

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL398518122M
Compliance #: HL398518872C

Date Concluded: March 30, 2026

Name, Address, and County of Licensee

Investigated:

Fantum Home Health LLC
8032 France Avenue North
Brooklyn Park, MN, 55443
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Angela Vatalaro, RN
Special Investigator

Finding: Inconclusive

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 and alleged perpetrator (AP) neglected the resident when they failed to provide adequate supervision and ensure the resident's safety. The resident was found deceased.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was inconclusive. The resident had a cancer diagnosis. A nurse stated the resident stopped receiving chemotherapy months prior to his death. The resident's medication administration record (MAR) indicated the resident's naltrexone (anti-substance use medication) taken for increased alcohol intake was documented as "out of stock" for a period of time. It could not be determined if the facility's failure to provide naltrexone caused the resident's increased alcohol use, because the resident also had a history of medication refusals. The morning the resident died, the AP left their shift early and had a non-employee cover the rest of the AP's shift. However, there was a lack of evidence to determine if the resident had any unmet needs when the non-employee was at the facility prior

to finding him deceased. The resident's primary cause of death was due to cancer with a secondary cause as liver failure.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The AP did not respond to a subpoena. The investigation included review of the resident records, death record, facility incident report, a personnel file, staff schedules, law enforcement report, and related facility policy and procedures. Also, the investigator observed the facility and staff interactions with other residents.

The resident resided in an assisted living facility. The resident's diagnoses included prostate cancer, cirrhosis of the liver, severe alcohol use. The resident's service plan included assistance with management of the resident's behaviors and safety checks twice daily. The resident's assessment indicated the resident was independent with bed mobility, transferring in and out of bed, and walked independently using a cane and/or walker. The resident required staff assistance with incontinence care and brief changes. The resident was oriented to person, place, and time. The resident was on the medication naltrexone due to increased alcohol use. The resident was at risk of falls while intoxicated. The resident's abuse prevention plan did not include specific interventions to include what to do if the resident was under the influence of alcohol.

Two months prior to the resident's death, the resident's MAR indicated the resident received naltrexone the entire month. At the beginning of the next month, the resident was compliant taking naltrexone. Towards the end of that month, the resident did not receive naltrexone for 11 consecutive days due to no supply and indicated "nurse notified." The following month, the MAR indicated the resident continued to not receive naltrexone for 22 consecutive days, until the resident died. The MARs also indicated the resident frequently refused other medications.

The resident's progress notes indicated within 2 weeks of the resident's death ULP staff documented the resident drank alcohol and/or showed signs of intoxication or was intoxicated daily. Behaviors identified included restlessness, agitation, disorganized behaviors, confused, "clear signs of intoxication" hands on assistance due to "residual intoxication effects." Records did not indicate ULP staff notified the nurse of changes of condition or of the resident's intoxication. Earlier in the same month, the resident's record did not indicate the resident was observed drinking alcohol daily.

The month of the resident's death progress notes by a nurse indicated an appointment would be scheduled at the resident's addiction clinic to address naltrexone orders after missing naltrexone for 15 days. Almost two weeks later, progress notes indicated the resident was seen at the addiction clinic, two days before his death.

Progress notes within 24 hours of the resident's death, indicated during morning shift at the start of the shift, a routine safety and environmental check was completed. Unlicensed personnel (ULP) staff documented "during this assessment" staff noted the resident appeared

unwell, weak, and fatigued. The resident had reported he had vomited three times earlier in the morning at approximately 6:00 a.m. They immediately checked the resident's vital signs and documented the results in the system. The nurse on-call was promptly notified of the resident's condition and updated on his symptoms and status. ULP staff documented "following the assessment," the resident declined to go to the hospital despite staff recommendations, stating he preferred to rest in his room. Progress notes entered by the nurse after the resident's death, indicated ULP staff reported the resident was not well. The resident reported vomiting and feeling weak. Vitals checked and blood pressure low. The resident refused to go to the hospital. The nurse advised staff to encourage fluids and blood pressure was rechecked. The resident refused morning medications and reported he felt better after drinking a coke and some water.

Progress notes during evening shift did not indicate the resident was observed consuming alcohol.

The staff schedule on the day of the resident's death indicated the AP was the only staff member scheduled to work the overnight shift. The AP's timesheet indicated the AP started shift at 11:00 p.m., and ended his shift at 5:55 a.m.

A law enforcement report indicated law enforcement responded to a call at the facility at approximately 6:45 a.m. for a resident who needed CPR (cardiopulmonary resuscitation). Upon arrival a male individual was providing CPR to the deceased. Emergency medical services (EMS) provided life saving measures, until the doctor advised to cease life saving measures. The male individual present at the facility falsely provided the name of AP, however law enforcement looked at records in their system and the photograph in records was evident this was not the worker present with the AP's name. Law enforcement called and spoke to the facility. The facility was provided a photograph of the male individual, who law enforcement thought was a worker at the facility at the time of the resident's death. The facility told law enforcement they did not know who the individual was, the individual was not an employee at the facility. Law enforcement called the AP who stated he was scheduled to work from 11:00 p.m. to 7:00 a.m. The AP said he became sick at 5:30 a.m., so he had his friend come to cover his shift until the replacement staff arrived at 7:00 a.m. The AP stated his friend was not an employee of the facility.

Progress notes documented by the AP indicated the day of the incident, the resident was asleep when the AP shift started. Staff did a safety check on him. The resident woke up to use the restroom around 2:00 a.m. and returned to his room. Staff did another safety check around 5:00 a.m. The resident was sleeping in his room. Around 6:45 a.m., (the AP was no longer at the facility) staff heard a loud sound from the resident's room. When staff rushed to the resident's room, the resident was found unconscious on the floor. Staff immediately called 911 and started CPR. When EMS arrived, they continued resuscitation until the resident was pronounced dead around 7:15 a.m.

Service delivery records indicated during the overnight shift the resident required one safety check, escort/mobility assistance, and behavior management. The area to document if the safety check occurred during the overnight left blank.

The resident's death record indicated immediate cause of death was prostate cancer, cirrhosis of the liver, and severe alcohol disorder.

During an interview, ULP 2 stated she worked the shift prior to the AP coming into work at 11:00 p.m. ULP 2 stated she provided the resident incontinent care, helped clean him up, and the resident was comfortable. She provided his meals even though the resident did not eat much and he watched sporting events on TV. ULP 2 stated the resident had seen his medical providers routinely and had a terminal condition. The AP was scheduled to work from 11:00 p.m. until 7:00 a.m. the day of the incident. The AP left shift early and had a non-employee come to the facility to cover. ULP 2 stated non-employees covering shifts at the facility had not occurred prior to this incident, and this was not allowed.

During an interview, ULP 1 stated the AP had called her because the AP became sick during the overnight shift and asked ULP 1 to come into work early. ULP 1 stated she told AP she was unable to come early and would be there at her scheduled time of 7:00 a.m. ULP 1 stated when she arrived at 7:00 a.m., the resident was on the ground and EMS was working on the resident. ULP 1 stated the AP was not present at the facility. ULP 1 stated an unknown male individual was present, who she did not know, and had not seen before.

During an interview, a nurse stated the resident had cancer and was not actively receiving chemotherapy treatment for it. The resident had been seeing his medical provider. The resident had struggled with alcohol use for quite some time, and his naltrexone doses were adjusted in attempts to reduce his alcohol intake. The nurse stated staff did not alert her the resident was drinking alcohol the month of his death. The nurse stated staff did not notify her the resident's naltrexone was out of stock, and she did not receive any calls from pharmacy. The nurse stated the resident chose not to take certain medications at certain times; she said it was not because medications were unavailable. The nurse stated staff may have documented "out of stock" and they may have meant he was choosing not to take the medication. The nurse stated upon disposal of the resident's medications, the resident had 27 tablets of naltrexone that were destroyed.

During an interview, leadership stated the day the resident passed away, the AP was working however the AP had left before end of shift. The AP did not call management to let them know. Leadership stated the AP called a non-employee to come in and cover his shift. Leadership stated the AP did not come back into the facility after the incident. Leadership stated the AP still had access to the medical record documentation system and could document a progress note and incident report by using a password. Leadership stated no other person had access to AP's password. Leadership stated even though AP had left and was not present at the facility, the AP still had the ability to document.

The AP did not respond to a subpoena.

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

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.

"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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: No. The resident was deceased.

Family/Responsible Party interviewed: Not applicable.

Alleged Perpetrator interviewed: No. Attempted, did not respond to subpoena.

Action taken by facility:

The facility stated they verbally investigated the incident. The AP received discipline. The AP is no longer employed by the facility.

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: 39851	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/21/2026
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NAME OF PROVIDER OR SUPPLIER FANTUM HOME HEALTH CARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 8032 FRANCE AVENUE NORTH BROOKLYN PARK, MN 55443
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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>HL398516062C/HL398516762M HL398518872C/HL398518122M</p> <p>On January 21, 2026, the Minnesota Department of Health conducted complaint investigations at the above provider, and the following correction orders are issued. At the time of the complaint investigations, there were two residents receiving services under the provider's Assisted Living license.</p> <p>The following correction orders are issued for HL398516062C/HL398516762M, tag identification 450, 2360.</p> <p>The following correction orders are issued for HL398518872C/HL398518122M, tag identification 330, 450, 1690.</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>	
0 330 SS=F	144G.30 Subd. 4 Information provided by facility	0 330		

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

Minnesota Department of Health

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0 330	<p>Continued From page 1</p> <p>(a) The assisted living facility shall provide accurate and truthful information to the department during a survey, investigation, or other licensing activities.</p> <p>(b) Upon request of a surveyor, assisted living facilities shall within a reasonable period of time provide a list of current and past residents and their legal representatives and designated representatives that includes addresses and telephone numbers and any other information requested about the services to residents.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide accurate and truthful information surrounding the death of one of one resident (R2) to Minnesota Adult Abuse Reporting Center (MAARC) with records reviewed. The licensee reported a staff member heard a loud sound, responded, found R2 unresponsive on the floor, called 911, and started CPR (cardiopulmonary resuscitation). In addition, R2's progress notes and incident report which indicated unlicensed personnel (ULP)-E documented and entered into the R2's medical record, were also not accurate or truthful. This had the potential to affect all residents.</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 is 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>The findings include:</p>	0 330		
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0 330	<p>Continued From page 2</p> <p>R2's diagnoses included prostate cancer, hepatic cirrhosis, and severe alcohol use disorder.</p> <p>The licensee staff schedule for overnight shift starting November 22, 2025, into November 23, 2025, indicated ULP-E was the only staff member scheduled to work the overnight shift.</p> <p>A law enforcement report dated November 23, 2025, at 2:05 p.m., indicated law enforcement responded to a call at the licensee at approximately 6:45 a.m., for R2 who needed CPR. Upon arrival a male individual was providing CPR to the deceased. Emergency medical services (EMS) provided life saving measures until the doctor advised to cease life saving measures. The male individual present at the licensee falsely identified himself as ULP-E. Law enforcement looked at records in their system and the picture/photograph in records was evident the male individual was not ULP-E. Law enforcement called and spoke to the licensee. The licensee was provided a picture/photograph of the male individual, who law enforcement thought was a worker at the licensee at the time of R2's death. The licensee told law enforcement they did not know who the individual was, the individual was not an employee at the licensee. Law enforcement called ULP-E who stated he was scheduled to work from 11:00 p.m. to 7:00 a.m. ULP-E said he became sick at 5:30 a.m., so he had his friend come to cover his shift until the replacement staff arrived at 7:00 a.m. ULP-E stated his friend was not an employee of the licensee.</p> <p>A MAARC report dated November 23, 2025, at 5:25 p.m. (ten hours after the incident), indicated the licensee reported "staff" heard a loud sound</p>	0 330		

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0 330	<p>Continued From page 3</p> <p>from R2's room around 6:45 a.m., When "staff" rushed to his room R2 was found unconscious on the floor. "Staff" immediately called 911 and started CPR. When EMS arrived, they continued resuscitation until R2 was pronounced dead at 7:15 a.m.</p> <p>An incident report dated November 23, 2025, entered by ULP-E time-stamped entries from 5:35 p.m. to 5:39 p.m., indicated an incident at 6:45 a.m., "staff" heard a loud sound from R2's room. When "staff" rushed to R2's room, R2 was found unconscious on the floor. "Staff" immediately called 911 and started CPR. EMS continued resuscitation when they arrived.</p> <p>R2's progress note dated November 23, 2025, at 7:30 a.m., indicated R2 was asleep when shift started. Staff did a safety check on him. R2 woke up to use the restroom around 2:00 a.m. and returned to his room. Staff did another safety check around 5:00 a.m., R2 was in his room sleeping. Around 6:45 a.m., "staff" heard a loud sound from R2's room. When "staff" rushed to R2's room, R2 was found unconscious on the floor. "Staff" immediately called 911 and started CPR. When EMS arrived, they continued resuscitation until R2 was pronounced dead around 7:15 a.m. ULP-E's progress note was electronically signed by ULP-E on November 23, 2025, at 6:01 p.m.</p> <p>ULP-E's timesheet the evening of November 22, 2025 into November 23, 2025, indicated ULP-E ended shift at 5:55 a.m. A law enforcement report indicated the non-employee was at the licensee upon arrival at 6:45 a.m. ULP-E told law enforcement he called his friend at 5:30 a.m. to cover his shift. R2's progress notes and incident report entered by ULP-E indicated "staff" heard a</p>	0 330		
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0 330	<p>Continued From page 4</p> <p>loud sound from R2's room, "staff" called 911, and "staff" started CPR.</p> <p>During an interview on February 2, 2026, at 8:53 a.m., ULP-B, who identified as the administrator, stated ULP-E was scheduled to work from 11:00 p.m. until 7:00 a.m. the day of the incident. ULP-E left shift early and had a non-employee come in to cover. ULP-B stated herself and licensed assisted living director (LALD)-A conducted an internal investigation regarding the incident and stated this was not documented. ULP-B stated the licensee's internal investigation was conducted verbally by talking to people.</p> <p>During an interview on February 2, 2026, at 3:51 p.m., LALD-D stated the day R2 passed away, ULP-E was working however ULP-E had left before end of shift. ULP-E called a non-employee to come in and cover his shift. LALD-D stated that same day, LALD-D figured out it was not ULP-E who worked at the time of the incident on the day of the incident. LALD-D stated the licensee filed a MAARC report. LALD-D stated the licensee did not know it was not ULP-E who was on shift when the licensee filed the MAARC report. LALD-D stated the report indicated it was staff who responded to R2's room because it was supposed to be ULP-E who was there on shift. LALD-D stated ULP-E did not come back to the licensee after leaving shift early. LALD-D stated progress notes entered on November 23, 2025, at 6:01 p.m., as well as an incident report were entered by ULP-E because ULP-E still had access to the medical record documentation system and could document by using a password. LALD-D stated no other person had access to ULP-E's password. LALD-D stated even though ULP-E had left and was not present at the licensee, ULP-E still had the ability to</p>	0 330		
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0 330	<p>Continued From page 5</p> <p>document. LALD-D stated the licensee did not know it was not ULP-E present at the licensee during the incident when the licensee filed the MAARC report.</p> <p>The licensee's policy titled Reporting Maltreatment of Vulnerable Adult, undated, indicated when reporting to MAARC, the reporting information would contain, the nature and extent of suspected maltreatment and the perpetrator. The same policy also indicated one of the licensee's responsibilities included the licensee would conduct an internal investigation interviewing witnesses who may have information concerning the incident and documenting the witnesses' statements concerning the incident.</p> <p>TIME PERIOD FOR CORRECTION: Two (2) days</p>	0 330		
0 450 SS=K	<p>144G.41 Subdivision 1 Minimum requirements</p> <p>All assisted living facilities shall:</p> <p>(1) distribute to residents the assisted living bill of rights;</p> <p>(2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285;</p> <p>(3) utilize a person-centered planning and service delivery process;</p> <p>(4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285;</p> <p>This MN Requirement is not met as evidenced by:</p>	0 450		

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0 450	<p>Continued From page 6</p> <p>Based on interview and record review, the licensee staff failed to provide person centered services, non-nursing staff provided care planning and coordination with medical providers outside of their scope of practice, failed to update the registered nurse (RN) on resident incidents and behaviors and the RN failed provide appropriate supervision of delegated tasks by reviewing progress notes, assessing after hospitalizations and implementing specific interventions for substance abuse for two of two residents (R1, R2) reviewed.</p> <p>This practice resulted in a level four violation (a violation that harmed a resident ' s health or safety, not including serious injury or death, or a violation that was likely to lead to serious injury or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly but is not found to be pervasive).</p> <p>The findings include:</p> <p>The Nurse Practice Act, Minnesota Statute 148.171, subdivision 15, practice of professional nursing, indicated responsibilities and authority of licensed registered nurse included:</p> <ul style="list-style-type: none"> -collaborating and coordinating with health care professionals and develop integrated plan of care -developing nursing interventions -implement interviews that are delegated, ordered or prescribed by a licensed health care provider -evaluate responses to interventions and effectiveness <p>R1 R1's diagnoses included bipolar disorder, schizoaffective disorder, agitation due to</p>	0 450		
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0 450	<p>Continued From page 7</p> <p>methamphetamine (illegal stimulant), methamphetamine use disorder, and alcohol abuse.</p> <p>R1's progress notes dated August 7, 2025, indicated R1 called the licensee to let them know he was in the hospital. R1 was brought into the hospital from jail, was medically cleared, and moved to psychiatric emergency for evaluation. Unlicensed personnel (ULP)-B, who identified as the administrator, and licensed assisted living director (LALD)-D were both on the phone and spoke to the hospital's nurse about R1's drug use of methamphetamine and cocaine, and R1's unwillingness to stop drug use. R1 had trespassed on neighbor's property and a history of provoking and attacking other residents.</p> <p>R1's progress notes dated August 7, 2025, indicated ULP-B spoke to R1's psychiatric clinic, to update R1's psychiatrist of R1's admission to acute psychiatric services (APS) at a hospital.</p> <p>R1's progress notes dated August 8, 2025, indicated ULP-B called R1's case manager and informed the case manager R1 was in the hospital and was transferred there from jail. R1 had repeatedly declined treatment and refused to stop doing drugs. ULP-B told R1's case manager that they would begin service termination if R1 continued to decline treatment and continued to use drugs making him unstable in the community.</p> <p>R1's progress notes dated August 8 through August 22, 2025, indicated R1 remained hospitalized at an inpatient psychiatric unit.</p> <p>R1's progress notes dated August 21, 2025, indicated the hospital spoke to ULP-B and LALD-D who were made aware that R1 had been</p>	0 450		

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0 450	<p>Continued From page 8</p> <p>banned from most treatment facilities however R1 was enrolled with a clinic who worked closely with R1's psychologist who would monitor him in the meantime. The plan was R1 would admit to a program early October 2025.</p> <p>R1's progress notes dated August 22, 2025, indicated R1 discharged back to the facility.</p> <p>R1's master care plan dated August 22, 2025, indicated R1 was independent with health service decisions and needed assistance when unstable. Staff were to call 911 when R1 became violent. A new plan of care need indicated R1 required a nurse to follow-up on health issues and medical appointments. R1 had substance abuse and was aggressive when under the influence of drugs.</p> <p>R1's assessment dated August 23, 2025, indicated R1 was alert, oriented, and coherent. R1 had a history of removing clothing, walking around nude, lying on other residents' beds, hitting staff and other residents, throwing items, verbal aggressiveness towards staff and residents.</p> <p>R1's signed service plan dated August 23, 2025, indicated R1's services included medication administration and managing the resident's behaviors to include agitation, anxiety, physical aggression, receptiveness, self-injurious, verbal aggression, depression, and other mental health needs.</p> <p>R1's individual abuse prevention plan (IAPP) dated August 23, 2025, identified R1's risk to harm other with behaviors of agitation, disrobing, physical aggression, property destruction, repetitive behaviors, verbal aggression, mental illness identified as anxiety, and bipolar. The</p>	0 450		

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0 450	<p>Continued From page 9</p> <p>IAPP did not include any specific interventions for any of R1's behaviors or mental illness.</p> <p>R1's Behavior Plan, undated, identified R1's behaviors as agitation, anxiety, physical aggression, repetitive behavior, self-injury, verbal aggression, depression, and other mental health needs. Each behavior included various interventions. Triggers for R1's behaviors included substance use, drinking alcohol, or using drugs. R1's interventions for some of the identified behaviors included calling COPE (mobile mental health crisis team) or 911. For all R1's identified behaviors the plan indicated if R1's behaviors escalated instructions indicated notifying the "supervisor." The behavior plan did not indicate specific interventions to address R1's substance abuse that was the trigger for behaviors.</p> <p>R1's progress notes dated September 27, 2025, during morning shift, indicated R1 returned from an overnight stay at a friend's house. R1 told staff he had some sort of mist sprayed in his eyes, and a hard time seeing. ULP staff asked if R1 would like to go to the hospital. R1 declined. R1 appeared to be under the influence of a substance. R1 was non-stop talking throughout shift. R1 screamed and was verbally aggressive with staff and other residents. ULP staff documented R1 admitted to staff he was under the influence of a substance (unknown substance), stating the substance would not let him sleep, stop talking, and the substance was energizing him. The progress notes did not indicate ULP staff notified the RN.</p> <p>R1's progress notes dated September 27, 2025, during the evening shift, indicated R1's eyes were red, and R1 stated he could not see properly. R1</p>	0 450		

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0 450	<p>Continued From page 10</p> <p>was clumsy, bumping into chairs, tables, doors, walls, and the kitchen cabinet. ULP staff indicated R1 was high on drugs which made him behave differently. R1 left the facility around 8:34 p.m. At 10:36 p.m., R1 was brought back to the licensee by three law enforcement officers. The law enforcement officers told ULP staff R1 was harassing people in the neighborhood and was trespassing on the neighbors' properties. The progress notes did not indicate ULP staff notified the RN.</p> <p>R1's progress notes dated September 29, 2025, during the morning shift, indicated R1 talked non-stop, told staff how methamphetamine made him feel better. R1 came in and out of the licensee, moved items between upstairs and downstairs, banged on tables, slammed cabinet doors, and told ULP staff he fell seven times a couple days prior, and R1 had bruises on his legs. R1 left the licensee at 2:30 p.m. During the evening shift, R1 returned at 5:00 p.m., R1 was agitated and left again. By end of the shift, R1 had not returned. The progress notes did not indicate ULP staff notified the RN.</p> <p>R1's progress notes dated September 30, 2025, during the overnight shift, R1 was not at the licensee and returned at 3:12 a.m. R1 was brought back to the licensee by two law enforcement officers. R1 had a small scratch on his leg. R1 could not sleep and was restless throughout shift. ULP staff documented they attempted to calm R1 however he would not listen. ULP staff documented the way R1 behaved was like he was under the influence of a substance. R1 entered another resident's room who was not present and disorganized the other resident's personal items in their room. The progress notes did not indicate ULP staff notified</p>	0 450		
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0 450	<p>Continued From page 11</p> <p>the RN.</p> <p>R1's mental health incident report dated September 30, 2025, indicated R1 threatened other residents and staff, had extreme agitation, and was combative. R1 told staff he was under the influence of some drugs, and that helped him think. R1 went onto neighbors' porches and went through their trash cans. ULP staff documented they attempted to calm the resident and redirect, however, R1 was under the influence of a substance, and indicated it was hard to get through to R1 when he was like that. The incident report indicated the licensee nurse was notified, however the incident report review was completed by ULP-A and not the RN. The incident report area to document if a medical provider was notified, other care team members notified, or further actions taken all left blank.</p> <p>A law enforcement report dated September 30, 2025, indicated law enforcement conducted a wellness check on R1.</p> <p>R1's progress notes dated September 30, 2025, during the evening shift, indicated R1 disturbed the neighbors, argued with people on the streets, and yelled at others in the community.</p> <p>R1's progress notes dated October 1, 2025, at 12:30 p.m., indicated RN-C called a provider's office nurse to report episodes of hyperactivity, aggression, possible drug use, and was picked up by law enforcement after an altercation, and that staff had reported R1 used an orange spray and sprayed this into his eyes. The progress notes indicated R1's eyes were irritated and R1 refused treatment for this. The progress notes did not indicate what the primary care provider stated or recommended. The progress note did not</p>	0 450		
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0 450	<p>Continued From page 12</p> <p>indicated RN-C assessed R1 after reporting he had seven falls two days prior.</p> <p>R1's progress notes dated October 1, 2025, during the evening shift, indicated R1 was not at the licensee. R1 called the house phone and reported he had been beaten up downtown by teenage boys. R1 said he was talking with the police and would call back. ULP staff documented they called R1 back, R1 said he was fine, he was going to a friend's house, and would be back later. The progress notes did not indicate ULP staff notified the RN.</p> <p>R1's progress notes dated October 2, 2025, during the overnight shift, indicated R1 returned to the licensee at 1:15 a.m., restless. R1's clothes were dirty. R1 was aggressive, yelled, cussed, and attempted to slap a staff member. R1 called law enforcement and said law enforcement was no help. R1 took a shower and was sleeping by end of shift. The progress notes did not indicate ULP staff notified the RN.</p> <p>R1's mental health incident report dated October 2, 2025, at 1:40 a.m., indicated when R1's returned to the licensee at 1:15 a.m. R1 stated he fell into a pond on the way home. R1 was verbally aggressive towards staff. The incident report indicated the "director" (LALD-D) was notified. There was no documentation the RN was notified and the incident report review was completed by ULP-H, not the RN. The incident report area to document if a medical provider was notified, other care team members notified, or further actions taken all left blank.</p> <p>R1's progress notes dated October 2, 2025, during the morning shift, indicated R1 had extreme behaviors. R1 called 911 stating he</p>	0 450		

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0 450	<p>Continued From page 13</p> <p>thought the staff were going to call law enforcement on him. R1 used profanity toward other residents, defecated in the basement bathroom. COPE was contacted and advised staff to call back within an hour and to call law enforcement if R1 became physical. R1's agitation began to decrease around 9:00 a.m. R1 continued to enter other residents' rooms despite reminders this was not allowed. The progress notes did not indicate ULP staff notified the RN.</p> <p>R1's mental health incident report dated October 2, 2025, at 7:30 a.m., indicated R1 had extreme agitation, and tore down off the wall the "No Drug Use" signs, and ripped food menus off the wall. R1 threw plates. R1 banged on other residents' room doors, unplugged cameras, "messed" with the lighting panel, unplugged the house phone, threw it on the floor, and removed the battery. The incident report indicated the "director" (LALD-D) was notified. There was no documentation the RN was notified and the incident report review was completed by ULP-G, not the RN. The incident report area to document if a medical provider was notified, other care team members notified, or further actions taken all left blank.</p> <p>R1's progress notes dated October 3, 2025, during the overnight shift, indicated R1 was out of the licensee upon staff arrival. R1 called the house phone and stated law enforcement was bringing him back. R1 arrived about 1:00 a.m. R1 went downstairs to his room and banged on other residents' doors to wake them up.</p> <p>R1's progress notes dated October 3, 2025, during the morning shift, indicated R1 woke around 9:00 a.m. R1 yelled at another resident while they watched television and went into</p>	0 450		

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0 450	<p>Continued From page 14</p> <p>another resident's room going through their personal items. R1 came upstairs, moved items around, cursed and yelled at staff. Staff offered him an as needed medication, he agreed, however this did not help. Around 12:00 p.m., ULP staff documented they informed the nurse the as needed (PRN) medication was not working, and sent images of bruises R1 had from falling out on the street. The nurse instructed staff to ask if R1 wanted to go to urgent care. ULP staff documented that they asked, but R1 declined. Around 2:00 p.m., R1 called COPE before staff could. COPE arrived, and R1 went outside and yelled in their faces. Staff spoke to COPE outside, R1 grabbed another resident's mail and ripped it up in front of them. As COPE was leaving, R1 followed them to their car, pushed the COPE member and slammed the car door several times causing his glasses to break. R1 followed a female COPE member and called her names, cursed, and blew his nose into a napkin, and tried to put it her face. R1 slammed the car door on COPE's arms. Staff tried to stop him. R1 turned around and told staff "You're next." A neighbor told R1 to get way from the car. R1 went back into the facility, slammed doors, and attempted to hit staff. R1 seen the COPE member outside and went back out, however law enforcement told him to go back inside. R1 was taken to a hospital. The progress notes did not indicate ULP staff notified the RN of the incident and R1 was at the hospital.</p> <p>R1's mental health incident report dated October 3, 2025, at 2:00 p.m., indicated R1 had extreme agitation and threatened staff. Staff documented they attempted to redirect R1 from the start and gave a PRN medication and staff kept other residents away from the situation. There was no documentation the RN was notified. The incident</p>	0 450		
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0 450	<p>Continued From page 15</p> <p>reported indicated the "director" (LALD-D) was notified. There was no documentation the RN was notified and the incident report review was completed by ULP-G, not the RN. The incident report area to document if a medical provider was notified, other care team members notified, or further actions taken, all areas left blank.</p> <p>R1's progress notes dated October 3, 2025, during the evening shift, indicated the hospital called and said R1 would be discharged. LALD-D asked R1 to be put on hold due to aggressive behavior, however they declined and confirmed discharge. LALD-D documented he spoke to the nurse and administrator about how to handle the situation moving forward. They decided to call the medical provider tomorrow as it was already late and indicated the nurse had already spoken to the provider about R1 two days ago (this progress note also lacked documentation of what the provider's response was). During the evening shift, R1 returned from the hospital at 10:00 p.m. R1 returned and said he did not feel bad about what happened with COPE today, he woke up other residents, yelled, and moved items around in the kitchen.</p> <p>R1's emergency room discharge records dated October 3, 2025, indicated R1 was seen for leg pain, fall, abrasions of multiple sites, fluid retention in legs, and contusion of his right chest.</p> <p>R1's progress notes dated October 3, 2025, during the overnight shift, indicated R1 had a restless night. R1 yelled and threw items at others. Staff attempted to stop him, however R1 would not listen, cussed at staff, and attempted to hit staff. R1 said he was going to call law enforcement and everyone would be going to jail. R1 went downstairs and unplugged the box to</p>	0 450		
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0 450	<p>Continued From page 16</p> <p>turn the lights out in the house. R1 turned the lights off in the house. R1 returned upstairs cussed at everyone, asked for a phone, left the house, and said he would be back. R1 returned at 4:30 a.m. ULP staff documented R1 was still aggressive with staff and the other residents. R1 made himself food and went back to his room until the end of shift. The progress notes did not indicate ULP staff notified the RN.</p> <p>R1's records did not include a nurse assessment after R1's emergency room discharge October 3, 2025, nor an assessment of R1 after he reported being assaulted in the community, having several falls in the community, falling into a pond and R1 assaulting COPE for changes in condition, injury and evaluation of current interventions.</p> <p>R1's mental health incident report dated October 4, 2025, at 2:40 a.m., indicated R1 had threatened other residents, had extreme agitation, and threatened staff. ULP staff documented they stopped R1 and other residents from getting into a physical fight. The incident reported indicated the "director" (LALD-D) was notified. There was no documentation the RN was notified and the incident report review was completed by ULP-H, not the RN. The incident report area to document if a medical provider was notified, other care team members were notified, or further actions taken, all areas left blank.</p> <p>R1's mental health incident report dated October 4, 2025, at 7:00 a.m. indicated R1 had threatened other residents, staff, and had extreme agitation. R1 came upstairs at 7:00 a.m. and went to the kitchen to bake cookies. R1 saw another resident sleeping, took a frying pan threw it at the other resident who he saw sleeping, and continued to cuss at him. The other resident got up to try and</p>	0 450		
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0 450	<p>Continued From page 17</p> <p>hit R1 back, staff documented they rushed in-between to stop them from fighting. R1 tried to take the fry pan from staff, was physically aggressive towards staff, and R1 shoved the staff member into the other resident. ULP staff indicated they called 911. The incident report indicated the "director" (LALD-D) was notified. There was no documentation the RN was notified and the incident report review was completed by ULP-H, not the RN. The incident report area to document if a medical provider was notified, other care team members were notified, or further actions taken, all areas left blank.</p> <p>R1's progress notes dated October 4, 2025, during the morning shift, indicated R1 was taken to the hospital at the beginning of the shift at 7:42 a.m., and was still there until end of shift.</p> <p>R1's emergency room APS (acute psychiatry services) discharge records dated October 4, 2025, indicated R1 was seen for agitation and substance abuse.</p> <p>R1's records did not include a nurse assessment after an emergency room discharge October 4, 2025, nor evaluating R1 for hitting another resident with an object for implementation of new safety interventions.</p> <p>R1 progress notes dated October 5, 2025, during the evening shift, indicated R1 returned from the hospital at 4:41 p.m. R1 was restless, verbally aggressive, hyperactive, and physically aggressive with staff. R1 looked for his left-over cookie dough, got agitated, was unable to locate it, and threw a plastic bowl at staff. Staff did not get hurt. R1's behavior fluctuated from calm and normal to "provocative" and loud. R1 went into other residents' rooms who were out of the</p>	0 450		
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0 450	<p>Continued From page 18</p> <p>facility. Around 7:00 p.m., R1 took a shower, left the facility at 7:43 p.m. R1 returned at 9:21 p.m. with a shopping cart full of groceries and left it in the driveway. ULP staff documented R1's behaviors were "worse" than before. R1 was aggressive, yelling, shouting, cursing, and throwing items all over the kitchen. R1 made fresh cookie dough and left it in the refrigerator to chill. When the evening shift ended R1 was in his room. The progress notes did not indicate ULP staff notified the RN of his worsening behaviors.</p> <p>R1's mental health incident report dated October 5, 2025, at 5:13 p.m., indicated R1 was threatening staff, had extreme agitation, was combative and threw a "big" plastic bowl at staff out of agitation. The incident report indicated the "director" (LALD-D) was notified as well as ULP-B. There was no documentation the RN was notified and the incident report review was completed by ULP-I, not the RN. The incident report area to document if a medical provider was notified, other care team members were notified, or further actions taken, all areas left blank.</p> <p>R1's progress notes dated October 6, 2025, during the overnight shift, indicated R1 was waiting for his cookie dough to chill to make cookies. Around 12 midnight, R1 went into kitchen, made a "mess," became aggressive, shouted, yelled, and disorganized a table and chairs in the living room. A few minutes later, R1 went into the kitchen and turned on the stove. ULP staff documented they attempted to supervise R1 from a distance so R1 would not get more agitated, and documented that did not work. R1 used a pot and mixed something flammable on the stove (staff could not identify substance in the pot) to boil. R1 took the hot boiling pot, started following staff, threatened, and yelled at</p>	0 450		

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0 450	<p>Continued From page 19</p> <p>the staff. ULP staff documented they remained calm to avoid R1 being provoked. At 12:28 a.m., ULP staff went downstairs to call 911. While staff were in the basement calling 911, R1 followed holding a boiling pot of water. While ULP staff were on the call with 911, R1 tampered with the facility power source. The facility went dark. In the kitchen, R1 put the pot back on the stove to boil more. There was heavy smoke in the kitchen caused by the boiling water, smoke detectors went off. Law enforcement and the fire department arrived. R1 was taken to the hospital. The progress notes did not indicate ULP staff notified the RN of the threatening violent behavior and hospitalization.</p> <p>R1's mental health incident report dated October 6, 2025, indicated R1 threatened staff, had extreme agitation, was combative, and R1 threatened staff with a pot of boiling water. The incident report indicated ULP-B, the administrator, called the psychiatry clinic to inform R1's psychiatrist of R1's status. ULP-B documented that she contacted R1's case manager and the facility nurse regarding R1's mental health crisis. The incident report review was completed by ULP-B, not the RN.</p> <p>R1's progress notes dated October 6, 2025, indicated ULP-B, who was not a nurse, called R1's psychiatrist office to inform the provider about R1's mental health crisis, safety concerns with other residents, with the staff, and neighbors and the three emergency room visits over the weekend. ULP-B indicated R1 needed to have inpatient substance use treatment in a locked facility where he has no access to substances. ULP-B told R1's psychiatrist's office that in the past, when they had called to inform R1's psychiatrist about his mental health crisis, the</p>	0 450		
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0 450	<p>Continued From page 20</p> <p>provider always recommended having R1 brought over to APS (acute psychiatry services). However, ULP-B stated the resident was brought over to APS this past Saturday, October 4, 2025, due to his mental health crisis, but was discharged the next day back to their facility where R1 continued to escalate mentally. ULP-B told the psychiatrist that APS was no longer a good option for R1. Clinic staff stated he would pass the message over to the provider and someone will follow up with a call. ULP-B provided her phone number to call back.</p> <p>R1's progress notes dated October 6, 2025, indicated a nurse from R1's psychiatrist clinic called ULP-B to get more information regarding R1's mental health crisis. ULP-B informed the nurse that R1 needs a higher level of care than assisted living to manage his mental health and the cycle of mental health crisis, COPE, emergency room visits, and discharge back to their facility was not what R1 needs. R1 needs to have substance use treatment in a substance use facility. The nurse said she would talk to R1's psychiatrist and get back to ULP-B. The progress notes did not indicate ULP-B notified the RN after acting beyond their scope of practice by communicating with the provider, coordinating care.</p> <p>R1's progress notes dated October 6, 2025, indicated RN-C contacted R1's primary provider about R1's episodes of aggression, admissions over the weekend, and informed the provider R1 was back in the hospital. The progress notes did not indicate what the primary care provider stated or recommended.</p> <p>R1's hospital records dated October 6, 2025, indicated R1 was sent to the emergency room</p>	0 450		
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0 450	<p>Continued From page 21</p> <p>due to aggressive behavior. R1 admitted to the hospital due to agitation and psychosis. Hospital records indicated R1 threatened to turn off the breaker for the lights within the facility, as well as harm someone with hot water that he was boiling on the stove. R1 nearly set fire to the stove by laying flammable material on the hot surface, resulting in smoke and need for the licensee to be evacuated. Four days prior, R1 pushed licensee staff and threatened to assault someone at the licensee with a frying pan. In addition, R1 also reported being in a physical altercation recently. R1 stated he used methamphetamine whenever he could afford it, whenever it was available, and his preference was daily use. R1 reported his most recent use was a few days prior to admission. The licensee told the hospital R1 had been decompensating for two weeks.</p> <p>R1's record did not include a nursing assessment within the two weeks of R1's decompensation.</p> <p>R1's progress notes dated October 7, 2025, indicated a nurse from R1's psychiatrist office called ULP-B to inform them about the recommendations from R1's psychiatrist. The progress notes did not indicate ULP-B notified the RN.</p> <p>R1's progress notes and discharge summary indicated R1 did not return to the licensee after hospitalization.</p> <p>During an interview, on January 28, 2026, at 10:15 a.m., ULP-A stated R1 was restless, agitated, and would not sleep for a period of days. The substance R1 used was methamphetamine. R1 would be hyperactive on drugs. R1 would have extreme behaviors and would be aggressive and threaten others. R1 had thrown a pan at</p>	0 450		
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0 450	<p>Continued From page 22</p> <p>ULP-A. ULP-A stated when these behaviors occurred, staff would attempt to calm R1. ULP-A stated staff documented a report, and informed LALD-D of R1's behaviors. ULP-A stated LALD-D would be the person who would inform the licensee's nurse of R1's behaviors.</p> <p>During an interview, on February 2, 2026, at 8:53 a.m., ULP-B, who identified as the administrator, stated she was not a licensed nurse. ULP-B stated the only licensed nurse at the licensee was RN-C and they had one other licensed nurse available as needed for back up. ULP-B stated her role as the administrator was to ensure compliance with paperwork, ensure documentation of staff training, employee records, resident intake documentation, payroll, and ULP-B assisted in covering shifts as a caregiver. ULP-B stated R1 had a history of using methamphetamine and he also used cocaine. ULP-B stated staff were able to tell R1 was using illicit drugs based on R1's symptoms and when R1 had behaviors. ULP-B stated the licensee managed R1's behaviors due to R1's drug use. In August of 2025, ULP-B stated the licensee was in touch with R1's case manager and had discussions of terminating R1's services however R1 hospitalized, and they did not pursue termination at that time. ULP-B stated a licensed nurse was involved in R1's care and ULP-B stated the nurse was aware when behaviors escalated. ULP-B stated RN-C was updated after every behavior escalation episode. When asked about the eight mental health incidents that occurred between September 30 and October 6, 2025, and how not all incidents indicated RN-C was updated, ULP-B stated R1's progress notes dated October 1, 2025, indicted RN-C informed the provider, and the note indicated "episodes," and said that was "plural" meaning more than</p>	0 450		
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0 450	<p>Continued From page 23</p> <p>one. When asked what about incidents after September 30, 2025, ULP-B stated all these incidents were occurring in very quick succession. ULP-B stated by the time RN-C could have come in, R1 was already back at the hospital. ULP-B stated what was going on with R1 was not a situation where they would have a RN-C come in to talk with R1 because R1 was already escalating.</p> <p>During an interview, on February 2, 2026, at 2:04 p.m., RN-C stated when she conducted assessments for residents, the IAPP was developed, and vulnerabilities were assessed. When asked where on the IAPP were specific interventions for R1's drug use and behaviors, RN-C stated that should have been identified. RN-C stated the interventions included staff trained on redirection, providing counseling, and attempting to calm residents down with any behaviors. If these interventions were not working, staff were supposed to call COPE or call 911. RN-C stated she has heard about behavior plans at other licensee's however she was not aware R1 had a behavior plan at this licensee. RN-C stated she had worked at the licensee since April 2025. RN-C stated she would consider a change of condition requiring an assessment to include hospitalization, significant change, major incidents, falls, or a crisis. RN-C stated she was aware of one time where staff reported what they were seeing, and suspected R1 of using illicit drugs and she said she updated R1's provider. RN-C stated it was an expectation staff notified her if R1 was under the influence of substances and/or illicit drugs such as methamphetamine. When asked what the staff are supposed to do if R1 was under the influence, she said notify the supervisor/director (LALD-D), and RN-C stated she would also want to know. RN-C stated she</p>	0 450		
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0 450	<p>Continued From page 24</p> <p>was unaware R1 was seen in the emergency room on October 3, 2025, for leg pain, a fall, abrasions, fluid retention, and a contusion of his right chest. RN-C stated she was told R1 went to the emergency room for his behavior. RN-C stated if she knew what R1 had been seen for a fall she would have conducted a reassessment. RN-C stated she was unaware R1 boiled water and followed staff with a pot and RN-C stated she was unaware of R1 throwing a mixing bowl at ULP staff. RN-C stated she was unaware R1 was physically aggressive towards staff and others. RN-C stated she was unaware of R1 having a fry pan attempting to hit someone. RN-C stated she was not informed R1 had gone to the electrical box and turned off electricity at the licensee and was not aware of R1 throwing items. RN-C stated she was not made aware that R1 had reported being beaten up by teenage boys' downtown, or that R1 reported he fell seven times, or was told R1 was returned to the licensee multiple times by law enforcement. RN-C stated if she had known she would have gone to the licensee and done an assessment right away. RN-C stated these were all situations that required an assessment. RN-C stated with R1 coming and going from the hospital, and the incidents, she would have conducted an assessment to try to troubleshoot. RN-C stated it was obvious the licensee was not a safe place for R1. RN-C stated the LALD-D would get the full story from ULP staff about incidents occurring and relay this to RN-C as a summary at the time R1 had been sent to the hospital. RN-C stated she was not informed of all of R1's mental health incident's occurring that same day, or in the moment. RN-C stated she did not know why that was. RN-C stated she was available to be contacted by staff 24/7.</p> <p>During an interview, on February 2, 2026, at 3:51</p>	0 450		
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0 450	<p>Continued From page 25</p> <p>p.m. LALD-D stated R2 used methamphetamine and cocaine. LALD-D stated R1's routine was to use methamphetamine, he would have a crisis, and be sent to the hospital. LALD-D stated ULP staff were trained to fill out an incident report after every incident. LALD-D stated himself or ULP-B who identified as the administrator, reviewed incident reports. When asked about the eight mental health incidents that occurred between the dates of September 30 and October 6, 2025, LALD-D stated RN-C was notified after every incident. LALD-D stated staff documented who they notified. When questioned if he had any evidence that RN-C was notified after every one of R1's mental health incidents, LALD-D stated he may not have written that down. LALD-D stated RN-C documented whenever she notified the provider and said RN-C would notify the provider when R1 was in crisis.</p> <p>R2 R2's diagnoses included prostate cancer, hepatic cirrhosis, and severe alcohol use disorder.</p> <p>R2's signed service plan dated October 10, 2025, indicated R2's services included with medication administration, bathing, dressing/grooming, incontinence care, managing the resident's behaviors to include agitation, anxiety, physical aggression, repetitiveness, self-injurious, verbal aggression, depression, and other mental health needs.</p> <p>R2's assessment dated October 10, 2025, indicated R2 was independent with bed mobility, transferring in and out of bed, and walked independently using a cane and/or walker. R2 required staff medication administration, assistance with dressing/grooming, and assistance with incontinence care and brief</p>	0 450		
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0 450	<p>Continued From page 26</p> <p>changes. R2 was oriented to person, place and time.</p> <p>R2's individual abuse prevention plan (IAPP) dated October 10, 2025, indicated R2 was "now" on medication naltrexone (anti-substance abuse medication) due to increased alcohol intake. R2 was at risk of abusing themselves. R2 had increased alcohol use. R2 was at risk of falls while intoxicated. R2's IAPP did not include any specific interventions to include what to do if R2 was under the influence of alcohol. The same IAPP identified behaviors to include physical aggression, self-isolation, verbal aggression, and mental illness identified as depression. The IAPP did not include any specific interventions for any of R2's behaviors or mental illness.</p> <p>R2's Behavior Plan, undated, identified R2's behaviors as agitation, anxiety, physical aggression, repetitiveness, self-injurious, and verbal aggression. Triggers for R2's behavior identified alcohol use/consumption, and getting drunk. Each behavior included various interventions. For all of R2's behaviors, the IAPP indicated if behaviors escalated, then instruction to notify the "supervisor." The behavior care plan did not indicate notifying the nurse. Additionally, the behavior care plan failed to include interventions when R2 abused alcohol.</p> <p>R2's Medication Administration Record (MAR) dated September 2025, indicated R2 received naltrexone the entire month and it was not "new" as indicated in the IAPP dated October 10, 2025. R2's MAR dated October 2025, indicated R2 was compliant taking the naltrexone. On October 22, 2025 indicated R2 did not receive naltrexone because it was out of stock/no supply. R2 did not receive naltrexone for 7 days, the remainder of</p>	0 450		
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0 450	<p>Continued From page 27</p> <p>October 2025. R2's MAR dated November 2025, indicated R2 did not receive naltrexone 22 days due to no supply.</p> <p>R2's progress notes lacked documentation ULP reported R2 did not receive naltrexone to the RN.</p> <p>R2's progress notes dated November 11, 2025, during overnight shift, indicated R2 slept on and off , was restless, and irritated. R2 slept walked while hallucinating. ULP staff documented they monitored R2 until end of shift. The progress notes did not indicate ULP staff notified the RN of sleep walking and hallucinations.</p> <p>R2's progress notes dated November 13, 2025, during the overnight shift, indicated R2 appeared intoxicated, and was lying in bed fully clothed. R2 was alert, restless, displayed signs of agitation, and disorganized behavior. R2 talked to himself and appeared confused. The progress notes did not indicate ULP staff notified the RN of the change in cognition.</p> <p>R2's progress notes dated November 14, 2025, during the overnight shift, indicated R2 was awake, restless, and showed "clear signs of intoxication." R2 talked to himself, gait was unsteady and appeared disoriented to time. R2 was agitated and paced intermittently in his room. ULP staff documented they utilized verbal redirection and reassurance. ULP staff documented they assisted R2 with morning hygiene and provided verbal prompts and hand-on assistance due to "residual intoxication effects." The progress notes did not indicate ULP staff notified the RN of the change in cognition and intoxication with needing additional assistance for activities of daily living.</p>	0 450		

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0 450	<p>Continued From page 28</p> <p>R2's progress notes dated November 15, 2025 through November 22, 2025, indicated R2 continued consuming alcohol. At times he was aggressive while intoxicated, was unsteady, restless and irritable. ULP staff documented they provided education and reminders regarding the risks associated with drinking, excessive alcohol intake, impact on health, safety, and overall well being. Staff had to reorient R2. Staff continued periodic safety checks and monitoring due to alcohol consumption. The progress notes did not indicate ULP staff notified the RN.</p> <p>R2's progress notes dated November 22, 2025, during the overnight shift, indicated the shift started at 7:00 p.m. with a routine safety check on R2 to ensure his environment was secure and free of potential hazards. At the time of the initial check, R2 was observed to be restless and appeared agitated. R2 paced intermittently in his room and the hallway. ULP staff documented they redirected and reassured R2 by having a conversation with him, and his medications were administered. Later in the shift, R2 was noted consuming alcohol in his room. ULP staff documented they approached him to provide education and reminders regarding the risks associated with excessive alcohol intake, including its impact on his health, safety, and overall well-being. Despite these efforts, R2 continued drinking for a period of time and remained resistant to staff education. The progress notes did not indicate ULP staff notified the RN.</p> <p>R2's progress notes dated November 22, 2025, during morning shift, indicated at the start of the shift, a routine safety and environmental check was completed. ULP-B, the administrator, staff documented "during this assessment," staff noted</p>	0 450		
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0 450	<p>Continued From page 29</p> <p>R2 appeared unwell, weak, and fatigued. R2 reported he had vomited three times earlier in the morning at approximately 6:00 a.m. ULP-B documented they immediately checked R2's vital signs and documented the results in the system. The nurse on call was promptly notified of R2's condition and updated on his symptoms and current status. ULP-B documented "following the assessment," R2 declined to go to the hospital despite staff recommendations, stating he preferred to rest in his room.</p> <p>R2's progress notes for November 22, 2025, during evening shift, did not indicate R2 was observed consuming alcohol.</p> <p>R2's late-entry progress note dated November 23, 2025, at 7:30 a.m., written by ULP-E at 6:01 p.m., indicated R2 was asleep when shift started. Staff did a safety check on him. R2 woke up to use the restroom around 2:00 a.m. and returned to his room. Staff did another safety check around 5:00 a.m., R2 was in his room sleeping. Around 6:45 a.m. (ULP-E was no longer at the facility), "staff" heard a loud sound from R2's room. When "staff" rushed to R2's room, R2 was found unconscious on the floor. "Staff" immediately called 911 and started CPR. When EMS arrived, they continued resuscitation until R2 was pronounced dead around 7:15 a.m.</p> <p>R2 late-entry progress notes dated November 22, 2025, written by RN-C after R2's death on November 23, 2025 at 6:33 p.m., indicated staff reported R2 was not well. R2 reported vomiting and feeling weak. Vitals checked and blood pressure low. R2 refused to go to the hospital. RN-C advised staff to encourage fluids. Blood pressure rechecked was 104/81. R2 refused morning medications and reported he felt better</p>	0 450		
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0 450	<p>Continued From page 30</p> <p>after drinking a coke and some water. RN-C documented will continue to monitor.</p> <p>R2's death record indicated R2 passed away November 23, 2025. Manner of death was natural with causes of death to include prostate cancer and liver cirrhosis from severe alcohol use disorder.</p> <p>During an interview on January 28, 2026, at 10:15 a.m., ULP-A stated R2 would sneak or force alcohol into the licensee and this was not allowed. When drunk, R2 would become agitated, verbally and physically aggressive. If this occurred, and R2's behaviors escalated, ULP-A stated staff would provide R2 redirection, offer privacy, and provide a calm environment.</p> <p>During an interview on February 2, 2026, at 2:04 p.m., RN-C stated R2 had struggled with alcohol use for quite some time, and R2's naltrexone doses were adjusted in attempts to reduce his alcohol intake. RN-C stated R2 had continued to drink alcohol although he was advised not to. RN-C stated her last assessment of R2 was October 10, 2025. RN-C stated R2 had stopped drinking towards the end of life. RN-C stated she had conversations with R2 and R2 told her he had not been drinking alcohol. RN-C stated staff were supposed to alert her if R2 drank. When asked if she knew R2 was observed drinking alcohol and/or intoxicated during November 2025, she stated no, staff did not make her aware. RN-C stated she had access to progress notes and read progress notes. RN-C stated prior to R2 passing away, R2 was on a medication that could cause drowsiness. R2 was advised not to drink. RN-C stated when she conducted assessments for residents, the IAPP was developed, and vulnerabilities were assessed. When asked</p>	0 450		

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0 450	<p>Continued From page 31</p> <p>where on the IAPP were specific interventions for R2's alcohol use and behaviors, RN-C stated that should have been identified. RN-C stated the interventions included staff trained on redirection, providing counseling, and attempting to calm residents down with any behaviors. If these interventions were not working, staff were supposed to call COPE (mobile crisis mental health services) or call 911. RN-C stated she has heard about behavior plans at other licensee's however she was not aware R2 had a behavior plan at this licensee. RN-C stated she had worked at the licensee since April 2025.</p> <p>An email dated February 2, 2026, at 7:58 p.m., from LALD-D, indicated attached to the email was the alcohol and drug use notice posted in the facility.</p> <p>Review of the attached notice indicated: NO ALCOHOL NO DRUGS NO SMOKING NO WEAPONS.</p> <p>Review of document titled "Observations to Report to the Supervising Nurse" undated, indicated to observe closely, accurately, and report promptly. The document included a list of what to report. On the list included to report, all symptoms complained by the resident including symptoms observed but not complained about. The document included to report mental disturbances. The document did not include notifying the nurse regarding anything related to alcohol use.</p> <p>The licensee's policy titled Nursing assessment and Reassessment of Residents, undated, indicated ongoing reassessment and monitoring would be conducted as needed based on changes in needs of the resident. The RN would</p>	0 450		

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0 450	Continued From page 32 reassess the resident any time the resident had a change in condition or experienced any unusual symptoms. The licensee's policy titled Abuse Prevention Plan, undated, indicated the Abuse Prevention Plan document would identify areas of vulnerability and safety concerns. Interventions to address areas of concern would be documented on the plan and included on the resident care plan. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 450		
01690 SS=G	144G.71 Subdivision 1 Medication management services (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber,	01690		

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01690	<p>Continued From page 33</p> <p>pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement medication management policies and procedures with orderly medications timely and address medication omissions with the rationale as "out of stock" for one of one resident (R2) reviewed.</p> <p>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>R2's diagnoses included prostate cancer, hepatic cirrhosis, and severe alcohol use disorder.</p> <p>R2's signed service plan dated October 10, 2025, indicated R2's services included medication administration.</p> <p>R2's assessment dated October 10, 2025,</p>	01690		
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01690	<p>Continued From page 34</p> <p>indicated the licensee managed the resident's medications. The assessment indicated the licensed nurse was responsible for medication supplies and reordering as needed. R2 was oriented to person, place, and time.</p> <p>R2's individual abuse prevention plan (IAPP) dated October 10, 2025, indicated R2 was "now" on medication naltrexone (anti-substance abuse medication) due to increased alcohol intake. R2 was at risk of abusing themselves. R2 had increased alcohol use. R2 was at risk of falls while intoxicated.</p> <p>R2's Medication Administration Record (MAR) dated September 2025, indicated R2 received naltrexone 50 milligrams (mg) once daily. R2 received the naltrexone 29 out of 30 days.</p> <p>R2's MAR dated October 2025, indicated R2 received naltrexone everyday from October 1 through October 20, 2025. Unlicensed personnel (ULP) failed to document administration on October 21, 2025. ULP documented starting on October 22, 2025, naltrexone medication was "out of stock," and the nurse was notified.</p> <p>R2's progress notes dated October 22, 2025, written by ULP-A, indicated R2 was frustrated waiting for his medications to be delivered by the pharmacy and the delay was taking too long.</p> <p>A review of R2's progress notes dated October 23, 2025 through November 3, 2025, lacked evidence of attempting to fill R2's naltrexone medication or contact with the pharmacy. R2 experienced on several occasions increased agitation and ULP documented R2 drank alcohol.</p> <p>R2's progress note dated November 4, 2025,</p>	01690		

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01690	<p>Continued From page 35</p> <p>written by registered nurse (RN)-C, indicated R2 had congestion. RN-C documented she would schedule an appointment with the provider and addiction clinic to address naltroxone [sic] orders (after not receiving the medication for 15 days).</p> <p>R2's progress notes dated November 5, 2025 through November 9, 2025, lacked evidence of R2 attending a medical provider appointment to address naltrexone orders. R2 continued with occasions of agitation and alcohol consumption.</p> <p>R2's progress noted dated November 10, 2025, written by RN-C, indicated RN-C called R2's provider to inform of a fall, but the note lacked indication the naltrexone prescription was addressed.</p> <p>R2's progress notes dated November 11, 2025 through November 14, 2025, lacked evidence of R2 attending a medical provider appointment to address naltrexone orders. R2 continued with occasions of agitation and alcohol consumption.</p> <p>R2's progress noted dated November 15, 2025, written by RN-C, indicated R2 was seen by this medical provider and had medication order changes, but did not include any changes in the naltrexone. The provider also ordered a cough suppressant medication. The note indicated the medical provider was updated about R2's refusal of gabapentin. The note lacked indication if there was an issue obtaining a prescription to reorder the naltrexone.</p> <p>R2's progress notes dated November 16, 2025 through November 20, 2025, lacked evidence of R2 attending a medical provider appointment to address naltrexone orders. R2 continued with occasions of agitation and alcohol consumption.</p>	01690		

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01690	<p>Continued From page 36</p> <p>R2's progress noted dated November 21, 2025, written by ULP-A, indicated R2 had an appointment with his addiction medicine provider and he attended the appointment. The note lacked indication a prescription was received to reorder naltrexone.</p> <p>R2's MAR dated November 2025, indicated R2's naltrexone medication was not administered any of the days from November 1 through November 22, 2025. ULP documented the rationale was out of stock, and the nurse was notified.</p> <p>R2's death record indicated R2 died on November 23, 2025.</p> <p>During an interview on March 24, 2026, at 12:00 p.m., RN-C stated she was not informed by staff the resident's naltrexone was out of stock, she said she did not receive any calls from pharmacy, nor was she told R2 was not taking naltrexone in October or November 2025. RN-C stated it was an expectation and protocol staff informed her right way if a medication was out of stock or if a resident was not taking a medication so she could find out why. RN-C stated R2 chose not to take certain medications at certain times, it was not because medications were unavailable. RN-C stated staff may have documented "out of stock" and they may have meant he was choosing not to take the medication. RN-C stated upon disposal of R2's medications, 27 tablets of R2's naltrexone were destroyed.</p> <p>The licensee's policy titled Medication Management Plan and Record, undated, indicated the medication plan identifies persons responsible for monitoring medication supplies and ensure medication refills are ordered on</p>	01690		

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01690	<p>Continued From page 37</p> <p>timely basis.</p> <p>The licensee's policy titled Content of Resident's Medication Records, undated, indicated if the medication was not administered as prescribed, the reason why the medication was not administered as prescribed would be documented and any follow up procedures that were provided.</p> <p>The licensee's policy titled Medication Prescription and Refills, updated, indicated if concerns arise about a medication, such as potential side effects, interactions, or ineffectiveness of the medication the RN or LPN would contact the prescriber, and would facilitate communication between the resident and the prescriber to resolve the problem.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	01690		
02360	<p>144G.91 Subd. 8 Freedom from maltreatment</p> <p>Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act.</p> <p>This MN Requirement is not met as evidenced by: The facility failed to ensure one of two resident(s) reviewed (R1) was free from maltreatment.</p> <p>Findings include:</p> <p>The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, the facility and an individual person were</p>	02360	Refer to the maltreatment report sent separately.	

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02360	Continued From page 38 responsible for the maltreatment in connection with incidents which occurred at the facility. Please refer to the public maltreatment reports for details.	02360		