Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL373626944M
Compliance #: HL373621485C

Date Concluded: February 27, 2025

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: Substantiated, facility responsibility

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

Initial Investigation Allegation(s):
The facility neglected a resident when they failed to adequately clean the resident's catheter which resulted in mold in the tubing, failed to turn/reposition the resident which resulted in pressure ulcers, falsely documented cares completed when not done, and failed to provide necessary supplies.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to ensure adequate staffing for repositioning and caring for the resident's indwelling urinary catheter. The facility failed to follow-up when cares were not completed and/ or were not documented as completed. The facility failed to ensure indwelling urinary catheter supplies were available which resulted in the resident being transferred to the emergency room for catheter changes.

Regarding mold in the resident's catheter, evidence supporting the of allegation of mold in the catheter tubing was not obtained, however, records indicated the resident had multiple urinary tract infections.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident facility records, hospital records, staff schedules, documentation of services delivered, and related facility policy and procedures. Also, the investigator observed the facility, staff/resident interactions, and the resident's room.

The resident lived in an assisted living facility. The resident's diagnoses included spinal cord injury, quadriplegia, pressure ulcers, and history of urinary tract infections. The resident's service plan included assistance with bathing seven days per week, catheter care ten times per day, two staff for repositioning ten times per day, range of motion exercises, incontinence care twice daily, transfers by two staff twice daily, and wound care by a nurse three times daily.

The resident's nursing assessment noted three new areas of skin breakdown approximately three months prior to the investigation with an abrasion on the outer side of his right knee, and abrasion on the outer side of his left knee, and a pressure ulcer on his bottom.

The facility was unable to provide any skin assessments.

Review of the resident's record indicated staff failed to complete 97 of 300 scheduled catheter cares, 70 of 300 scheduled repositioning, 19 of 120 scheduled incontinence cares, and 19 of 120 scheduled transfers.

The resident's record indicated the resident required two hospital visits for indwelling urinary catheter replacement.

During an interview the resident stated the facility did not have enough staff to provide his cares including catheter cares, repositioning, transferring him out of and into bed, and cleaning his room. The resident stated he had complained to administration many times about lack of cares and lack of catheter supplies and felt they retaliated by removing his socialization services without discussing it with him. The resident stated he now resorted to ordering his own supplies. The resident stated he felt none of the staff had received any education on spinal cord injuries, based on how they responded to his physical concerns.

During an interview an administrative nurse stated the resident had sensitive skin that broke down easily and stated the pressure ulcers on the resident's heels were related to his footwear choices. The administrative nurse stated the resident looked for things to report when he was out to get a staff [in trouble].

During an interview a family member stated the facility did not take good care of the resident. Examples provided were giving the resident milk products knowing he is lactose intolerant, not providing catheter cares or replacing his blocked catheter, not caring for the resident's skin breakdown, not doing his exercises [range of motion], and not giving him showers. The family member stated the facility made excuses and blamed the residents. The family member took photos and shared with the investigator, pressure ulcers on the resident's heels.

During an interview a licensed nurse stated the facility did not provide staff education on spinal cord injuries. The licensed nurse stated she observed the resident's catheter during the alleged mold incident, and stated she did not believe there was mold in it, just sediment and dark urine.

During an interview, a former administrative employee stated the resident's catheter supplies and wound supplies went missing on a regular basis. The employee stated staff used supplies designated to one resident for other residents. The employee stated the facility had no tracking system for supplies.

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: Yes.
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
Brooklyn Park City Attorney
Brooklyn Part Police Department
Board of Executives for Long-Term Services and Supports

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37362	A. BUILDING: _____ B. WING _____	C 01/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKLYN PARK ASSISTED LIVING	7711 HUMBOLDT AVENUE NORTH BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL373626944M/#HL373621485C #HL373627462M/#HL373622783C #HL373628022M/#HL373624141C #HL373627902M/#HL373623664C On January 6, and January 7, 2025, 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 27 residents receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL373626944M/#HL373621485C; #HL373627462M/#HL373622783C; #HL373628022M/#HL373624141C; #HL373627902M/#HL373623664C , tag identification 2310, and 2360.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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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02310	Continued From page 1	02310		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for seven of seven residents (R1, R4, R7, R8, R11, R16, and R19) reviewed for care and services. This caused actual harm to multiple residents and potential for serious harm to all residents. 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: Bedrails Potential for harm occurred when the licensee failed to assess and maintain bed rails per the Food and Drug Administration (FDA) and manufacturer's guidelines for R1, R4, R7, and R11. R1's record was reviewed. R1 admitted on	02310	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. 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.	

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02310	Continued From page 2 October 13, 2022, due to diagnoses that included quadriplegia. R1's care plan dated December 10, 2024, indicated R1 utilized bilateral upper bed rails. The care plan indicated the facility provided "regular safety maintenance and consumer product safety checks" of R1's bedrails installed and maintained according to manufacturer instructions. R1's service plan dated January 6, 2025, failed to include safety checks of R1's bed rails. R4's record was reviewed. R4 admitted on November 3, 2022, due to diagnoses that included quadriplegia. R4's care plan dated October 16, 2024, indicated R4 used an air bed mattress with quarter length bed rails at the head of the bed. The care plan indicated bed rails installed and maintained according to manufacturer instructions and the Consumer Product Safety Commission site reviewed for any recalls of this device with regular safety maintenance and consumer product safety checks. R4's service plan dated January 6, 2025, failed to include safety checks of R4's bed rails. R7's record was reviewed. R7 admitted on Jun 13, 2029, due to diagnoses that included quadriplegia. R7's care plan dated October 3, 2024, indicated R7's hospital bed had U shaped grab bar side rails attached at the head of R7's bed. The care plan indicated bed rails installed and maintained according to manufacturer instructions and the Consumer Product Safety Commission site reviewed for any recalls of this device with regular safety maintenance and consumer product safety checks.	02310	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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02310	Continued From page 3 R7's service plan dated January 6, 2025, failed to include safety checks of R7's bed rails. R11's record was reviewed. R11 admitted on October 10, 2024, due to diagnoses that included quadriplegia. R11's care plan dated November 11, 2024, indicated R11 used an electric bed. The care plan failed to indicate R11's bed had attached side rails. R11's service plan dated January 6, 2025, failed to identify R11 had bedrails or safety checks of R11's bedrails. R11's assessment dated October 30, 2024 indicated on page 6, that R11 had no bed rails in used or had portable bed rails that were installed on a consumer bed. R11's assessment dated November 15, 2024, indicated on page 6, that R11 had no bed rails in used or had portable bed rails that were installed on a consumer bed. During an observation on January 6, 2025, at 2:17 p.m. the Minnesota Department of Health (MDH) investigator observed and video recorded R11's side rail, which was loosely attached, moved from side to side (away from and towards the mattress) and back and forth (parallel to the mattress) which increased by several inches the gap in zone 3 (identified by the U.S. Department of Health and Human services Food and Drug Administration as the space between the bedrail and mattress). During an interview on January 6, 2025, at 2:15 p.m. family member (FM)-J stated the bed rails currently attached to R11's bed did not fit, were loose, and she was concerned. FM-J stated the	02310		

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02310	Continued From page 4 bed the facility provided was not specifically for R11, and she was promised a bed for R11. During an interview on January 8, 2025, at 10:48 a.m., former operations manager (OM)-C stated the facility did not complete monitoring for compatibility of the bedrail with the bed frame/mattress, no one was responsible to check for appropriate installation, and there was no one to regularly check for safety, as the facility did not have maintenance personnel. Siderails policy dated December 13, 2022, indicated the facility completed an assessment of resident bedrails upon initiation of use and quarterly to ensure the bedrail was used consistent with manufacturer's directions, ensuring bedrails were secure and not "wobbly", and to ensure the bedrail was appropriate for use based on manufacturer guidelines and met residents' size and weight requirements. The Food and Drug Administration (FDA) Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment document dated March 10, 2006, indicated evaluating the dimensional limits of the gaps in hospital beds was one component of an overall assessment and mitigation strategy to reduce entrapment. The guidance document identified the hospital bed system used in the guidance consisted of the bed frame, mattress, bed rails, head, and foot boards. The guidance document indicated facilities should inspect, evaluate, maintain, and upgrade equipment (bed/mattress/bed rails) to identify and remove potential fall and entrapment hazards. The FA Recommendations for Health Care Providers Using Adult Portable Bedrails website	02310		

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02310	Continued From page 5 (https://www.fda.gov/medical-devices/adult-portable-bed-rail-safety/recommendations-health-care-providers-using-adult-portable-bed-rails) retrieved January 21, 2025, at 4:37 p.m. included the following information for used of bed rails: " Inspect and regularly check the mattress and bed rails to make sure they are still installed correctly and for areas of possible entrapment and falls. Regardless of mattress width, length, and depth, the bed frame, bed rail, and mattress should leave no gap wide enough to entrap a patient's head or body. " Regularly assess that bed rails remain appropriately matched to the equipment and to the patient's needs, considering all relevant risk factors. " Inspect, evaluate, maintain, and upgrade equipment (beds, mattresses, and bed rails) to identify and remove potential fall and entrapment hazards. " Re-assess the person's needs and re-evaluate the equipment if an episode of entrapment or near-entrapment occurs, with or without serious injury. This should be done immediately because fatal "repeat" events can occur within minutes of the first episode. " Be aware that gaps can be created by movement or compression of the mattress which may be caused by patient weight, patient movement or bed position, or by using a specialty mattress, such as an air mattress, mattress pad or waterbed. The manufacturer's guidelines for the beds, mattresses, and siderails used by residents (R1, R4, R7, R11) was requested but not received. Services Harm occurred when the licensee failed to provide services for residents' (R4, R7, R8, R11,	02310		

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02310	Continued From page 6 and R16) assessed needs per the care plan and service plan. The licensee failed to follow up on omission of services and R4 R4 admitted to the facility on November 3, 2022, due to diagnoses that included quadriplegia. R4's service plan dated January 6, 2025, included staff assistance as follows: catheter care two times per day and as needed, colostomy assist five times per day, eating assistance five times per day, two staff for repositioning five times per day, socialization one to one for 30 minutes daily, range of motion twice daily, toileting/incontinence care six times per day, two staff for transfers four times per day, and nursing wound care two times per day/three days per week. R4's hospital discharge note dated November 23, 2024, indicated R4 previously had an unstageable (full thickness tissue loss covered by dead tissue) pressure injury of his right ischial region on April 2, 2024, that developed into a large, deep, malodorous ulcer. R4's medical record indicated he was hospitalized from December 15, 2024, through December 26, 2024, due to a urinary tract infection. R4's hospital discharge note dated December 26, 2024, indicated the hospital treated R4 (December 15, 2024 through December 26, 2024) for a complicated urinary tract infection and a stage four ischial to ischial (wound from the lower part of the left buttock to the lower part of the right buttock) pressure injury. R4's services delivered documents dated	02310		

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02310	Continued From page 7 December 1-15, 2024, and December 26, 2024, through January 5, 2025, indicated staff failed to provide R4 services on the following dates/times as evidenced by lack of documentation of services completed: Catheter care -12/1- 8 pm, 12/3- 8am, 12/8- 8am, 12/11- 8am, 12/12- am, 8pm; 12/27-8am; 12/28-8am; 12/29- am; 1/3-8am; 01/04-8am. Colostomy assist-12/1- bedtime, overnight; 12/3- am, midday, pm; 12/8- am, midday, pm; 12/11- am, midday, pm, overnight; 12/12- bedtime, overnight; 12/26- pm; 12/27-am, midday, pm; 12/28-midday; 12/29- midday, pm; 1/3-am, midday, pm; 1/4-am, midday, pm. Eating- total assist for thirty minutes-12/1- 8 pm; 12/3- 8am, 10am, 12pm, 5pm; 12/8- 8am, 10am, 12pm, 5pm; 12/11- 8am, 10am, 12pm, 5pm; 12/12- 8pm; 12/26- 5pm; 12/27- 8am, 10am, 12pm, 5pm; 12/28- 8am, 10am, 12pm, 5pm; 12/29-8am, 10am, 12pm, 5pm. Repositioning by 2 staff-12/1- 10 pm; 12/2- 12am, 2am, 4am, 6am; 12/3- 10am; 12/11- 10pm; 12/12- 12am, 2am, 4am, 6am, 10pm; 12/13- 12am, 2am, 4am, 6am; 12/26-4pm; 12/30- 12am, 2am, 4am, 6am; 12/31-2am. Repositioning by 1 staff- 12/1- 8pm; 12/3-12pm, 4pm, 6pm; 12/8- 10am, 12pm, 4pm, 6pm; 12/11- 10am, 12pm, 4pm,6pm 8pm; 12/12- 6pm, 8pm; 12/26-4pm; 12/27-10am, 4pm, 6pm; 12/28-10am, 12pm, 4pm, 6pm; 12/29- 10am, 12pm, 4pm, 6pm; 1/3-10am, 12pm, 4pm, 6pm; 01/04- 10am,12pm, 4pm, 6pm; 1/5- 6pm. Range of motion (no am service listed, listed in services twice at 8pm)- 12/1- 8pm; 12/11 8pm; 12/12- 8pm. Socialization 1:1 for thirty minutes- 12/3- am, 3pm; 12/7- 3pm; 12/8- 3pm; 12/11 3pm; 12/26- 3pm; 12/27- 3pm; 12/28-3pm; 12/29-3pm; 1/3- 3pm; 01/04- 3pm. Toileting/incontinence cares- 12/1- 8 pm; 12/2-	02310		

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02310	Continued From page 8 12am, 4am; 12/3- 8am, 12pm, 4pm; 12/8- 8am, 12pm, 4pm; 12/11- 8am, 12pm, 4pm, 8pm; 12/12- 12am, 2am, 4am, 8pm; 12/13-12am, 4am; 12/26-4pm; 12/27-8am, 12pm; 12/28-8am, 12pm, 4pm; 12/29-8am, 12pm, 4pm; 12/30-12am, 4am; 1/3-8am, 12pm, 4pm; 1/4- 8am, 12pm, 4pm. Transfers- 2 staff- 12/1- 8 pm; 12/3- 11am, 2pm, 4pm; 12/8- 11am, 2pm, 4pm; 12/11- 11am, 2pm, 4pm, 8pm; 12/12- 8pm; 12/27-11am, 4pm; 12/28-11am, 2pm, 4pm; 12/29-11am, 4pm; 1/3-11am, 2pm, 4pm; 1/4-2pm, 4pm. R4's nurse progress note dated December 31, 2024, at 5:40 p.m. indicated R4 informed a registered nurse that range of motion exercises helped with pain, but staff were not completing the exercises. The note indicated the facility was going to make a signature sheet for staff to document staff did not complete the exercises. R4's nurse charting bedtime note dated January 5, 2025, at 11:47 p.m. indicated R4 did not get up due to staff declining to assist him as they were too busy. The note indicated R4 stated he had been in bed for four consecutive days. During an interview on January 6, 2025, at 11:45 a.m. R4 stated staff neglected to provide the range of motion exercises, regardless of what they documented. R4 stated a signature sheet was up for three days, but made no difference, so it was removed. R4 stated his arms were sore when he did not receive range of motion exercises. R4 stated staff completed turning/repositioning about 50% of the time. R4 attributed the lack of services a problem due to lack of staff.	02310		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKLYN PARK ASSISTED LIVING	7711 HUMBOLDT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
02310	Continued From page 9 During an interview on January 8, 2025, at 10:09 a.m., former operations manager (OM)-C stated R4 did not receive range of motion exercises, which affected his physical abilities, which were declining. OM-C stated staff were supposed to reposition R4 ever 2 hours, but it did not happen due to staffing. OM-C stated there were residents in the house who needed feeding and other tasks. OM-C stated R4 gave up on hoping for improvements. During an interview on January 14, 2025, at 9:55 a.m. R4's case manager (CM)-L stated on admission R4 was told the facility had a nurse at each house, which had proven to not be true. CM-L stated staff levels were a concern even before R4 developed pressure injuries. CM-L stated staff did not reposition or provide range of motion exercises to R4. During an interview on January 14, 2025, at 10:55 a.m. director of nursing (DON)-I stated she questioned R4's ability to report accurately. DON-I stated R4 was a hard sleeper and so maybe he did not realize he received the exercises or repositioning. DON-I stated most of the residents have mental health issues due to their circumstances and the facility provided education and training but was unable to provide documentation of the mental health education. During an interview on January 28, 2025, at 3:15 p.m. home health registered nurse (RN)-O stated R4's wound was long, wide, and deeper than she had ever seen. RN-O stated she searched for staff for 10 minutes after the wound care appointment and stated, "if there was a fire, the residents would not get out." RN-O stated R4 was hospitalized from January 22, 2025, through	02310		

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02310	Continued From page 10 January 28, 2025, for a urinary tract infection. RN-O stated urinary tract infections could be prevented with improved cleaning of the resident and the catheter. R7 R7 admitted to the facility on October 15, 2021, due to diagnoses that included quadriplegia. R7's assessment dated October 3, 2024, indicated R7 was lactose intolerant. The assessment indicated the facility provided R7 with a regular diet. The assessment indicated "Resident prefers to take medications orally with milk/juice". R7's service plan dated January 6, 2025, included bathing assistance seven days per week, catheter care 10 times per day, assistance of two staff for repositioning 10 times per day, range of motion once per day, toileting/incontinence care twice daily, assistance of two staff for transfers four times daily, and wound care by a nurse three times daily. (noted to lack services for socialization 1:1 or 1:2-5 activity) R7's progress notes indicated R7 was admitted to the hospital February 11, 2024, through February 14, 2024, for replacement of a blocked catheter and December 18, 2024, to December 21, 2024, for influenza and catheter replacement due to mispositioning. R7's services delivered documents dated December 1, 2024, through December 18, 2024, and December 21, 2024, through January 5, 2025, indicated staff failed to provide the following services on the following dates/times as	02310		

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02310	Continued From page 11 evidenced by lack of documentation of services completed: Bathing-12/2- pm, 12/9-pm; 12/12-pm, 12/23-pm, 12/28- am; 1/1- am. Catheter care-12/1-8am, 10am, 2pm; 12/2-12am, 2am, 4am, 6am, 8am, 10am, 2pm, 4pm, 6pm, 8pm; 12/3-12am, 2am, 4am, 6am; 12/6-12am, 2am, 4am, 6am, 8am, 10am, 2pm, 4pm, 6pm; 12/9-8am, 10am, 2pm, 4pm, 6pm; 12/10-12am, 2am, 4am, 6am; 12/12-am,; 12/13-bedtime; 12/14- 8am, 10am, 2pm, 4pm, 6pm; 12/15- 8am, 10am, 2pm, 4pm; 12/17- 8pm; 12/21- 8pm; 12/22- 12am, 2am, 4am, 6am; 12/23- 10am, 2pm, 4pm, 6pm; 12/24- 12am, 2am, 4am, 6am; 12/25- 12am, 2am, 4am, 6am, 8am, 10am, 4pm, 6pm; 12/28- 8am, 10am, 2pm, 4pm, 6pm; 12/31- 12am, 2am, 4am, 6am, 8am, 10am, 2pm, 4pm, 6pm; 01/02- 12am, 2am, 4am, 6am; 01/03- 12am, 2am, 4am, 6am, 2pm, 4pm, 6pm; 1/6- 2am, 4am, 6am, 10am. Repositioning by two staff-12/2- 12am, 2am, 4am, 6am, 8am, 10am, 12pm, 2pm, 10pm; 12/3-12am, 2am, 4am, 6am; 12/6- 6am, 12pm, 2pm; 12/9- 8am, 10am, 12pm, 2pm; 12/10- 12am, 2am, 4am, 6am; 12/14- 8am, 10am, 12pm, 2pm; 12/15- 8am, 10am, 12pm, 2pm; 12/17- 8pm, 10pm; 12/22- 12am, 2am, 4am, 6am; 12/23-8am, 10am, 12pm, 2pm; 12/24- 12am, 2am, 4am, 6am; 12/25- 12am, 2am, 4am, 6am, 2pm; 12/31- 12am, 2am, 4am, 6am, 8am, 10am, 12pm, 2pm; 01/02-12am, 2am, 4am, 6am; 01/03-12am, 2am, 4am, 6am. 1/6- 2am, 4am, 6am. Range of motion- for 60 minutes-12/2- 10am; 12/6-10am, 2pm; 12/9 10am; 12/12-10am; 12/14-10am; 12/15- 10am; 12/23- 10am; 12/31- 10am. Toileting/incontinence care-12/1- 10am; 12/2- 10 am, 12/3- 12am, 2am, 4am, 6am; 12/6- 10am; 12/9- 10am; 12/10-4am; 12/14- 4am, 10am; 12/15- 10am; 12/23- 10am; 12/24- 4am; 12/25-10am; 12/28- 10am; 12/31- 4am, 10am; 01/03-	02310		

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02310	Continued From page 12 4am. Transfers- two staff-12/2- AM, midday, PM; 12/6 midday, 2pm, PM; 12/9- AM, midday, PM; 12/14- midday, pm; 12/15- midday, pm; 12/17- bedtime; 12/23- midday, pm; 12/25-pm; 12/31- midday, pm. Wound care-12/12- am, 1/6 am, 10am. During an interview on January 6, 2025, at 1:17 p.m. R7 stated the facility did not have enough staff to provide the cares he was supposed to receive, such as taking care of his catheter, repositioning, transferring him out of/into bed, and cleaning his room. R7 stated he had been hospitalized many times for urinary tract infections and pressure ulcers that he attributed to poor care. R7 stated the facility did not train staff on spinal cord injuries and dysreflexia. R7 stated staff do not come into his room much, not even to clean. R7 stated he had complained about his cares and the facility retaliated by removing socialization from his service plan. On January 6, 2025, at 1:18 p.m. Minnesota Department of Health investigator observed and photographed R7's previous evening meal container (meatloaf, corn, and mash potatoes/gravy) on R7's bed. Also observed were multiple items on tables, dressers, and the floor. During an interview on January 8, 2025, at 9:00 a.m. former operations manager (OM)-C stated R7 had multiple complaints about staffing and lack of catheter supplies. OM-C stated he felt the facility retaliated against R7, removing services in his plan without talking with R7. OM-C gave the example of removing the socialization service which was typically 60 minutes per day of one to one with a staff and 60 minutes per day of group activity.	02310		

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02310	Continued From page 13 During an interview on January 14, 2025, at 10:28 a.m., director of nursing (DON)-I stated R7 had sensitive skin especially his heels, that easily broke down, not due to lack of repositioning, but related to R7's footwear. DON-I confirmed that R7's service plan did not include socialization. DON-I stated she did not see any photos of alleged mold in R7's catheter tubing and doubted the report. DON-I stated staff receive training on spinal cord injuries, and staff "absolutely receive education on dysreflexia." DON-I was unable to provide education materials addressing spinal cord injuries or dysreflexia. During an interview on January 14, 2025, at 3:32 p.m., family member (FM)-K stated the facility did not provide the cares R7 needed, like repositioning, and range of motion exercises. FM-K stated R7 was lactose intolerant, but the staff still gave him food with milk products, which made R7 sick. FM-K stated she saw mold growth in R7's catheter and took a photo of it. FM-K was unable to provide the photo. FM-K stated the facility made lots of excuses and blamed the residents for problems. R8 R8 admitted to the facility on September 4, 2024, due to diagnoses that included right side paralysis of upper and lower extremities after a stroke, difficulty with speech and swallowing due to a stroke, and insulin dependent diabetes. R8's progress note dated December 9, 2024, at 4:12 p.m. indicated R8's primary care provider ordered diabetic testing supplies (glucometer, lancets, and test strips) and sent the order to a local pharmacy for delivery to R8. The note indicated a blood draw ordered the previous	02310		

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02310	Continued From page 14 month had not been completed. R8's progress note dated December 26, 2024, at 10:49 p.m. indicated interim DON spoke with R8's family member reported the following concerns: R8 ran out of insulin, did not receive eye drops as was told they did not get delivered, but the family member called the pharmacy who confirmed the eye drops had been delivered. The family member also stated staff failed to respond to call lights on the night shift. R8's progress note dated December 27, 2024, at 5:36 p.m. indicated R8's family member expressed concerns of the facility running out of food, R8 needing to supply his own food, failure to supply test strips, and medication errors. R8's care plan dated December 26, 2024, indicated R8 was unable to walk and relied on a wheelchair for mobility. R8's service plan dated January 6, 2025, included blood sugar checks four times daily, ambulation assistance nine times daily, bathing assistance daily, dressing twice daily, eating supervision/cueing three times per day, repositioning four times daily, one to one socialization daily, and transfer assistance six times per day. R8's services delivered document dated December 1, 2024, through January 5, 2025, indicated the facility failed to provide R8 services on the following dates/times as evidenced by lack of documentation of services completed: Bathing: 12/2- am; 12/17-bedtime; 12/19- am; 12/23- am; 12/28- am. Blood Sugar checks:12/5- 7am; 12/6- 4pm; 12/7- 7am; 12/8- 7am; 12/14- 7am, 4pm; 12/19- 4pm;	02310		

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02310	Continued From page 15 12/20- 4pm. Ambulation:12/2- 7:30am, 8:30am, 11:30am, 1pm, 2pm, 3:30pm, 5pm, 6p; 12/6- 8:30am, 11:30am, 1pm, 2pm, 3:30pm, 5pm, 6pm, 7pm; 12/14- 7:30am, 8:30 am, 11:30 am, 1pm, 2pm, 3:30pm; 12/15- 7:30am, 8:30am, 11:30am, 1pm, 2pm, 3:30pm, 5pm, 6pm; 12/15- 7:30am, 8:30am, 11:30am, 1pm, 2pm, 3:30pm, 5pm; 12/17- 7pm; 12/19- 8:30am, 5pm, 6pm, 7pm; 12/21- 1pm, 2pm; 12/23- 8:30am, 11:30am, 1pm, 2pm, 3:30pm, 5pm, 6pm; 12/28- 6pm; 12/29- 8:30am, 11:30am, 1pm, 2pm, 3:30pm, 5pm, 6pm; 12/31- 7:30am,8:30am, 11:30am, 1pm, 2pm, 3:30pm, 5pm, 6pm; 1/04- 6pm,7pm. Dressing:12/2- am; 12/17- bedtime; 12/19-am; 12/23- am; 12/31-am. Eating- supervision: 12/2-8am, 12pm, 5pm; 12/6- 12pm, 5pm; 12/14- 8am, 12pm; 12/15- 8am, 12pm, 5pm; 12/19- 5pm; 12/23- 8am, 12pm, 5pm; 12/29- 8am, 12pm, 5pm; 12/31- 8am, 12pm, 5pm. Repositioning: 12/2- 1am, 3am, 5am; 12/3- 3am, 5am; 12/4- 5am; 12/6- 1am, 3am, 5am; 12/10- 1am, 3am, 5am; 12/17- 11pm; 12/18- 1am, 3am, 5am; 12/19- 1am, 3am, 5am; 12/20- 1am, 3am, 5am; 12/22- 1am, 3am, 5am; 12/25- 1am, 3am, 5am; 12/31- 1am, 3am, 5am; 1/02- 1am, 3am, 5am; 1/03- 3am, 5am; 1/6- 1am, 3am, 5am. Socialization- one to one for thirty minutes: 12/1- am, 12/2- am; 12/4- am; 12/5- am; 12/6- am;12/15- am; 12/16- am; 12/17- bedtime; 12/19- am; 12/21-bedtime; 12/23- am; 12/28- am; 12/29- am; 12/31- am; 1/6- am. Transfers- one staff:12/2- 6am, 9am, 12pm, 3pm, 6pm; 12/3- 6am; 12/6- 6am, 9am, 12pm, 3pm, 6pm; 12/10- 6am; 12/14- 9am, 12pm, 3pm; 12/15- 9am, 12pm, 3pm, 6pm; 12/17- 6am; 12/19- 12pm, 6pm; 12/20- 6a; 12/22- 6am; 12/23- 9am, 12pm, 3pm, 6pm; 12/28- 6pm; 12/29- 9am, 12pm, 3pm, 6pm; 12/31- 6am, 9am, 12pm, 3pm,	02310		

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02310	Continued From page 16 6pm; 1/02- 6am; 1/03- 6am; 1/04- 6pm; 1/6-6am. During an interview on January 7, 2025, R8 stated the staff neglected to transfer him in and out of his chair, staff consistently made errors setting up his medications, the facility often ran out of blood sugar testing supplies. R8 stated he stayed in his room most days and staff did not answer call lights in a timely fashion. R8 stated the facility was short staffed and he did not receive the agreed upon services. R11 R11 admitted to the facility on October 10, 2024, due to diagnoses that included quadriplegia. R11's care plan dated October 10, 2024, indicated R11's weight was 154 pounds. R11's care plan dated November 15, 2024, indicated R11 had physical difficulty with verbalization and expressed a "diminished will to live" related to his condition. R11's service plan dated January 6, 2025, included bathing assistance seven days per week, total assistance with eating six times per day, assistance of two staff for positioning five times per day, one to one socialization daily for thirty minutes, management of depressive symptoms daily, range of motion exercises twice daily, assistance of two staff with a mechanical lift for transfers four times per day and toileting/incontinence care nine times per day. R11's services delivered document dated December 1, 2024, through January 5, 2025, indicated the facility failed to provide R11 services on the following dates/times as evidenced by lack of documentation of services completed:	02310		

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02310	Continued From page 17 Bathing: 12/4 am; 12/5 am; 12/8 am; 12/13 am; 12/14 am; 12/17 am; 12/21 am; 1/1 am. Manage Behavior-Depression- 12/4 am; 12/5 am; 12/6 am; 12/8 am; 12/12 am; 12/14 am; 12/15 bedtime; 12/17 am; 12/19 am; 12/21 am; 1/01 am; 1/02 am. Eating - total assist: 12/4 12pm, 2pm, 5pm; 12/5 8am, 10am, 12pm, 2pm, 5pm; 12/6 2pm, 5pm; 12/8 8am, 10am, 12pm, 2pm; 12/12 10am, 12pm; 12/14 8am, 10am, 12pm, 2pm; 12/17 12pm, 2pm, 5pm; 12/19 12pm, 5pm; 12/20 5 pm; 12/21 8am, 10am, 12pm, 2pm, 5pm; 1/1 8am, 10am, 12pm, 2pm, 5pm. Repositioning by two staff - 12/15 10pm; 12/16 12am, 2am, 4am, 6am; 12/24 6am. Safety checks: 12/4 6pm; 12/5 6pm; 12/6 6pm; 12/12 6pm; 12/14 6pm; 12/17 6pm; 12/19 6pm; 12/20 6pm; 12/21 6pm; 1/1 6pm. 1:1 Socialization: 12/4 am; 12/5 am; 12/6 am; 12/8 am; 12/12 am; 12/14 am; 12/15 bedtime; 12/17 am; 12/19 am; 12/21 am; 1/1 am; 1/02 am; 1/6 am. Range of Motion: 12/4 5pm; 12/5 10am, 5pm; 12/6 5pm; 12/8- 10am; 12/12- 10am, 12/14 10am, 5pm; 12/17 5 pm; 12/19 10am, 5pm; 12/20 5pm; 12/21 10am, 5pm; 1/1 10am, 5pm. Transfers by two staff: 12/4 1pm, 3pm; 12/5 9am, 1pm, 3pm; 12/6 3pm; 12/8- 9am, 1pm, 3pm; 12/12/1pm; 12/14 9am, 1pm, 3pm; 12/15 8pm; 12/17 9am, 1pm, 3pm; 12/21 9am, 1pm, 3pm; 1/1 9am, 1 pm, 3pm. Toileting/incontinence care: Not included in services delivered- no documentation of completion for any days from December 1, 2024, through December 19, 2024. 12/20 4pm, 6pm; 12/21 10am, 12pm, 4pm, 6pm, 8pm, 11pm; 12/27 6pm; 1/1 10am, 12pm, 4pm, 6pm; 1/6 8am,10am. During an interview on January 8, 2025, at 10:48 a.m. former operations manager (OM)-C stated	02310		

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02310	Continued From page 18 R11 needed everything done for him and on admission family members emphasized mental health and socialization, due to R11's difficulty coping with his situation. OM-C stated R11 needed more eyes on and socialization than other residents for safety and emotional support. OM-C stated the facility promised 10 hours of one-to-one staff. OM-C stated the facility was not offering to assist with eating or getting creative with efforts after R11 initially declined help but provided a supply of nutritional supplement (Ensure). During an interview on January 14, 2025, at 11:27 a.m., R11's family member (FM)-J stated the facility told her R11 would receive four to five hours per day of one-to-one staffing. FM-J stated they had concerns about services and placed a camera in R11's room. FM-J stated she observed, on a family placed camera, staff spending no more than three to four minutes at a time with R11. FM-J stated the staff did not engage with R11 to encourage him to eat and at the time of the interview R11's intake consisted of ensure nutritional supplement. FM-J expressed concern about R11's weight, as the facility was unable to weigh anyone, because they did not have a working scale. FM-J expressed concern that if the facility had to evacuate in an emergency, they would not be able to get everyone out. During an interview on January 14, 2025, at 9:00 a.m. director of nursing (DON)-I stated the facility encouraged socialization of at least 30 minutes in two settings per day for all residents. DON-I stated she did not know if R11's family was promised 10 hours of "socialization" and "maybe they were confused." DON-I stated staff should document the actual amount of time they spend	02310		

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02310	Continued From page 19 completing a service, but they don't. DON-I stated R11 refused services. R16 R16 admitted to the facility on June 10, 2024, due to diagnoses that included quadriplegia. R16's care plan included bathing seven days per week, catheter care six times per day, total assistance for eating six times per day, assistance of two staff for repositioning 13 times per day, range of motion twice daily, wound care daily, weights daily, toileting/incontinence care twice daily, and assistance of two staff with a mechanical lift for transfers five times per day. (noted to lack services for socialization 1:1 or 1:2-5 activity) R16's services delivered document dated December 1, 2024, through December 18, 2024, and December 30, 2024, through January 7, 2025, indicated the facility failed to provide R16 services on the following dates/times as evidenced by lack of documentation of services completed: Bathing: 12/1 bedtime "not resident shower day", 12/17 bedtime, 1/1 "not his day". Catheter care: 12/1 10am, 2pm, 6pm, 12/3 6pm, 12/9 10am, 12/10 am (due to lack of supplies), 10am, 2pm, 6pm; 12/11 6pm; 12/12 10am, 2pm, 6pm; 12/16 6pm; 12/17 2pm, 6pm, 10pm; 1/01 6pm; 1/02 10pm; 1/03 2am, 6am, 10am, 2pm, 6pm; 1/04 2am, 10am, 2pm, 6pm; 1/5 10am, 2pm, 6pm; 1/7 10am, 2pm, 6pm. Eating-total assist: 12/1 8am, 10am, 12pm, 2pm, 5pm; 12/3 5pm; 12/9 8am, 10am; 12/10 5pm; 12/16 5pm; 12/17 5pm, 7pm; 1/03 8am, 10am, 12pm, 2pm, 5pm; 1/7 5pm. Repositioning- two staff: 12/1 8am, 10am, 12pm,	02310		

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	37362	A. BUILDING: _____ B. WING _____	C 01/07/2025

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02310	Continued From page 20 2pm, 4pm, 6pm; 12/3 4pm, 6pm; 12/9 10am; 12/10 6pm; 12/16 4pm, 6pm; 12/17 4pm, 6pm, 8pm, 10pm; 1/01 12am 6pm; 1/03 8am, 10am, 12pm, 2pm, 4pm, 6pm, 10pm; 1/04 12am; 1/7 6pm. Range of motion: 12/1 am; 12/9 am; 12/12 am; 12/17 bedtime; 1/03 am. Daily weights: No weights documented as the facility had no working scale. Toileting/incontinence care: 12/1 7am; 12/10 7am; 12/12 7am; 12/17 10pm; 12/31 7am; 1/02 10pm; 1/03 7am, 10pm; 1/05 7am; 1/7 7am Transfers- two staff: 12/1 7:30am, 11am, 1pm, 4pm, 6pm; 12/3 4pm, 6pm; 12/9 7:30am, 11am; 12/10 6pm; 12/16 4pm, 6pm; 12/17 4pm, 6pm; 1/01 6pm; 1/03 7:30am, 11am, 1pm, 4pm, 6pm; 1/7 6pm. Wound care: 12/1 am; 12/9 am; 12/13 bedtime; 1/03 am; 1/07 am. R16's discharge summary document dated June 17, 2024, indicated R16's weight at discharge (from Courage Kenny Rehabilitation Institute) was 134 pounds. The summary indicated R16 had a stage four pressure ulcer on his sacrum and a stage two pressure ulcer on his left hip. R16's nursing home visit note dated July 30, 2024, indicated R16 admitted to the transitional care unit (TCU) of the nursing home (The Villas at St. Louis Park from July 12, 2024, through July 30, 2024) after a hospitalization, for intravenous (IV) antibiotic treatment of a urinary tract infection. The note indicated he discharged back to the facility with a stage four pressure ulcer on his coccyx area (sacrum) and a stage two pressure ulcer on his left hip. R16's facility record dated December 28, 2024, listed R16's weights as follows:	02310		

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02310	Continued From page 21 July 30, 2024 - 100.4 pounds October 22, 2024 - 96 pounds October 28, 2028 - 105.8 pounds October 31, 2024 - 105 pounds December 18, 2024 - 99.6 pounds. "Per Allina Health visit" R16's care plan dated December 6, 2024, indicated R16's weight was "145 as of 01/02/25". R16 progress note dated October 30, 2024, at 10:53 a.m. indicated DON-I received a phone call from a provider who explained R16 had acute osteomyelitis (a bone infection) in his sacral wound which required debridement of the bone. The note indicated the facility would continue to manage wound care. R16's progress note dated November 7, 2024, at 5:48 p.m. indicated "staff was at wound appointment [with R16] when provider was upset at the current status of his wound. Provider stated the staff did not use the most current wound treatment supplies. [LPN-P] informed provider that staff was instructed to use what was available until appropriate supplies arrived." R16's hospital record December 18, 2024, indicated R16 admitted to the hospital due to full thickness, infected pressure ulcers on his left hip, right hip, and a possible bone infection in his sacral pressure ulcer. The records indicated on admission R16 weighed 103 pounds and on discharge was 99 pounds. R16's hospital discharge summary dated December 30, 2024, included directions for daily dressing changes for bilateral hip wounds, bilateral foot wounds, and every other day dressing changes to his sacral wound. The	02310		

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02310	Continued From page 22 discharge summary also directed to turn/repositioning every two hours from left side to right side, avoiding R16's back. On January 6, 2025, at 11:11 a.m. the Minnesota Department of Health (MDH) investigator observed and photographed an unopened pudding snack and an opened soda on a tray table located behind R16, where he was unable to access. During an interview on January 6, 2025, at 11:30 a.m. R16 stated staff "forget to feed me". R16 indicated he drank nutritional supplement drinks (Ensure) provided by FM-G when staff give them to him. R16 stated he received an assistive device for eating in December (which was supposed to be ordered in June when he admitted) but could only use it if staff placed in on his hand. R16 stated staff did not transfer him out of his wheelchair once he was in it. R16 stated the staff did not provide him with range of motion exercises, and was aware the exercises would help prevent stiffness and contractures in his arms and legs. During an interview on January 7, 2025, at 11:45 a.m. residence permit director (RP)-D stated the facility director of nursing (DON-I) had been on vacation for the last three weeks, so he called in the DON from another of the licensee's facilities to "clean up skin assessments" as he was aware skin assessments for all residents were lacking. During an interview on January 8, 2025, at 10:34 a.m. case manager (CM)-F stated at previous placement (Courage Kenny) R16 used an assistive device for eating and could eat on his own. CM-F stated Courage Kenny communicated (in discharge documents on June 10, 2024) that	02310		

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02310	Continued From page 23 R16 required an assistive device for eating, but the facility did not order it. CM-F stated R16 admitted with healing pressure ulcers on his lower back (sacrum), but now R16 has new wounds on both hips that are deep and down to the bone. CM-F stated it "looked like his [R16's] skin was not taken care of". During an interview on January 8, 2025, at 11:16 a.m., OM-C stated R16 required assistance with feeding as the facility did not provide him with a required assistive device used for eating (called a U-cuff). OM-C stated R16 lost a significant amount of weight since admission. During an interview on January 9, 2025, at 12:39 p.m., family member (FM)-G stated the facility failed to provide R16 with turning, repositioning, skin care, and eating. FM-G stated R16 was hospitalized for two weeks in December for worsening pressure ulcers. FM-G stated R16 now had another pressure on his right hip, three on his foot, and they were all very deep. FM-G stated she observed R16 was losing weight, but the facility did not have a working scale, so the facility never weighed R16. FM-G stated she provided food for R16, but when looked in R16's refrigerator, the fruit was moldy, and chocolate milk was unopened and expired. FM-G stated she feared R16 would die from lack of cares. FM-G stated she had weekly meetings with administration, but cares have not improved. During an interview on January 14, 2025, at 10:08 a.m., director of nursing (DON)- I stated R16 acquired additional pressure ulcers while at the TCU. DON-I stated she did not know how much weight R16 lost because the facility did not have a working scale, but thought 10 pounds would be a significant weight loss. DON-I doubted that	02310		

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02310	Continued From page 24 R16's admission weight was in the 130s. DON-I stated the facility did not track consumption or percentage of meals eaten. During an interview on January 28, 2025, at 3:22 p.m. home health registered nurse (RN)- O stated she completed wound care for R16 twice (January 3 and January 10, 2025). RN-O stated R16 had two pressure ulcers on his lower back (sacrum), one pressure ulcer on each hip, and one pressure ulcer on each ankle. RN-O stated R16's pressure ulcers were larger and worse during the second appointment. RN-O stated on the January 3, 2025, appointment she observed R16 sitting in his wheelchair with his catheter bag in the trash next to him leaking. RN-O stated urine was leaking all over his foot pedals and the wheelchair. RN-O stated she looked around awhile to find a nurse, let her know her concerns, and recommended a change of R16's catheter due to the leak. RN-O stated the nurse told her she could not change R16's catheter because the facility did not have the supplies. RN-O stated she used her stock supplies and replaced R16's catheter, noted dark amber urine with thick sediment, recommended the nurse request a urinalysis. RN-O stated on her visit on January 10, 2025, she was informed the facility did not get an order for a urinalysis. Supplies R4 R4 admitted to the facility on November 3, 2022, due to diagnoses that included quadriplegia. R4's service plan dated January 6, 2025, included staff assistance as follows: catheter care two times per day and as needed, colostomy assist five times per day, eating assistance five times	02310		

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02310	Continued From page 25 per day, two staff for repositioning five times per day, socialization one to one for 30 minutes daily, range of motion twice daily, toileting/incontinence care six times per day, two staff for transfers four times per day, and nursing wound care two times per day/three days per week. During an interview on January 6, 2025, at 11:45 a.m. R4 requested the MDH investigator hand him his water bottle that was sitting on a table, out of his reach. During an interview on January 28, 2025, at 3:15 p.m. home health registered nurse (RN)-O stated R4 previously had an adaptive device attached to his bed that held his water bottle (which had a long straw for him to access without picking it up), it broke, so R4 could only access water if someone handed it to him. R4 told RN-O that the facility would not replace the adaptive device. R7 R7 admitted to the facility on October 15, 2021, due to diagnoses that included quadriplegia. R7's service plan dated January 6, 2025, included bathing assistance seven days per week, catheter care 10 times per day, assistance of two staff for repositioning 10 times per day, range of motion once per day, toileting/incontinence care twice daily, assistance of two staff for transfers four times daily, and wound care by a nurse three times daily. R7's progress notes indicated R7 admitted to the hospital February 11, 2024, through February 14, 2024, for replacement of a blocked catheter and December 18, 2024, to December 21, 2024, for influenza and catheter replacement due to mispositioning.	02310		

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02310	Continued From page 26 R7's services delivered document service note dated October 18, 2024, indicated wound care not completed due to "no wound supplies". R7's services delivered document service note dated October 31, 2024, indicated catheter care not completed and "catheter had resistance, needs to be changed. Could not locate kit". During an interview on January 6, 2025, at 1:17 p.m. R7 stated the facility did not have enough staff to provide the cares he was supposed to receive, such as taking care of his catheter, repositioning, transferring him out of/into bed, and cleaning his room. R7 stated he had to go to the emergency room on more than one occasion to have his catheter replaced when the facility did not have a replacement supply. R7 stated he currently ordered his own supplies, but when delivered to the main office, he often did not receive them, so would have to make calls to track down his supplies. During an interview on January 8, 2025, at 9:00 a.m. former operations manager (OM)-C stated R7 required supplies for his catheter and wound care, but they would consistently go missing after delivery. OM-C stated R7 was tired of having his supplies go missing, so he began to order his own supplies. R8 R8 admitted to the facility on September 4, 2024, due to diagnoses that included right side paralysis of upper and lower extremities after a stroke, difficulty with speech and swallowing due to a stroke, and insulin dependent diabetes. R8's progress note dated December 9, 2024, at 4:12 p.m. indicated R8's primary care provider	02310		

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02310	Continued From page 27 ordered diabetic testing supplies (glucometer, lancets, and test strips) and sent the order to a local pharmacy for delivery to R8. The note indicated a blood draw ordered the previous month had also not been completed. R8's progress note dated December 27, 2024, at 5:36 p.m. indicated R8's family member reported R8 needed to supply his own food when the facility ran out, and they failed to supply blood sugar testing supplies. R16 R16 admitted to the facility on June 10, 2024, due to diagnoses that included quadriplegia. R16's service plan dated January 6, 2025, included bathing seven days per week, catheter care six times per day, total assistance for eating six times per day, assistance of two staff for repositioning 13 times per day, range of motion twice daily, wound care daily, weights daily, toileting/incontinence care twice daily, and assistance of two staff with a mechanical lift for transfers five times per day. R16's progress note dated November 7, 2024, at 5:48 p.m. indicated "staff was at wound appointment [with R16] when provider was upset at the current status of his wound. Provider stated the staff did not use the most current wound treatment supplies. [LPN-P] informed provider that staff was instructed to use what was available until appropriate supplies arrived." R16's services delivered document service note dated December 10, 2025, indicated catheter care not completed due to "no supply". During an interview on January 6, 2025, at 11:30	02310		

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02310	Continued From page 28 a.m. R16 stated staff "forget to feed me". R16 indicated he drank nutritional supplement drinks (Ensure) provided by FM-G when staff give them to him. R16 stated he received an assistive device for eating in December (which was supposed to be ordered in June when he admitted) but could only use it if staff placed in on his hand. During an interview on January 9, 20925, at 12:39 p.m. family member (FM)-G stated she observed R16 getting thinner, and when she asked about the assistive device for eating, R16 stated he never got one. FM-G ordered the assistive device, and when asked staff about using it they would say they "tried it one day". During an interview on January 28, 2025, at 3:22 p.m. home health registered nurse (RN)- O stated she completed wound care for R16 twice (January 3 and 10, 2025). RN-O stated during the January 3rd appointment she observed R16 sitting in his wheelchair with his catheter bag in the trash next to him leaking. RN-O stated urine was leaking all over his foot pedals and the wheelchair. RN-O stated she looked around awhile to find a nurse, let her know her concerns about the leaking bag, and recommended a change of R16's catheter due to the leak. RN-O stated the nurse told her she could not change R16's catheter because the facility did not have the supplies. RN-O stated she used her stock supplies and replaced R16's catheter. During an interview on January 30, 2025, at 9:32 a.m. licensed practical nurse (LPN)-P stated R16's incident on November 7, 2024, occurred due to the facility using incorrect supplies. LPN-P stated R16 had weekly appointments, and the wound care plan would often change weekly.	02310		

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02310	Continued From page 29 LPN-P stated at the time the facility had an unlicensed staff ordering supplies and by the time they reached the facility R16 had new orders. LPN-P stated the facility made decisions for purchasing supplies based on cost and whether the administration felt they could afford it. The Minnesota Department of Health (MDH) investigator requested but did not receive the following documents: 1) Skin assessments for R4, R7, R11, and R16 dated October 26, 2024, through January 6, 2025. 2) Provider orders for wound care supplies and documentation of receipt of the supplies for R4. 3) Provider orders for catheter supplies and documentation of receipt of the supplies for R7. 4) Provider orders for diabetic supplies and documentation of receipt of the supplies for R8. 5) Provider order for assistive device for eating and documentation of receipt of the assistive device for R16. Medication and supplies reordering policy dated September 23, 2020, indicated if a resident needed medication and/or supplies reordered from the pharmacy or supplier, staff would contact them. The policy indicated unlicensed personnel and nursing staff responsibility. Wound and skin considerations policy dated August 14, 2024, indicated routine skin checks performed on bath days by unlicensed personnel, who would update the nurse of any changes. The policy indicated a licensed nurse would complete a skin care audit weekly to identify trends or training needs and current wound status and treatment. The policy indicated residents with wound care would have a weekly wound assessment performed and documented in the	02310		

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02310	Continued From page 30 electronic medical record or on the wound flow sheet by a licensed nurse or clinical manager, even if an outside provider is performing wound care. Contents of service plans policy dated October 28, 2024, indicated the facility would implement and provide all services required by the current service plan unless unable for reasons such as, but not including resident refusal. The unlicensed personnel job description (undated) indicated the position was responsible for providing personal care and designated health-related services designed to maintain the resident's physical and emotional well-being for those residents living at The Lodges Company. This position assists residents with tasks of daily living as indicated on the Service Agreement, the Medication Administration Record (MAR), and other services as delegated by the RN. The licensed practical nurse job description (undated) indicated the position would ensure that the health and safety of all residents was met. The policy indicated an LPN would assist the Director of Nursing with planning, coordinating, and managing resident services and act within the Assisted Living regulations. The policy indicated an LPN was responsible for the overall direction, coordination, and monitoring of assisted living service delivery under the direction of the Director of Nursing. TIME PERIOD FOR CORRECTION: Seven days	02310		
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 31 sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure four of four resident(s) reviewed (R4, R7, R11, and R16) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		