2 argued	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36221	A. BUILDING: _____ B. WING _____	C 04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGANCARE BEHAVIORAL HEALTH	1766 GABBRO TRAIL EAGAN, MN 55122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01640	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 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 October 26, 2021 nursing assessment and IAPP.	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36221	A. BUILDING: _____ B. WING _____	C 04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGANCARE BEHAVIORAL HEALTH	1766 GABBRO TRAIL EAGAN, MN 55122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01640	Continued From page 24 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 the facility's bottle of non-alcoholic beverage from the refrigerator. R2 responded by spitting in R1's face. R2 grabbed an empty glass bottle and struck R1 over the head multiple times. Unlicensed personnel (ULP)-D attempted to intervene. 911 and law enforcement were called. R1 was taken 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 service plan lacked evidence it was revised after R1 was physically assaulted in December 2021. R1's service delivery record dated September 2021 through April 2022, indicated R1 received daily assistance with behaviors, bathing, assistance with her CPAP machine, housekeeping, two hour nightly oxygen and safety checks, and daily COVID-19 screening. R1's service plan lacked evidence safety checks and 24/7 safety monitoring were implemented in her service plan along with instruction for ULP on how to perform the scheduled services. R1's service delivery records lacked documentation R1 received all of her services that were to be provided as indicated in her record. R2 R2's medical record was reviewed. R2 admitted to the licensee on October 16, 2020, under the	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36221	A. BUILDING: _____ B. WING _____	C 04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGANCARE BEHAVIORAL HEALTH	1766 GABBRO TRAIL EAGAN, MN 55122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01640	Continued From page 25 comprehensive home care license, and began receiving assisted living services on August 1, 2021. R2's diagnoses included, but were not limited to bipolar 2, borderline personality disorder, PTSD, diabetes Type 2, and depression. R2 used a quad cane and a wheelchair for long distances. R2's medication management plan dated October 18, 2020, indicated R2 received medication management services. R2's treatment and therapy plan dated October 18, 2020, indicated R2 received three times daily blood glucose checks. R2's service plan dated October 18, 2020, indicated R2 received assistance with medication management, three times per day blood glucose checks, and other unknown scheduled services. R2's service delivery record dated September 2021 through December 2021, indicated R2 received daily assistance with behaviors, housekeeping, laundry, meals, toileting, daily safety checks, assistance with activites, and stand-by assistance with walking. R2's service delivery records lacked documentation R2 received all of her services that were to be provided as indicated in her record. R2's IAPP dated December 14, 2021, indicated R2 received 24/7 safety monitoring and scheduled safety checks. R2's service plan lacked evidence it was revised after R2 physically assaulted R1 on September 11, 2021 and December 10, 2021.	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36221	A. BUILDING: _____ B. WING _____	C 04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGANCARE BEHAVIORAL HEALTH	1766 GABBRO TRAIL EAGAN, MN 55122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01640	Continued From page 26 R4 R4's medical record was reviewed. R4 admitted to the licensee on March 28, 2022. R4's diagnoses included bipolar affective disorder and generalized anxiety disorder (GAD). R4 used a cane for walking. R4's service plan dated March 28, 2022, indicated R4 received assistance with medication management, personal cares, toileting, and stand-by assist with transfers. R4's service delivery record dated April 2022, lacked documentation R2 received all of her services that were to be provided as indicated in her record. R5 R5's medical record was reviewed. R5 admitted to the licensee on January 23, 2021, under the comprehensive home care license, and began receiving assisted living services on August 1, 2021. R5's diagnoses included suicidal ideation, Schizoaffective disorder, substance abuse, and anxiety. R5 walked independently. R5's service delivery record dated January 23, 2021, indicated R5 received daily assistance with behaviors, oxygen and temperature checks, and meals. R5's medication management plan dated January 23, 2021, indicated R5 received assistance with medication management. R5's IAPP dated January 23, 2021, indicated R5 received 24/7 monitoring. R5's service plan dated January 23, 2021,	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36221	A. BUILDING: _____ B. WING _____	C 04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGANCARE BEHAVIORAL HEALTH	1766 GABBRO TRAIL EAGAN, MN 55122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01640	Continued From page 27 indicated R5 received assistance with unknown scheduled services. R5's service plan failed to include services for medication management, oxygen and temperature checks, assistance with behaviors and monitoring. R5's incident report dated February 19, 2021, at 12:45 p.m., R5 attempted to sever his penis using a pair of scissors he found. R5 told staff he did not like his penis and wanted a vagina, and told staff he would use any means to sever it. R5 stated, "I have been trying to cut it off but it is taking too long and it is painful." The facility registered nurse (RN) observed a one-inch long horizontal, superficial cut at the base of R5's penis. R5 was transported to the hospital for a psychiatric evaluation and treatment. A safety plan was implemented to include continuous monitoring while inside the facility and staff person to accompany R5 on all outings. In addition, staff would perform a daily room checks, and bag searches after outings. R5's record lacked evidence R5's service plan was revised to include R5's increased needs of continuous monitoring, daily room checks, bag searches, and staff to accopany R5 on all outings. R5's service record dated October 23, 2021, at 3:50 p.m., and documented by ULP-C, indicated R5 went to the store alone. ULP-C documented, "R5 walks in and out of the house often." R5's service delivery record dated April 2022, lacked documentation R5 received all of his services that were to be provided as indicated in his record. R6	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36221	A. BUILDING: _____ B. WING _____	C 04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGANCARE BEHAVIORAL HEALTH	1766 GABBRO TRAIL EAGAN, MN 55122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01640	Continued From page 28 R6's medical record was reviewed. R6 admitted to the licensee on April 12, 2022. R6's diagnoses included delusional disorder, schizophrenia, and anxiety. R6 walked independently. R6's service delivery record dated April 2022, indicated R6 received the following daily services: bathing reminders, behavior managment, and housekeeping. R6's service delivery record lacked documentation R6 received all of his services that were to be provided as indicated in R6's service plan. R6's service plan dated April 2022, indicated R6 received assistance with medication management and meals. R6's service plan failed to included services for bathing reminders, behavior management and housekeeping. On April 14, 2022, at 1:50 p.m., RN-A stated service plans were updated when a resident experienced a change in condition. RN-A stated ULP followed a resident's service plan. The licensee policy titled Service Plan, dated August 1, 2021, indicated service plans were developed based on agreement with the resident or responsible party and on the assessed needs identified in the comprehensive assessment. Service plans would include the following: (a) a description of the services to be provided; the service description may be in the form of the resident's care plan; (b) fees for services and the frequency of each service according to the resident's current review or assessment and resident preferences; identification of staff or categories of staff who provided the services; schedule and method of monitoring reviews or	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36221	A. BUILDING: _____ B. WING _____	C 04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGANCARE BEHAVIORAL HEALTH	1766 GABBRO TRAIL EAGAN, MN 55122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01640	Continued From page 29 assessments of the resident. TIME PERIOD TO CORRECT: Seven (7) days.	01640		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record reivew the	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36221	A. BUILDING: _____ B. WING _____	C 04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGANCARE BEHAVIORAL HEALTH	1766 GABBRO TRAIL EAGAN, MN 55122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01650	Continued From page 30 licensee failed to ensure service plans contained the required content for five of six residents (R1, R2, R4, R5, R6) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings Include: R1 R1's medical record was reviewed. R1 admitted to the licensee on February 26, 2021 under the comprehensive home care license, and began receiving assisted living services on August 1, 2021. R1's diagnoses included major depressive disorder, Post-Traumatic Stress Disorder (PTSD), Dissociative identity disorder, and panic disorder with agoraphobia. R1 walked independently. R1's service plan, dated February 26, 2021, indicated R1 received daily assistance and other unknown services from unlicensed personnel (ULP). R1's service plan lacked a description of the services to be provided, names and contact information of persons R1 wished to have notified in an emergency or if there was a significant change in R1's condition, including identification of and information as to who had the authority to sign for R1 in an emergency, and R1's code status.	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36221	A. BUILDING: _____ B. WING _____	C 04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGANCARE BEHAVIORAL HEALTH	1766 GABBRO TRAIL EAGAN, MN 55122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01650	Continued From page 31 R2 R2's medical record was reviewed. R2 admitted to the licensee on October 16, 2020, under the comprehensive home care license, and began receiving assisted living services on August 1, 2021. R2's diagnoses included bipolar 2, borderline personality disorder, PTSD, diabetes Type 2, and 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, three times per day blood glucose checks, and other unknown scheduled services. R2's service plan lacked a description of the services to be provided. R4 R4's medical record was reviewed. R4 admitted to the licensee on March 28, 2022. R4's diagnoses included bipolar affective disorder and generalized anxiety disorder (GAD). R4 used a cane for walking. R4's service plan dated March 28, 2022, indicated R4 received assistance with medication management, personal cares, toileting, and stand-by assist with transfers. R4's service plan lacked a contingency plan; action to be taken if the scheduled services could not be provided; information and method to contact the facility, the names and contact information of persons R1 wished to have notified in an emergency or if there was a significant change in R1's condition, including identification of and information as to who had the authority to sign for R1 in an emergency; and the circumstances in which emergency medical	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36221	A. BUILDING: _____ B. WING _____	C 04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGANCARE BEHAVIORAL HEALTH	1766 GABBRO TRAIL EAGAN, MN 55122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01650	Continued From page 32 services were not to be summoned, information and a method to contact the facilit, R4's code status, and acknowledgement R4 received copies of the assisted living bill of rights (ALBOR), notice of personal health information privacy, complaint and grievance process, uniform disclosure of AL services and amenities, evacuation plan, and understanding of the availability of a dementia notice. R5 R5's medical record was reviewed. R5 admitted to the facility on January 23, 2021, under the comprehensive home care license, and began receiving assisted living services on August 1, 2021. R5's diagnoses included suicidal ideation, Schizoaffective disorder, substance abuse, and anxiety. R5 walked independently. R5's service plan dated January 23, 2021, indicated R5 received assistance with unknown scheduled services. R5's service plan lacked a description of the services to be provided. R6 R6's medical record was reviewed. R6's diagnoses included delusional disorder, schizophrenia, and anxiety. R6 walked independently. R6's service plan dated April 2022, indicated R6 received assistance with medication management and meals. R6's service plan lacked the schedule and methods of monitoring staff providing services, when to notify a registered nurse (RN), R6's code status, and acknowledgement that R4 received	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36221	A. BUILDING: _____ B. WING _____	C 04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGANCARE BEHAVIORAL HEALTH	1766 GABBRO TRAIL EAGAN, MN 55122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01650	Continued From page 33 copies of the assisted living bill of rights (ALBOR), notice of personal health information privacy, complaint and grievance process, uniform disclosure of AL services and amenities, evacuation plan, and understanding of the availability of a dementia notice. On April 14, 2022, at 1:50 p.m., RN-A stated he and another RN were resposible for developing resident service plans. The licensee policy titled Service Plan, dated August 1, 2021, indicated service plans would include the following: (a) a description of the services to be provided; the service description may be in the form of the resident's care plan; (b) fees for services and the frequency of each service according to the resident's current review or assessment and resident preferences; identification of staff or categories of staff who provided the services; schedule and method of monitoring reviews or assessments of the resident. TIME PERIOD TO CORRECT: Seven (7) days.	01650		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following:	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36221	A. BUILDING: _____ B. WING _____	C 04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGANCARE BEHAVIORAL HEALTH	1766 GABBRO TRAIL EAGAN, MN 55122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01730	Continued From page 34 (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to complete an individualized medication management services plan with required content for one of six residents (R4) with records reviewed.	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36221	A. BUILDING: _____ B. WING _____	C 04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGANCARE BEHAVIORAL HEALTH	1766 GABBRO TRAIL EAGAN, MN 55122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01730	Continued From page 35 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R4 R4's medical record was reviewed. R4 admitted to the licensee on March 28, 2022. R4's diagnoses included bipolar affective disorder and generalized anxiety disorder (GAD). R4 used a cane for walking. R4's service plan dated March 28, 2022, indicated R4 received assistance with medication management, personal cares, toileting, and stand-by assist with transfers. R4's record lacked a medication management plan to include the following required content: *Description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with manufacturer's directions; *Documentation of specific resident instructions relating to the administration of medications; *Resident-specific requirements relating to documenting medication administration, verification all medications were administered as prescribed; *Monitoring of medication used to prevent possible complications or adverse reactions. On April 26, 2022, at 2:00 p.m., unlicensed	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36221	A. BUILDING: _____ B. WING _____	C 04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGANCARE BEHAVIORAL HEALTH	1766 GABBRO TRAIL EAGAN, MN 55122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01730	Continued From page 36 personnel (ULP)-C stated he administered medications to all of the residents. The licensee policy titled, Clinical Records, dated August 1, 2021, indicated a legible, clinical record would be maintained for all residents that included, but not limited to medications, treatment and/or therapies. TIME PERIOD TO CORRECT: Fourteen (14) days.	01730		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: Based on observations, interviews, and document review, the facility failed to ensure two of four residents reviewed (R1, R2) were free from maltreatment. R1 and R2 were neglected. Findings include: On June 21, 2022, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	02360		
03000 SS=I	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36221	A. BUILDING: _____ B. WING _____	C 04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGANCARE BEHAVIORAL HEALTH	1766 GABBRO TRAIL EAGAN, MN 55122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
03000	Continued From page 37 believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36221	A. BUILDING: _____ B. WING _____	C 04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGANCARE BEHAVIORAL HEALTH	1766 GABBRO TRAIL EAGAN, MN 55122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
03000	Continued From page 38 reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to comply with the requirements for reporting suspected maltreatment of vulnerable adults for three of six residents (R1, R2, R5) with records reviewed. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings Include: R1 R1's medical record was reviewed. R1 was admitted to the facility on February 26, 2021, under the comprehensive home care license and began receiving assisted living services on August 1, 2021. R1's diagnoses included depressive disorder, Post-Traumatic Stress Disorder (PTSD), and panic disorder. R1 walked independently. R1's service plan dated February 26, 2021,	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36221	A. BUILDING: _____ B. WING _____	C 04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGANCARE BEHAVIORAL HEALTH	1766 GABBRO TRAIL EAGAN, MN 55122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
03000	Continued From page 39 indicated R1 received assistance with medication management, R1's registered nurse (RN) assessment dated October 26, 2021, indicated R1 needed cueing, reminders, and assistance with her personal cares. 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 was vulnerable to abuse due to mental instability. Staff were trained to recognize and report abuse. R1 had no history of attempted suicide or suicidal thoughts but did report chronic thoughts of suicidal ideation to staff with needed intervention of R1 would report suicidal thoughts to staff. R1 was assessed as not vulnerable to self-abuse, however, her IAPP indicated she was vulnerable to self-abuse due to mental instability with a needed intervention of received 24-hour daily monitoring. R1 was verbally aggressive, resisted cares and taking her medication, with needed intervention of staff encouraged R1 to engage in wellness activities. R1 had a history of hallucinations during psychotic episodes with needed intervention of staff locked sharp objects and cleaning solutions. R1 had depression with needed interventions of managed with medications and scheduled wellness activities. R1's IAPP indicated R1 received scheduled safety checks. R2 R2's medical record was reviewed. R2 admitted to the facility on October 16, 2020, under the comprehensive home care license, and began receiving assisted living services on August 1,	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36221	A. BUILDING: _____ B. WING _____	C 04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGANCARE BEHAVIORAL HEALTH	1766 GABBRO TRAIL EAGAN, MN 55122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
03000	Continued From page 40 2021. R2's diagnoses included bipolar 2, borderline personality disorder, PTSD, diabetes Type 2, and 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. R2's RN assessment dated October 26, 2021, indicated R2 required assistance with personal cares. R2 required stand-by assistance with transfers. R2 required medication management. R2 required staff supervision when outside the facility. R2 had unprovoked outbursts of verbal aggression that quickly escalated to physical aggression. Staff were to encourage R2 to take deep breaths and express frustration as needed. R2 had a history of physically assaulting a staff and resident at a previous facility. Staff were educated on R1's behaviors (packing, verbal aggressions, throwing items, swearing). R2 had poor coping skills resulting in violent actions. R2's IAPP dated December 14, 2021, indicated R2 was vulnerable to being abused by others with a needed intervention of constant staff supervision when outside the facility. R2 was at risk to abuse others with needed intervention of staff supervision when outside the facility. R2 had a history of attempted suicide and suicidal thoughts with a needed intervention of R2 was constantly monitored by staff. Sharp objects were stored and locked away. R2 was to report suicidal thoughts to staff. R2 had scheduled safety checks. A facility incident report dated September 11, 2021, at 6:10 p.m., indicated R1 and R2 argued in the lower level of the facility. R1 accused R2 of	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36221	A. BUILDING: _____ B. WING _____	C 04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGANCARE BEHAVIORAL HEALTH	1766 GABBRO TRAIL EAGAN, MN 55122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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 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.	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36221	A. BUILDING: _____ B. WING _____	C 04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGANCARE BEHAVIORAL HEALTH	1766 GABBRO TRAIL EAGAN, MN 55122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
03000	Continued From page 42 Facility records lacked evidence a MAARC report was filed for the December 10, 2021 assault. On April 14, 2022, at 11:55 a.m., R1 stated the facility never moved R2 after she physically assaulted her. R1 stated R2's room was directly across the hall from hers. R1 stated after the second physical assault in December 2021, the facility moved her to a vacant room upstairs. R1 stated she has been receiving physical therapy for her hand and left leg that were injured during the assaults. R1 stated she could no longer use her right thumb. R1 stated she developed PTSD after the incidents. R1 stated after the first assault, the facility installed a lock on her door and told R1 and R2 to stay away from each other, stating, "that was all they did." On April 14, 2022, at 1:50 p.m., RN-A stated the facility filed MAARC reports for the two physical assaults. RN-A stated after the first assault the facility had R1 sleep on the sofa located on the upstairs level of the facility. RN-A stated he felt it was safer for R1 to sleep upstairs on the sofa because staff were upstairs and close by. RN-A stated R2 was confined to her room, stating there was a call pendant R2 used if she needed anything. RN-A stated this was to prevent another altercation from occuring. RN-A stated R2 eventually came out her room, stating, "it took a while." On April 15, 2022, at 8:15 a.m., RN-A confirmed the facility did not file MAARC reports for R1's two physical assaults. On April 25, 2022, at 11:30 a.m., medical doctor (MD)-B stated R1 expressed to her she did not feel safe after the incidents.	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36221	A. BUILDING: _____ B. WING _____	C 04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGANCARE BEHAVIORAL HEALTH	1766 GABBRO TRAIL EAGAN, MN 55122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
03000	Continued From page 43 On April 26, 2022, at 2:00 p.m., ULP-C stated R1 was afraid of R2 after R2 pushed her down the stairs. ULP-C stated staff tried to remain close to R1 after the first incident, to make sure R2 did not come near R1. ULP-C stated one time R2 physically assaulted another ULP, beating the ULP and throwing a computer at her. On April 29, 2022, at 10:00 a.m., ULP-D stated R1 was afraid of R2 and requested a lock be installed on her door after the first incident. ULP-D stated on December 10, 2021 R2 said to R1, "I'm going to kill you." ULP-D stated R1 and R2's room location was not changed right away after the the second assault. ULP-D stated staff were required to check on residents every two hours during the night and every four hours during the day. R5 R5's medical record was reviewed. R5 admitted to the facility on January 23, 2021, under the comprehensive home care license, and began receiving assisted living services on August 1, 2021. R5's diagnoses included suicidal ideation, Schizoaffective disorder, substance abuse, and anxiety. R5 walked independently. R5's service plan dated January 23, 2021, indicated R5 received assistance with medication management R5's incident report dated February 19, 2021, at 12:45 p.m., indicated R5 attempted to cut off his penis using a pair of scissors he found. R5 told staff he did not like his penis and wanted a vagina, and told staff he would use any means to sever it. R5 stated, "I have been trying to cut it off, but it is taking too long, and it is painful." A RN observed a one-inch long horizontal, superficial	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36221	A. BUILDING: _____ B. WING _____	C 04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGANCARE BEHAVIORAL HEALTH	1766 GABBRO TRAIL EAGAN, MN 55122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
03000	Continued From page 44 cut at the base of R5's penis. R5 was transported to the hospital for a psychiatric evaluation and treatment. A safety plan was implemented to include continuous monitoring inside and outside the facility. A staff person would accompany R5 on outings to the store. In addition, staff would perform a daily room checks, and bag searches after outings. R5's RN assessment dated September 6, 2021, indicated R5 tried to cut off his penis. R5 had a history of eloping and wandering from facilities. Staff were to monitor R5's safety and incidents of elopement. R5 had a history of physical and verbal aggression when under the influence of drugs. Staff would monitor his safety and use of drugs. R5 constantly requested to leave the facility to shop and often left the facility without facility staff. Staff were to encourage R5 to shop on scheduled shopping days or ask staff to pick up items for R5. R5's progress note dated November 8, 2021, at 6:28 p.m., indicated on November 8, 2021, at 5:22 p.m., R5's family member called the facility stating R5 left a voice message indicating he R5 wanted to kill himself with a knife. R5's progress note dated November 20, 2021, at 5:41 p.m., indicated R5 was found having seizure-like activity. Staff called 911 and sent R5 to a hospital for evaluation. R5's hospital record dated November 21, 2021, indicated R5 told health professionals he ingested 500 Tylenol pills to commit suicide. R5 stated he bought the bottle of Tylenol at a store. R5's hospital record indicated R5 had a history of suicide attempts and self-injurious behaviors. R5 was transferred to the intensive care unit for a	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36221	A. BUILDING: _____ B. WING _____	C 04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGANCARE BEHAVIORAL HEALTH	1766 GABBRO TRAIL EAGAN, MN 55122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
03000	Continued From page 45 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's IAPP dated November 29, 2021, indicated R5 was vulnerable to self-abuse due to his mental illness and unawareness of surroundings. Staff were to monitor R5's safety and were trained in reporting suspected or actual abuse in a timely manner. R5 was vulnerable to being abused. Staff were to monitor R5's safety. R5 was vulnerable to abuse other vulnerable adults. Staff were to monitor and report and suspected or actual abuse. R5's record lacked evidence the facility filed a MAARC reports for R5's two incidents. On May 4, 2022, at 9:13 a.m., RN-A stated he believed R5 went to the hospital due to seizure-like activity, not due to an overdose. The licensee policy titled, Vulnerable Adult, dated August 1,2021, indicated when abuse or neglect was discovered, the employee's first action was to remove the resident from danger, provide first aid as needed and contact local law enforcement if indicated. When abuse or neglect directed toward a vulnerable was discovered, the employee would immediately make an oral report to the RN and complete a written report of the abuse or neglect within 24 hours. The RN or director would review and investigate to determine if the incident was reportable, and if so, the information would then be reported to MAARC immediately, or as soon as possible. A copy of the report would be sent to MAARC and	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36221	A. BUILDING: _____ B. WING _____	C 04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGANCARE BEHAVIORAL HEALTH	1766 GABBRO TRAIL EAGAN, MN 55122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
03000	Continued From page 46 retained in the resident's record. The licensee policy indicated failure to report was a misdemeanor and could expose the non-reporter to potential civil damages. TIME PERIOD TO CORRECT: Seven (7) days.	03000		