Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL371972603M & HL371972551M
Compliance #: HL371974367C & HL371974451C

Date Concluded: October 27, 2022

Name, Address, and County of Licensee Investigated:
Unique Homes, LLC
3940 46th Avenue North
Robbinsdale, MN 55422
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Christine Bluhm, RN
Lena Gangestad, RN
Special Investigators

Finding: Substantiated, facility responsibility

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

Initial Investigation Allegation:
The facility neglected the resident when the facility failed to assess, care plan, and develop interventions for the resident who had mental health diagnoses and experienced a mental health crisis.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to assess the resident prior to admission to determine the facility's capability to ensure the resident received the court ordered treatment. The facility failed to develop or implement a plan to address when the resident refused court ordered medications or missed medications because the resident was away from the facility.

The resident had a mental health emergency which resulted in facility and personal property damage which placed himself and other residents at risk.

Additionally, reports from separate incidents indicated other residents were left unsupervised off facility grounds. The facility did not enforce a system for reporting and following-up on resident incidents and medication refusals. The facility failed to provide interventions and follow up to address or minimize ongoing resident behaviors which affected other residents and those living around the facility.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement, the resident's case managers, and the resident's primary medical provider. The investigation included review of the resident's facility record as well as other resident records. Also, the investigator observed staff providing resident care, the condition of the facility and interviewed other residents currently living there.

The resident resided in an assisted living facility. The resident's diagnoses included bipolar disorder and schizoaffective disorder. The resident's service plan included full assistance with medications and reminders for self-care. A review of the uniform assessment tool found the tool was incomplete because the nurse was unsuccessful in meeting with the resident to complete all admission documents.

Review of the resident's nursing notes indicated the registered nurse (RN) attempted to complete the admission and required assessments, but the resident was either not at the facility or refused the assessment. The same documents indicated the RN gave the resident his monthly Haldol injection in May, but the resident refused the injection for June, and refused most of his oral medications. The RN documented the facility would continue to monitor. The RN documented she updated the resident's case managers regarding the concern. The RN accompanied the resident to a psychiatric provider appointment and the provider was also aware of the medication refusals.

Review of the resident progress notes indicated during the early morning hours, the resident became violent and started to break windows. The same document indicated facility staff member tried to intervene, but the resident did not calm down and became more violent and damaged the stove and other appliances in the facility. Law enforcement arrived and removed the resident from the facility.

Review of the resident's court order indicated the authorization of neuroleptic medications. The order indicated the resident did not have sufficient insight to understand the consequences of not taking the prescribed medications, with the result that if he stopped taking the medication, he would decompensate. The order authorized a facility providing care and treatment to the resident to administer Haldol (haloperidol), Zyprexa (olanzapine), Clozaril (clozapine) and/or

Thorazine (chlorpromazine), in medically indicated dosages, and in all formulations, for the duration of the commitment.

Review of a psychiatry provider note indicated the resident was on a civil commitment and Jarvis order (A State statute that gives courts the power to order administration of medication for a committed person who is unwilling to take prescribed psychiatric medications). The note indicated that staff were advised to notify the case managers of the resident's medication non-compliance.

Review of the resident's medication records indicated blank entries, and resident refusals. The resident's medication indicated the resident refused his medications or did not receive his medication(s) due to "LOA/Not given".

During an interview, an unlicensed staff person, who was working the night of the mental health emergency incident, stated the resident came home that evening intoxicated. The staff person asked the resident to take his medications, but the resident refused and became upset. The staff person stated the resident damaged facility property and other residents were fearful.

During interview and email correspondence, the licensed assisted living director stated he met with the resident and nurse at the previous facility prior to admission. They informed him of the resident's non-compliance with medications and that it took a lot of reminders to get him to take his medications. The director stated the main concern was to watch the resident for self-injurious behavior. The director stated he met later with the RN and program director and decided the resident would be a good fit at their facility. The director stated he was aware of the medication commitment and knew it was important for the resident to take his medications. He stated the resident would go out almost every day, was once found panhandling and the director drove him back to the facility. The director stated residents are able to step off the property and go wherever they want, and the facility tries to track where they are.

During interview and email correspondence, the RN stated she did not complete the nursing pre-assessment for the resident prior to move-in. The RN stated she did not get a copy of the medication commitment letter but there was a note from the previous facility and a report made by the director that the resident was on a medication commitment. She stated monitoring for the resident included watching his overall behavior. The resident would come and go on his own without signing out saying he was going to visit friends. If staff witnessed something alarming, they were to contact the nurse and the nurse would contact the case manager. The RN stated there were no previous incidents like the one where the property was damaged. The RN stated she reached out to the resident's county case worker and mental health case worker that he refused medications. The RN was not sure if anyone else at the facility reached out to the case managers regarding the refusals.

During interview, the facility program manager stated she was not aware the resident had a court ordered medication commitment. The manager also stated that the facility did not have any documented incident reports to review on the resident or any recent incidents reported on other residents.

During an interview, the resident's case managers stated not all the case managers were aware of the extent of the resident's medication refusals. One case manager stated if a resident missed a couple of days of medications while under a medication commitment, there should be communication and further missed medication would trigger a revocation. The case manager stated the medications were the only thing which kept the resident stable. She stated that if they do not hear from a facility there were increased behaviors or a lack of medication compliance, it is assumed that everything is going all right. The case manager did not have any communication in her records from the facility regarding the resident's lack of medication compliance. A second case manager stated the facility should have communicated more about the resident not taking his medications and being gone from the facility often. The third case manager stated it was expected for the resident to start refusing medications but sometimes a case manager can convince the resident to take the medication. She stated after a certain period of time, without the medication, there is no coming back. The case manager stated she did receive communication but not until mid-June that the resident refused the injection.

During interviews, multiple witnesses stated the residents at the facility were not supervised. The examples mentioned by witnesses included the facility's residents wandering throughout the neighborhood, knocking on doors, and asking homeowners for help among other requests without facility staff have been present.

Review of police reports indicated a second resident (resident #2) has been the subject of calls related to loud and disruptive behavior outside of the facility and staff were witnessed doing nothing for the resident.

Investigator observations at the facility included resident #2 who received medications later than the scheduled time. A review of resident #2's medical record indicated resident #2 had not received some scheduled medications in the previous days. The RN stated she was not aware that resident #2 had missed medications. The RN stated medications given late would be considered a medication error. When interviewed, resident #2 stated that she had a bad day the day prior. Later that day, resident #2 was screaming during a verbal argument outside which could be heard from inside the facility.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.

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

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
Neglect means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: The resident was no longer at the facility.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
No action taken.

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

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

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

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

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

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Hennepin County Attorney
Robbinsdale City Attorney
Robbinsdale Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37197	A. BUILDING: _____ B. WING _____	C 08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIQUE HOMES LLC	3940 46TH AVENUE NORTH ROBBINSDALE, MN 55422

(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: HL371974367C / HL371972603M HL371972551M / HL371974451C On August 31, 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 (4) residents receiving services under the provider ' s Assisted Living license. The following correction order is issued for HL371974367C / HL371972603M and HL371972551M / HL371974451C, tag identification 1760. The following correction orders are issued for HL371974367C / HL371972603M only, tag identification 0620, 0730, 1610, 2360, and 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.	

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0 620 SS=D	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma 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 licensee failed to report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment for one of one resident (R1) 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). Findings include: R1's diagnosis included bipolar disorder and schizoaffective disorder. R1's undated and unsigned care plan indicated R1 received services from the licensee for medication management and reminders for self-care.	0 620		

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0 620	Continued From page 2 R1's Individual Abuse Prevention Plan assessment document was provided and undated and blank. Review of nursing progress note for R1 dated June 23, 2022, by registered nurse (RN)-D indicated R1 became violent during the early morning and started to break windows in the home. Staff at the home intervened trying to calm R1 down but R1 became more violent and went towards the kitchen and broke the stove in the home along with other appliances in the home. Writer went on site to access (sic) R1 and the situation but R1 was already taken away by law enforcement. Will continue to monitor and follow-up as needed. On August 31, 2022, at 12:10 p.m., program manager (PM)-C stated there were not an incident report created for the incident involving R1 on June 23, 2022. On September 6, 2022, at 11:02 a.m., the licensed assisted living director (LALD)-A stated that this was an incident that one that should have been reported to MAARC. He stated that it is usually the RN who submits the reports, but she was on vacation at that time. The licensee's Vulnerable Adult policy, undated, indicated the licensee prohibits the maltreatment of residents. To support this prohibition, the licensee educates clients, family members, and staff (mandated reporters) about how to report suspected maltreatment internally and to the Minnesota Adult Abuse Reporting Center (MAARC). The licensee also develops individualized vulnerable adult abuse prevention plans to identify vulnerability risks and develop measures to minimize maltreatment based on	0 620		

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0 620	Continued From page 3 identified information. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 620		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the	0 730		

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0 730	Continued From page 4 appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to complete a discharge summary or include emergency contact information for one of one (R1) resident 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). Findings include: R1's diagnosis included bipolar disorder and schizoaffective disorder. R1's undated and unsigned care plan indicated R1 received services from the licensee for medication management and reminders for self-care.	0 730		

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0 730	Continued From page 5 On August 31, 2022, at 10:30 a.m., a list of recent resident discharges was requested. R1 had a date of discharge on June 23, 2022. On August 31, 2022, the surveyor requested R1's record. The licensee provided a binder labeled with R1's name did not contain a discharge summary or emergency contact information for R1. During an interview on August 31, 2022, at 10:45 a.m., the licensed assisted living director (LALD) stated R1 discharged to the hospital and had not returned because of fear from other residents. During an interview on August 31, 2022, at 1:51 p.m., registered nurse (RN)-B stated R1 was his own person and made his own decisions, the licensee did not have any family contact information and acknowledged there was no emergency contact information in his record. RN-B also acknowledged there was no discharge summary in the record and stated the program manager would have that. On September 12, 2002, at 1:00 p.m., program manager (PM)-C stated that she did not think a discharge summary was completed and further stated everything moved so fast with R1. A policy for resident discharges was requested and a document titled Unique Homes, LLC, Resident Discharge Summary sample form was provided and indicated the summary included a final summary of the resident's status from the latest assessment or review, if applicable which included the resident status, including baseline and current mental, behavioral, and functional status. The same document indicated a	0 730		

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0 730	Continued From page 6 reconciliation of all pre-discharge medications with the resident ' s post-discharge prescribed and over the counter medications was required. While a policy addressing resident record requirements was requested, the licensee did not provide one. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 730		
01610 SS=D	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan 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. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to complete a pre-admission physical and cognitive assessment by a registered nurse (RN) for one of one (R1)	01610		

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01610	Continued From page 7 resident 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). Findings include: R1's diagnosis included bipolar disorder and schizoaffective disorder. R1's undated and unsigned care plan indicated R1 received services from the licensee for medication management and reminders for self-care. R1's Individual Abuse Prevention Plan assessment document was provided and undated and blank. During interview on September 12, 2022, at 12:10 p.m., RN-B stated she received information that R1 was on a medication commitment from the administrator and case workers. RN-B stated while R1 was a resident at the facility, it was hard to see him or to do an assessment with him. When R1 was home, R1 would stay in his room and locked the door however R1 was gone a lot. RN-B acknowledged he did not complete an assessment prior to R1's admission. In an email dated September 19, 2022, LALD-A stated he completed the initial assessment for R1 before R1 moved in. LALD-A stated he met with R1 and the nurse at the previous group home.	01610		

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01610	Continued From page 8 LALD-A stated he sat in the nurse's office and talked about R1's behaviors. The nurse said R1 was non-compliant, and it took a lot of reminders to get him to take his medication, of his once-a-month injection, and how important it was for him to take it every month. LALD-A stated that other than being easily agitated, the nurse stated he had shown no physically aggressive behaviors even though his record showed it. The nurse was more concerned his self-injury behavior and warned that we hide all sharpies [sic], which we did. The LALD-A, RN-B and program directors discussed and decided R1 would be a good fit. Facility policy titled 1.01 Admissions, undated, indicated the LALD, in cooperation with the clinical nurse supervisor, at Unique Homes, LLC is responsible for admitting residents to the facility according to the facility ' s admission policies. Unless otherwise agreed upon, Unique Homes, LLC will not admit or retain a resident unless it can provide sufficient care and supervision to meet the resident's needs, based on the resident's known physical, mental, cognitive, or behavioral condition. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01610		
01760 SS=E	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date	01760		

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01760	Continued From page 9 and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to administer medications per physician ' s orders to two of two (R1, R2) residents with records reviewed. Medications were not given per physician orders and the registered nurse (RN) was not always notified. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). Findings include: R1 R1 document titled Orders for Commitment, Jarvis order, dated and signed on July 7, 2021, indicated an order for the facility providing care and treatment pursuant to the order for commitment was authorized to administer to R1; Haldol, Zyprexa, Clozaril and/or Thorazine in	01760		

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01760	Continued From page 10 medically-indicated dosages, and in all formulations, for the duration of the current commitment, but not beyond one year without additional review by the court. The report also indicated R1 had been involved in incidents that included homicidal and suicidal ideation, property damage, threats to staff and other persons, resulting in hospitalization and jail time. Physician report supported an order for commitment of R1 as a person who poses a risk of harm due to mental illness. R1 admitted by the licensee on April 29, 2022. R1's diagnosis included bipolar disorder and schizoaffective disorder. R1's undated and unsigned care plan indicated R1 received services from the licensee for medication management and reminders for self-care. Document titled medication assessment/delegation form, signed by RN-B and dated May 9, 2022, indicated R1 required an aide to assist with medications three times daily. R1's medication administration record (MAR) dated May 2-16, 2022, indicated the following medications: Atenolol 25 milligrams (mg), take one tablet by mouth every evening. Atorvastatin 20 mg, take one tablet by mouth at bedtime. Benztropine 1 mg, take one tablet by mouth twice daily. Chlorpromazine 50 mg, take one tablet by mouth three times daily. Divalproex sodium 500 mg delayed release, take two tablets by mouth twice daily. Haldol decanoate 100mg/1 milliliters (ml), inject 3	01760		

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01760	Continued From page 11 ml intramuscular every four weeks. R1's MAR dated May 2-16, 2022, indicated staff circled entries for doses not given. Atenolol - Out of 15 possible doses, three were circled as not given and 11 entries were left blank. Atorvastatin - Out of seven possible doses, four were circled as not given and three entries were left blank. Benztropine - Out of 30 possible doses, nine were circled as not given and 17 entries were left blank, one entry was not legible. Chlorpromazine - Out of 45 possible doses, 14 were circled as not given and 19 entries were left blank. Divalproex - Out of 14 possible doses, nine were circled as not given and five entries were left blank. Haldol - one dose given as ordered. The remaining May 2022 nor a June 2022 MAR for R1 was provided. R1 ' s psychiatric clinic notes dated June 2, 2022, indicated R1 appeared more symptomatic, agitated, irritable, uncooperative, and delusional. R1 left the clinic visit abruptly after using foul language toward the psychiatric provider. No medication changes were made at the visit. Provider advised facility staff to notify R1 ' s case manager regarding R1 ' s medication non-compliance as R1 was still on commitment. The note further indicated the provider discussed with facility staff a safety plan should R1 become more agitated and violent. Civil commitment papers were received and extended until 2023. Nursing progress note by RN-B dated June 2, 2022, indicated R1's psychiatric provider knew he	01760		

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01760	Continued From page 12 was not taking his Depakote and therefore his Haldol would not be decreased. RN-B wrote that the provider stated she would talk to R1's caseworkers as he should be on commitment for his meds. Nursing progress note by RN-B dated June 7, 2022, indicated R1 took 3 of 7 morning meds, 1 of 7 noon meds and 0 of 7 bedtime meds that week because R1 was either absent from the home or declined to take the meds. RN-B documented R1 declined the Haldol injection that morning stating he did not want to take it. R1 ' s case workers, Katie and Tatiana were updated as R1 was on medication commitment. Nursing progress note by RN-B dated June 14, 2022, indicated RN-B again attempted to give R1 his monthly Haldol injection and R1 refused to open his door. RN-B updated program manager to see if program manager could talk to R1. R1 did not show up for the team meeting that was on June 10, 2022. R1 had been refusing meds throughout the day, 0 of 7 meds, the week of June 5-June 11 and none taken for week June 12-June 18. RN-B wrote program manager stated she would update R1 's case worker. Nursing progress note by RN-B dated June 14, 2022, indicated no medications were set up for the week of June 19-25, 2022, as R1 had been declining and/or has been out of the home when his meds are due. Nursing progress note by RN-E dated June 21, 2022, indicated R1 was not taking his medications. RN-E provided education and informed R1 of the importance of taking his meds and the adverse events that may occur. The note further indicated will continue to monitor.	01760		

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01760	Continued From page 13 R1's psychiatric clinic notes dated August 3, 2022, indicated R1's civil commitment with Jarvis order, was extended to summer of 2023. R2 R2 was admitted by the licensee on July 2, 2022. R2's diagnoses included anxiety and post-traumatic stress disorder. R2 's Service plan dated July 2, 2022, signed by R2 and RN-B indicated the licensee provided medication reminders, set-up, and monitoring. The cognitive/behavior health management section was blank and not completed. R2 's medication assessment signed by RN-B on July 3, 2022, indicated R2 was deemed unable to safely self-administer medications. R2 's initial individualized medication management plan, signed by RN-B on July 7, 2022, indicated verifications of medications administered as prescribed or ordered were located on the MAR. R2 's home health aide care plan signed by RN-B on August 1, 2022, indicated R2 needed assistance with medications which included verbal reminders, administration and set up. R2 's Individualized Treatment or Therapy management plan signed by RN-B on August 2, 2022, indicated the procedure for notifying an RN or appropriate licensed health professional when a problem arises with treatments or therapy management services. R2 's 24-hour customized living home health aide	01760		

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01760	Continued From page 14 care plan signed by RN-B on August 22, 2022, indicated R2 's goal was to take prescribed medications as directed by staff to maintain current mental stability. R2 's MAR indicated the following medications: Gabapentin 300 mg, take one capsule by mouth three times a day. Topiramate 25 mg, take one tablet by mouth twice daily. Olanzapine 10 mg, take one tablet by mouth every night at bedtime. Olanzapine 20 mg, take one tablet by mouth every night at bedtime. R2 's MAR dated August 2022 indicated circled staff entries for doses not given to R2. Gabapentin - Out of 91 possible doses, 22 were circled as not given and an additional 11 entries were left blank. Topiramate - Out of 61 possible doses, 13 were circled as not given and an additional 5 entries were left blank. Olanzapine - Out of 60 possible doses, 20 were circled as not given and an additional 2 entries were left blank. On August 31, 2022, at 11:20 a.m., R2 said hello to this surveyor and stated she "just woke up." R2 stated she had a bad day yesterday. On August 31, 2022, at 11:30 a.m., unlicensed personnel (ULP)-N stated R2 was sleeping so she did not get her 8:00 a.m. meds. ULP-N was asked about the next dose which was scheduled for noon and ULP-N stated it will just be given later. On August 31, 2022, at 12:42 p.m., RN-B stated that staff circle their initials on the MAR if the	01760		

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01760	Continued From page 15 resident does not get the medication. RN-B stated she was not aware that R2 was refusing medications and that any medication refusals should have been reported to her. On August 31, 2022, at 10:55 a.m., program manager (PM)-C stated there were no medication error incidents to provide to this surveyor. Policy titled 7.15 Medications & Treatment - Administration & Delegation, undated, indicated ordered or prescribed medications and or treatments/therapy may be administered by a nurse, physician, or other licensed health practitioner authorized to administer medications or to perform the treatment or therapy or by ULP ' s who have been delegated medication administration tasks by a registered nurse at Unique Homes, LLC. When administration of medications or treatment/therapy is delegated or assigned to a ULP, Unique Homes, LLC will ensure that the registered nurse has: 1. Instructed the ULP in the proper methods with respect to each resident to administer the medications or perform treatment/therapy, and the ULP has demonstrated the ability to competently follow the procedures. 2. Specified in writing specific instructions for each resident and documented those instructions in the resident ' s records. 3. Communicated with the unlicensed personnel about the individual needs of the resident. TIME PERIOD FOR CORRECTION: Seven (7) days.	01760		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

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02360	Continued From page 16 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 one of one resident reviewed (R1) was free from maltreatment. R1 was neglected. Findings include: 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.	02360	No plan of correction required for tag 2360. Please refer to the public maltreatment report (report sent separately) for details.	
03000 SS=D	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury 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	03000		

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03000	Continued From page 17 in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment for one of one resident (R1) with records reviewed. This practice resulted in a level two violation (a	03000		

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03000	Continued From page 18 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). Findings include: R1's diagnosis included bipolar disorder and schizoaffective disorder. R1's undated and unsigned care plan indicated R1 received services from the licensee for medication management and reminders for self-care. R1's Individual Abuse Prevention Plan assessment document was provided and undated and blank. Review of nursing progress note for R1 dated June 23, 2022, by registered nurse (RN)-D indicated R1 became violent during the early morning and started to break windows in the home. Staff at the home intervened trying to calm R1 down but R1 became more violent and went towards the kitchen and broke the stove in the home along with other appliances in the home. Writer went on site to access (sic) R1 and the situation but R1 was already taken away by law enforcement. Will continue to monitor and follow-up as needed. During an interview, on August 31, 2022, at 12:10 p.m., program manager (PM)-C stated there were not an incident report or MAARC report created for the incident involving R1 on June 23, 2022.	03000		

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03000	Continued From page 19 During an interview on September 6, 2022, at 11:02 a.m., the licensed assisted living director (LALD)-A stated that this was an incident that one that should have been reported to MAARC. He stated that it is usually the RN who submits the reports, but she was on vacation at that time. The licensee's Vulnerable Adult policy, undated, indicated the licensee prohibits the maltreatment of residents. To support this prohibition, the licensee educates clients, family members, and staff (mandated reporters) about how to report suspected maltreatment internally and to the Minnesota Adult Abuse Reporting Center (MAARC). The licensee also develops individualized vulnerable adult abuse prevention plans to identify vulnerability risks and develop measures to minimize maltreatment based on identified information. TIME PERIOD FOR CORRECTION: Seven (7) days.	03000		