

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL373625762M
Compliance #: HL373627974C

Date Concluded: December 9, 2024

Name, Address, and County of Licensee

Investigated:

Brooklyn Park Assisted Living
7711 Humboldt Avenue North
Brooklyn Park, MN 55444
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Peggy Boeck, RN,
Special Investigator

Finding: Not Substantiated

Nature of Investigation:

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

Initial Investigation Allegation(s):

The Alleged Perpetrator (AP) neglected a resident when the AP failed to appropriately replace the resident's indwelling urinary catheter, which caused pain, bleeding, and required hospitalization.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was not substantiated. The AP was trained as a licensed practical nurse and deemed competent by the facility. The error was an isolated incident. Although the resident required hospitalization, he returned to his baseline condition. The AP saw blood after replacing the resident's catheter, replaced the catheter again, and strongly recommended to the resident to go to the hospital to be checked out. The resident declined, went to work, and upon return from work, agreed to go to the hospital.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator reached out to law enforcement and the

hospital. The investigation included review of the resident record, hospital records, facility incident reports, personnel files, staff schedules, related facility policy and procedures. Also, the investigator observed staff/resident interactions.

The resident lived in an assisted living facility. The resident's diagnoses included quadriplegia and post-traumatic stress disorder. The resident's service plan included assistance with catheter cares and assistance of two staff with a mechanical lift for transfers. The resident's assessment indicated the resident was cognitively intact and made his own healthcare decisions.

The resident's progress note indicated one evening the resident requested the AP change his urinary catheter because no one had replaced it when it was due one week earlier. The note indicated upon insertion of the new catheter the AP noted urine and bright red blood draining from the tube. The note indicated the AP removed the catheter and placed a new one and again observed bright red blood, urine, and blood clots draining. The note indicated the AP recommended the resident go to the emergency department due to continued bleeding, but the resident refused. The note indicated the resident stated some blood was normal for him. The AP checked on the resident multiple times during the night and the resident still refused to go in. The note indicated the AP contacted an administrative nurse.

During an interview the administrative nurse stated the AP notified her of the incident and sent photos of the catheter tubing and collection bag with blood in it. The administrative nurse stated the next morning the resident went to work and when returned he felt discomfort, so called 911 to go to the emergency department.

During an interview the resident stated the AP had changed his urinary catheter many times and never had any problems. The resident stated the AP was very concerned with the blood in the catheter tube and repeatedly told him he needed to go to the emergency department.

The resident stated although he trusted the AP and felt she was a good nurse; he refused to go to the hospital and went to work in the morning. The resident stated while at work he began to feel his blood pressure rising and his head was pounding so he called the hospital. The resident stated the hospital recommended he come in, but he had no place to leave his wheelchair as it would be left at his workplace when the ambulance transported him to the emergency department (as he had experienced previously). The resident decided to finish his work shift and when returned to the facility they called 911. The resident stated the hospital determined the catheter balloon was inflated outside of the bladder and the resident also had a bladder infection.

During an interview the AP stated she had been a nurse for more than seven years and worked in several different long term care facilities as well as other assisted living facilities. The AP stated she had inserted hundreds of urinary catheters and was confident in her skills. The AP stated when she took out the resident's catheter, she could see that it was old, because it contained lots of discharge. The AP stated when she inserted the new one, she got urine flow

and then some blood. The AP stated the resident told her not to worry as it had happened before, but she removed the catheter and placed another one. The AP stated she followed up with the resident during the night due to continued bleeding and encouraged him to go to the emergency department. The AP stated when she came to work the next evening, the resident had returned from work, and she checked the catheter. The AP stated there was still bleeding, and even though the resident said not to, she called 911 because, "there comes a time when you have to do what is right for the resident."

During investigative interviews, multiple staff members stated the facility had problems with short staffing, which made it difficult to get all the services done as all the residents had high needs.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

"Not Substantiated" means:

An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

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: Yes

Family/Responsible Party interviewed: No, the resident was his own decision maker.

Alleged Perpetrator interviewed: Yes.

Action taken by facility:

The facility adjusted the resident's service plan to include supervision by a registered nurse for all catheter changes.

Action taken by the Minnesota Department of Health:

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

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

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

Deficiencies.

You may also call 651-201-4200 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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37362	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/25/2024
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NAME OF PROVIDER OR SUPPLIER BROOKLYN PARK ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 7711 HUMBOLDT AVENUE NORTH BROOKLYN PARK, MN 55444
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0 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p>#HL373627974C/#HL373625762M</p> <p>On October 25, 2024, 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 30 residents receiving services under the provider's Assisted Living license.</p> <p>The following orders are issued for #HL373627974C/#HL373625762M tag identification 0110, 0470, 0680, and 1600.</p>	0 000	<p>Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>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.</p>	
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required	0 110		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Minnesota Department of Health

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0 110	<p>Continued From page 1</p> <p>Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and document review the licensee failed to employ a licensed assisted living director (LALD). This had the potential to affect all residents receiving assisted living services.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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).</p> <p>Findings include:</p> <p>An e-mail received from ALD-A on October 28, 2024, at 9:41 a.m. indicated he was no longer with the company and referred the investigator to another individual, vice president (VP)-D.</p> <p>A review of the Board of Executives for Long Term Services and Supports (BELTSS) website (https://nha.hlb.state.mn.us/#/services/onlineEntitySearch) on October 28, 2024, revealed the licensee did not have an assisted living director (ALD). BELTSS review identified ALD-A's employment with the licensee's five facilities ended on October 27, 2024, and VP-D did not hold an assisted living director license.</p>	0 110		

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0 110	<p>Continued From page 2</p> <p>The Minnesota Department of Health (MDH) investigator sent an e-mail to VP-D on October 28, 2024, at 10:48 a.m. and again at 11:45 a.m. with a request for the name of the new ALD and received no reply.</p> <p>The MDH investigator spoke with director of nursing (DON)-B on October 30, 2024, at 1:44 p.m. requesting clarification of who is the LALD for the facility. DON-B stated she did not know, but VP-D would get back to the investigator. The investigator did not hear from VP-D at the time of case submission.</p> <p>TIME PERIOD FOR CORRECTION: TWO (2) DAYS.</p>	0 110		
0 470 SS=I	<p>144G.41 Subdivision 1 Minimum requirements</p> <p>(11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be:</p>	0 470		

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0 470	<p>Continued From page 3</p> <p>(i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions;</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the licensee failed to ensure adequate staffing for 30 of 30 residents (R1 through R30) reviewed for safety. The facility failed to ensure staff had the ability to promptly respond to emergent situations or to ensure staff met the resident's basic needs when the licensee scheduled one staff for each living unit with a float person (total of 7 staff on the property) between the hours of 7:00 p.m. and 7:00 a.m. for all residents. This had the potential for harm for R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, R14, R15, R16, R17, and R18 who required two staff for transfers with a full mechanical lift.</p> <p>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).</p> <p>Findings include:</p> <p>R1 admitted to the facility on October 13, 2022,</p>	0 470		
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0 470	<p>Continued From page 4</p> <p>due to injury of cervical spine at C7, quadriplegia. R1's resident profile indicated he was non-ambulatory, required frequent supportive nursing care, observation, and significant assistance in evacuation. R1's services include assistance of two staff for repositioning every two hours, assistance of two staff for transfers, range of motion exercises at 8:00 p.m. daily.</p> <p>R2 admitted to the facility on December 8, 2023, due to diagnoses that included quadriplegia. R2's resident profile indicated he was non-ambulatory, required frequent supportive nursing care, observation, and significant assistance in evacuation. R2's services included assistance of two staff with a mechanical lift for mobility, positioning, and transfers.</p> <p>R3 admitted to the facility on January 18, 2022, due to diagnosis that included multiple sclerosis. R3's resident profile indicated he was non-ambulatory, required frequent supportive nursing care, observation, and significant assistance in evacuation. R3's services included assist of two staff for mobility, positioning, and transfers.</p> <p>R4 admitted to the facility on November 3, 2022, due to complete lesion at fifth cervical spinal nerve (C5) with quadriplegia. R4's resident profile indicated he was non-ambulatory, required frequent supportive nursing care, observation, and significant assistance in evacuation. R4's services included assist of two staff for mobility, positioning, and transfers.</p> <p>R5 admitted to the facility on October 31, 2022, due to paraplegia with fourth thoracic vertebral injury (T4) with limited use of upper extremities and blindness in left and right eyes. R5's resident</p>	0 470		

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0 470	<p>Continued From page 5</p> <p>profile indicated he was non-ambulatory, required frequent supportive nursing care, observation, and significant assistance in evacuation. R5's services included assist of two staff for mobility, positioning, and transfers.</p> <p>R6 admitted to the facility on January 18, 2022, due to quadriplegia. R6's resident profile indicated he was non-ambulatory, required frequent supportive nursing care, observation, and significant assistance in evacuation.</p> <p>R7 admitted to the facility on October 15, 2021, due to unspecified injury at unspecified level of cervical spinal cord sequela. R7's resident profile indicated he was non-ambulatory, required frequent supportive nursing care, observation, and significant assistance in evacuation. R7's care plan dated October 3, 2024, indicated R7 required two staff for transfers and staff to assist with turning and repositioning every two hours (overnight).</p> <p>R8 admitted to the facility on September 4, 2024, due to hemiplegia (paralysis) affecting right dominant side. R8's resident profile indicated he was non-ambulatory, required frequent supportive nursing care, observation, and significant assistance in evacuation.</p> <p>R9 admitted to the facility on January 18, 2022, due to hemiplegia (paralysis) and hemiparesis (weakness) following a cerebrovascular accident (CVA-stroke). R9's resident profile indicated he was non-ambulatory, required frequent supportive nursing care, observation, and significant assistance in evacuation.</p> <p>R10 admitted to the facility on October 2, 2024, due to complete lesion at second cervical spinal</p>	0 470		

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0 470	<p>Continued From page 6</p> <p>cord (C2). R10's resident profile indicated she was non-ambulatory, required frequent supportive nursing care, observation, and significant assistance in evacuation. R10's care plan dated October 18, 2024, indicated R10 required assist of two staff for transfers.</p> <p>R11 admitted to the facility on October 25, 2024, due to quadriplegia. R11's resident profile indicated he was non-ambulatory, required frequent supportive nursing care, observation, and significant assistance in evacuation. R11's care plan dated October 10, 2024, indicated R11 required assistance of two staff with a mechanical lift for transfers. R11's care plan indicated R11 expressed a diminished will to live and required staff to monitor and report suicidal comments.</p> <p>R12 admitted to the facility on August 10, 2023, due to hemiplegia and hemiparesis following a cerebral infarction (stroke) affecting right dominant side. R12's resident profile indicated he was non-ambulatory, required frequent supportive nursing care, observation, and significant assistance in evacuation. R12's care plan dated September 13, 2024, indicated R12 required assist of two staff with a mechanical lift for transfers. R12's face sheet dated October 28, 2024, indicated R12 required repositioning every two hours (overnight).</p> <p>R13 admitted to the facility on October 31, 2022, due to quadriplegia with cervical cord injury at C1 through C4, complete. R13's resident profile indicated he was non-ambulatory, required frequent supportive nursing care, observation, and significant assistance in evacuation.</p> <p>R14 admitted to the facility on January 18, 2022, due to cerebral infarction (stroke). R14's resident</p>	0 470		

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0 470	<p>Continued From page 7</p> <p>profile indicated he was non-ambulatory, required frequent supportive nursing care, observation, and significant assistance in evacuation.</p> <p>R15 admitted to the facility on January 16, 2023, due to quadriplegia. R15's resident profile indicated he was non-ambulatory, required frequent supportive nursing care, observation, and significant assistance in evacuation.</p> <p>R16 admitted to the facility on June 10, 2024, due to unspecified injury at cervical cord level one (C1). R16's resident profile indicated he was non-ambulatory, required frequent supportive nursing care, observation, and significant assistance in evacuation.</p> <p>R17 admitted to the facility on October 16, 2023, due to acute encephalopathy (overall brain dysfunction) and obesity. R17's resident profile indicated she was non-ambulatory, required frequent supportive nursing care, observation, and significant assistance in evacuation. R17's care plan dated August 28, 2024, indicated R17 required assist of two staff with a hooyer (mechanical lift).</p> <p>R18 admitted to the facility on March 13, 2024, due to hemiplegia, hemiparesis following CVA of left non-dominant side, and epilepsy. R18's resident profile indicated he was non-ambulatory, required frequent supportive nursing care, observation, and significant assistance in evacuation. R18's care plan dated October 9, 2024, indicated R18 required assistance of two staff for transfers.</p> <p>The MDH investigator requested copies of service plans for R2, R3, R4, R5, R6, R8, R9, R13, R 14, R15, and R16, but did not receive</p>	0 470		

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0 470	<p>Continued From page 8</p> <p>them.</p> <p>During an interview on October 25, 2024, at 11:00 a.m. R14 stated the lack of staff impacted the timeliness of staff answering call lights as well as ability to provide meals. R14 stated staff did not make the meals, as they had no time to prepare meals, but heated up processed food. R14 stated the facility made minimal effort to make improvements.</p> <p>During an interview on October 25, 2024, at 1:00 p.m. R7 stated there were consequences of the lack of facility staffing including staff only making processed food out of a box because they do not have time to cook. R7 stated he did not receive catheter care (cleaning and changing) timely because there often was no nurse available. R7 stated he had to use the emergency department in order to change his catheter when there were no supplies at the facility. R7 stated the staff on night shift (7 p.m. to 7 a.m.) did not use two people for transfers with the mechanical lift, and he noticed his service plan changed recently with fewer services (but not reviewed with him, he did not sign off on it, and he did not receive a copy of the service plan). R7 attributed this to fewer staff. R7 stated he stopped attending resident council meetings to discuss his concerns because he feared retaliation from the facility.</p> <p>During an interview on October 25, 2024, at 1:12 p.m. director of operations/assisted living director (ALD)-A stated the facility was still in the hiring process for more staff and used staffing agencies when short staffed. ALD-A stated the licensee was trying to cut back on overtime. ALD-A stated awareness that many residents required assist of two staff with a mechanical lift for transfers. ALD-A stated the staffing plan on the 7:00 p.m. to</p>	0 470		

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0 470	<p>Continued From page 9</p> <p>7:00 a.m. shift consisted of one staff per living unit and one person who floated to all six living units. ALD-A stated that he was aware of incidents where one staff used the mechanical lift by themselves, which was against policy.</p> <p>During an interview on October 25, 2024, at 1:55 p.m. director of nursing (DON)-B stated on the night shift (7:00 p.m. to 7:00 a.m.) there was one staff in each living unit and if staff were needed for a two-person mechanical lift transfer, they would leave their current living unit un-staffed while they assisted on another living unit. DON-B stated she did not know any facility that would staff for something that only occurred twice per shift.</p> <p>During an interview on October 30, 2024, at 3:33 p.m. licensed practical nurse (LPN)-E stated the facility had an ongoing staffing issue. LPN-E stated the administrative staff expected the PM shift (7:00 p.m. to 7:00 a.m.) nurse to forgo their nursing tasks in order to assist the unlicensed personnel (ULPs) with resident cares. LPN-E stated the practice at the facility was to work short staffed regardless of the resident care needs. LPN-E stated she was aware that staff would transfer residents by themselves with a mechanical lift (which required two people). LPN-E stated there were four residents who were very large/overweight who required three staff to transfer with a mechanical lift, turn/reposition, and other cares. LPN-E stated none of those residents had "assist of three staff" in their care plan. LPN-E stated when they needed three staff to help a resident, the other houses would just be without staff for a while.</p> <p>The facility uniform disclosure of assisted living services and amenities (UDALSA) dated August</p>	0 470		

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NAME OF PROVIDER OR SUPPLIER BROOKLYN PARK ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 7711 HUMBOLDT AVENUE NORTH BROOKLYN PARK, MN 55444
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0 470	<p>Continued From page 10</p> <p>29, 2023, indicated the number of unlicensed direct care staff typically scheduled per shift as follows: "Day shift: Staffed based on Community Needs Evening shift: Staffed based on Community Needs Night shift: Staffed based on Community Needs."</p> <p>The MDH investigator requested the licensee's staffing policy but did not receive it.</p> <p>TIME PERIOD FOR CORRECTION: Two (2) days.</p>	0 470		
0 680 SS=I	<p>144G.42 Subd. 10 Disaster planning and emergency preparedness</p> <p>(a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are</p>	0 680		

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0 680	<p>Continued From page 11</p> <p>allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the licensee failed to ensure a written emergency disaster plan contained all required content, including a process for evacuation of 18 of 18 residents who required two person assistance with a full mechanical lift, in the event of an emergency. There was potential for harm when the licensee failed to develop a plan for emergency evacuation of all residents that occurred when the facility staffed each of the six living units on the campus with one staff person and a float (total seven staff for 30 residents) during the hours of 7:00 p.m. to 7:00 a.m. The licensee failed to ensure the safety of all residents who passed through the hallways between living units (houses) which contained hazards in the hallway (chemicals sitting out, electrical cords, etc.).</p> <p>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).</p> <p>Findings include:</p> <p>R1 admitted to the facility on October 13, 2022, due to injury of cervical spine at C7, quadriplegia.</p>	0 680		

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0 680	<p>Continued From page 12</p> <p>R1's resident profile indicated he was non-ambulatory, required frequent supportive nursing care, observation, and significant assistance in evacuation. R1's services include assistance of two staff for repositioning every two hours, assistance of two staff for transfers, range of motion exercises at 8:00 p.m. daily.</p> <p>R2 admitted to the facility on December 8, 2023, due to diagnoses that included quadriplegia. R2's resident profile indicated he was non-ambulatory, required frequent supportive nursing care, observation, and significant assistance in evacuation. R2's services included assistance of two staff with a mechanical lift for mobility, positioning, and transfers.</p> <p>R3 admitted to the facility on January 18, 2022, due to diagnosis that included multiple sclerosis. R3's resident profile indicated he was non-ambulatory, required frequent supportive nursing care, observation, and significant assistance in evacuation. R3's services included assist of two staff for mobility, positioning, and transfers.</p> <p>R4 admitted to the facility on November 3, 2022, due to complete lesion at fifth cervical spinal nerve (C5) with quadriplegia. R4's resident profile indicated he was non-ambulatory, required frequent supportive nursing care, observation, and significant assistance in evacuation. R4's services included assist of two staff for mobility, positioning, and transfers.</p> <p>R5 admitted to the facility on October 31, 2022, due to paraplegia with fourth thoracic vertebral injury (T4) with limited use of upper extremities and blindness in left and right eyes. R5's resident profile indicated he was non-ambulatory, required</p>	0 680		

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0 680	<p>Continued From page 13</p> <p>frequent supportive nursing care, observation, and significant assistance in evacuation. R5's services included assist of two staff for mobility, positioning, and transfers.</p> <p>R6 admitted to the facility on January 18, 2022, due to quadriplegia. R6's resident profile indicated he was non-ambulatory, required frequent supportive nursing care, observation, and significant assistance in an evacuation.</p> <p>R7 admitted to the facility on October 15, 2021, due to unspecified injury at unspecified level of cervical spinal cord sequela. R7's resident profile indicated he was non-ambulatory, required frequent supportive nursing care, observation, and significant assistance in an evacuation. R7's care plan dated October 3, 2024, indicated R7 required two staff for transfers and staff to assist with turning and repositioning every two hours (overnight).</p> <p>R8 admitted to the facility on September 4, 2024, due to hemiplegia (paralysis) affecting right dominant side. R8's resident profile indicated he was non-ambulatory, required frequent supportive nursing care, observation, and significant assistance in an evacuation.</p> <p>R9 admitted to the facility on January 18, 2022, due to hemiplegia (paralysis) and hemiparesis (weakness) following a cerebrovascular accident (CVA-stroke). R9's resident profile indicated he was non-ambulatory, required frequent supportive nursing care, observation, and significant assistance in an evacuation.</p> <p>R10 admitted to the facility on October 2, 2024, due to complete lesion at second cervical spinal cord (C2). R10's resident profile indicated she</p>	0 680		

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0 680	<p>Continued From page 14</p> <p>was non-ambulatory, required frequent supportive nursing care, observation, and significant assistance in an evacuation. R10's care plan dated October 18, 2024, indicated R10 required assist of two staff for transfers.</p> <p>R11 admitted to the facility on October 25, 2024, due to quadriplegia. R11's resident profile indicated he was non-ambulatory, required frequent supportive nursing care, observation, and significant assistance in an evacuation. R11's care plan dated October 10, 2024, indicated R11 required assistance of two staff with a mechanical lift for transfers. R11's care plan indicated R11 expressed a diminished will to live and staff need to monitor on a one to one and report suicidal comments.</p> <p>R12 admitted to the facility on August 10, 2023, due to hemiplegia and hemiparesis following a cerebral infarction (stroke) affecting right dominant side. R12's resident profile indicated he was non-ambulatory, required frequent supportive nursing care, observation, and significant assistance in an evacuation. R12's care plan dated September 13, 2024, indicated R12 required assist of two staff with a mechanical lift for transfers. R12's face sheet dated October 28, 2024, indicated R12 required repositioning every two hours (overnight).</p> <p>R13 admitted to the facility on October 31, 2022, due to quadriplegia with cervical cord injury at C1 through C4, complete. R13's resident profile indicated he was non-ambulatory, required frequent supportive nursing care, observation, and significant assistance in an evacuation.</p> <p>R14 admitted to the facility on January 18, 2022, due to cerebral infarction (stroke). R14's resident</p>	0 680		

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0 680	<p>Continued From page 15</p> <p>profile indicated he was non-ambulatory, required frequent supportive nursing care, observation, and significant assistance in an evacuation.</p> <p>R15 admitted to the facility on January 16, 2023, due to quadriplegia. R15's resident profile indicated he was non-ambulatory, required frequent supportive nursing care, observation, and significant assistance in an evacuation.</p> <p>R16 admitted to the facility on June 10, 2024, due to unspecified injury at cervical cord level one (C1). R16's resident profile indicated he was non-ambulatory, required frequent supportive nursing care, observation, and significant assistance in an evacuation.</p> <p>R17 admitted to the facility on October 16, 2023, due to acute encephalopathy (overall brain dysfunction) and obesity. R17's resident profile indicated she was non-ambulatory, required frequent supportive nursing care, observation, and significant assistance in an evacuation. R17's care plan dated August 28, 2024, indicated R17 required assist of two staff with a hooyer (mechanical lift).</p> <p>R18 admitted to the facility on March 13, 2024, due to hemiplegia, hemiparesis following a stroke of left non-dominant side, and epilepsy. R18's resident profile indicated he was non-ambulatory, required frequent supportive nursing care, observation, and significant assistance in an evacuation. R18's care plan dated October 9, 2024, indicated R18 required assistance of two staff for transfers.</p> <p>Service plans for R2, R3, R4, R5, R6, R8, R9, R13, R 14, R15, and R16 were requested, but not received.</p>	0 680		

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0 680	<p>Continued From page 16</p> <p>The following observations were conducted by the Minnesota Department of Health (MDH) investigator and photographed on October 25, 2024:</p> <p>The facility "campus" consisted of three buildings on one lot. Each building had two living units (identified as "houses").</p> <p>Each building's living units (house) were connected by a locked door.</p> <ol style="list-style-type: none"> 1) The door between house 5 and house 6 was held open with a bungee cord. 2) The hall between house 5 and house 6 contained washer and dryer, sprinkler equipment, fire alarm, water heater, electrical components, and an open gallon jug of "No Rinse Floor Cleaner", (noted pm the Safety Data Sheet to cause eye and skin irritation.) 3) The rear exit door of house 5 had boxes stacked up in front of it, making it impassible and unusable as an exit. 4) The rear exit door of house 6 had a mechanical lift stored in front of the door, making it impassible and unusable as an exit. 5) The doors between house 1 and house 2 were propped open with weights. 6) The hall between house 1 and house 2 contained a partially full gallon container of glass cleaner, electrical equipment, a small refrigerator labeled "insulin/med fridge", and a water heater. 7) The garage exit of house 1 contained multiple mechanical lifts, bed frames, wood, and boxes of miscellaneous items rendering it impassible and unusable as an exit. 8) The garage exit of house 2 contained multiple mechanical lifts, wheel chairs, mattresses, four wheeled walkers, and boxes of miscellaneous items, rendering it impassible and unusable as an 	0 680		

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0 680	<p>Continued From page 17</p> <p>exit.</p> <p>9) The rear exit door of house 1 had a wheelchair stored in the hall, making it impassible and unusable as an exit.</p> <p>10) The doors between house 3 and house 4 were propped open.</p> <p>11) The hall between house 3 and house 4 contained washer and dryer, water heater, and electrical components.</p> <p>During an interview on October 25, 2024, at 1:12 p.m. assisted living director (ALD)-A stated he observed clutter in the exits and the licensee had a "plan to clean up exits and make them accessible". ALD-A stated he was aware the door between two living units are all propped open, and he had no safety concerns of residents access to items located in the area because the facility had not experienced any safety issues. ALD-A stated in an emergency, he would have the staff of two houses and the nurse assist if there was a need to transfer a resident who required the assistance of three staff. ALD-A stated there would be times the staff would leave the residents in the adjoining house alone and without staff.</p> <p>During an interview on October 25, 2024, at 1:55 p.m. director of nursing (DON)-B stated, "If there is an emergency, we rely on 911" but indicated the licensee could call in staff that "live close by" and would "notify managers." DON-A stated each exit should have a clear path.</p> <p>During an interview on October 25, 2024, at 2:57 p.m. operations manager (OM)-C stated he had concerns about the open hallways between houses, and resident safety, but management disregarded his concerns. OM-C stated he brought up the concerns many times with no</p>	0 680		

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0 680	<p>Continued From page 18</p> <p>solution. OM-C stated there are two residents who require assist of three for transfers, and a resident who was recently admitted required a one-to-one staffing.</p> <p>During an interview on October 30, 2024, at 3:33 p.m. licensed practical nurse (LPN)-E stated the practice at the facility was to keep the door between houses open all the time. LPN-E stated most of the residents were in wheelchairs. LPN-E stated there were hazards in the hallway (chemicals sitting out, electrical cords, etc.) which made it a safety issue for residents, who frequently complained. LPN-E stated staff and residents would often call 911 for services for multiple issues including catheter changes (when short staffed or out of supplies), tube feedings, and for transfer assistance.</p> <p>Law enforcement documents indicated the police had been called to the facility 12 times in the previous seven months.</p> <p>The Minnesota Department of Health (MDH) investigator requested but did not receive a copy of the Emergency Preparedness policy and plan.</p> <p>TIME PERIOD FOR CORRECTION: Two (2) days.</p>	0 680		
01600 SS=I	<p>144G.70 Subdivision 1 Acceptance of residents</p> <p>An assisted living facility may not accept a person as a resident unless the facility has staff, sufficient in qualifications, competency, and numbers, to adequately provide the services agreed to in the assisted living contract.</p>	01600		

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01600	<p>Continued From page 19</p> <p>This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure the facility had sufficient staff to adequately provide the agreed upon services. Although the licensee was aware they did not have sufficient staff to provide resident services, they admitted a resident on October 25, 2024, who required one to one staffing for mental health safety. This had the potential to impact all 30 residents currently receiving services from the licensee.</p> <p>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).</p> <p>Findings include</p> <p>R11 admitted to the assisted living on October 25, 2024, due to diagnoses that included quadriplegia, impulsiveness, anxiety disorder, and depression. R11's care plan indicated R1 required the following services: full help with bathing, dressing, placement of compression stockings, feeding, turning/repositioning, assist of two staff for transfers with a mechanical lift, frequent incontinence cares, and medication administration. The care plan indicated R11's anxiety manifested as extreme emotions of sadness, episodes of impulsivity, and feelings of discomfort. According to the care plan R11 had expressed a diminished will to live and staff were to monitor and report suicidal statements.</p>	01600		
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01600	<p>Continued From page 20</p> <p>During an interview on October 25, 2024, at 1:55 p.m. director of nursing (DON)-B stated the decision for acceptance of residents came down to her but started with the licensees marketing department. DON-B stated admissions were dependent on reimbursement.</p> <p>During an interview on October 25, 2024, at 2:57 p.m. operations manager (OM)-C stated the facility frequently allowed staff to leave one house without staff to go to another house to help a staff with two or three-person transfer. OM-C stated the emergency response plan was "not looking good" and administration did not take his concerns about staffing seriously . OM-C stated the facility still took admissions and currently admitted a resident (R11) who required one to one staffing. OM-C stated he had concerns for the safety of all residents.</p> <p>The resident pre-admission assessment and monitoring process policy (undated) indicated the registered nurse in coordination with the assisted living director determined whether the facility could accept a prospective resident based on the resident's need, staffing levels, staff qualifications, and staff competencies.</p> <p>TIME PERIOD FOR CORRECTION: Two (2) days.</p>	01600		