Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL218039262M
Compliance #: HL218037843C

Date Concluded: May 7, 2025

Name, Address, and County of Licensee Investigated:
Brookside Senior Living
804 Benson Road
Montevideo, MN 56265
Chippewa County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name: Erin Johnson-Crosby, 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 the resident when the facility did not assess the resident's change in condition leading to hospitalization.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. Nursing staff failed to assess, monitor, and implement interventions to address the resident's change in condition following a diagnosis of influenza.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record, hospital records, facility incident reports, staff schedules, and related facility policy and procedures. Also, the investigation included an onsite visit, observations, and interactions between residents and facility staff.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia, depression, and high blood pressure. The resident's assessment indicated the resident was cognitively impaired, required one assist for toileting, and supervision or one assist for transfers, walking, and bed mobility.

The resident's service plan included assistance with medication administration, bathing, dressing, grooming, toileting, safety checks at night, and monitoring of skin conditions twice daily. The service plan did not indicate the resident required assistance with bed mobility, transfers, eating, drinking, or meal assistance.

The resident's medical record indicated the resident was sent to the Emergency Room (ER) for weakness, loss of appetite, low oxygen saturation and a fever. The resident was diagnosed with influenza and sent back to the facility with ordered medication. The resident was not assessed upon his return from the ER and no additional interventions or monitoring were implemented regarding the resident's change in condition.

The resident fell three days after his return from the ER. The resident's vital signs included oxygen saturation of 87% (normal rate 95-100%) and a blood pressure reading of 177/78 (normal 120/80). Staff were instructed to implement safety checks on the resident and report any additional change in cognition or pain level. The medical record did not include an updated assessment, follow-up or reporting of the abnormal vital signs, or additional interventions to support or monitor the resident's condition.

The next day, the resident was unable to stand or transfer from the recliner to a standing position due to weakness. The medical record did not include an updated assessment, change to the service plan, or additional interventions to support the resident's condition and change in transfer status.

Three days later, the medical record indicated the resident had a decline in functional status, and unlicensed staff had been using the EZ stand (mechanical lift) to transfer the resident for the last two days. The resident was now unable to use the EZ stand and required a three person assist off of the toilet. The resident had little to no oral intake in the past two or three days with minimal to no output. Staff called emergency medical services (EMS) for evaluation and the resident was discharged back to the facility with the same diagnoses of influenza A. The medical record did not include an updated assessment, service plan, or additional interventions implemented following the resident's decline in condition, change in transfer status, or second ER visit.

The resident's hospital records indicated the resident was sent to the ER, diagnosed with Influenza A, and sent back to the facility. Seven days later the resident was again sent to the ER for weakness. The resident still had EKG (electrocardiogram) patches on his chest from the previous ER visit and dried food on his clothing, but facility records indicated the resident hadn't eaten in the last two days. The resident also had no stool in his incontinent product but had

dried feces on his inner thighs and abdominal folds. Hospital documentation questioned if the resident was properly cared for when completing cares. The resident did not require hospitalization at that time but did need better care offering more food, fluids, and assistance with transfers. The resident returned to the facility with new orders. Two days later, the resident returned to the ER again for weakness and refusal to take food/fluids for over 24 hours but had chocolate pudding in his mouth. The resident was admitted with a diagnosis of pneumonia and passed away five days later.

During an interview, a licensed practical nurse (LPN) stated if a resident had a change in condition and required additional services, the resident may or may not be allowed to return to the facility after hours or on a weekend after an ER visit. The LPN stated unlicensed staff should have notified nursing right away about a change in condition. The LPN stated if a change in condition assessment and updated service plan was not completed, the unlicensed staff would not know how to care for the resident.

During an interview, the contracted registered nurse (RN) stated her first day as the interim director of health services (DHS) was four days after the resident's first ER visit. The RN stated she was not notified of the resident's decline for two days and should have been notified immediately and an assessment should have been completed. The RN stated she was contracted staff and was not expected to come in after hours or on the weekend.

During an interview, the licensed assisted living director (LALD) stated unlicensed staff should notify a nurse immediately if there was a change in a resident's condition. The LALD stated if there was a significant change in condition the RN would be expected to come in and complete an assessment and if there was not a RN available, the resident would have to stay at the hospital. The LALD stated if an assessment was not completed, and a service plan not updated the unlicensed staff would not know how to care for the resident. The LALD was not aware of the concerns regarding the resident's unkempt appearance while at the ER.

During an interview, the regional RN stated unlicensed staff should have notified nursing right away when a change of condition was observed. The RN stated if there was a change in condition the nursing staff should attempt to have the hospital wait until Monday to send the resident back so the facility could re-evaluate the resident if a nurse was not available after hours or on the weekend. The RN stated since a change in condition assessment and updated service plan was not completed unlicensed staff would not know how to care for the resident.

During an interview, the resident's family member (FM) was aware there was a lot of staff turnover, so it was difficult to receive consistent communication. The FM stated he asked staff questions and staff would not be able to answer the questions because the staff did not know the resident.

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: No. The resident was deceased.
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
Chippewa County Attorney
Montevideo City Attorney
Montevideo Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21803	A. BUILDING: _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE SENIOR LIVING	804 BENSON ROAD MONTEVIDEO, MN 56265

(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: #HL218037843C/#HL218039262M February 28, 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 64 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for ##HL218037843C/#HL218039262M, tag identification 1640, 1760, 2310, and 2360.	0 000		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must	01640		

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01640	Continued From page 1 include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan was revised and updated based on resident reassessment and needs for one of one resident (R2) reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) 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). The findings include: R2's was admitted on July 16, 2024, with	01640		

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01640	Continued From page 2 diagnoses including a stroke with left sided hemiplegia (one sided paralysis or weakness) and sleep apnea. R2's service plan dated February 4, 2025, indicated R1 required assist of one with ambulation. The plan also indicated assistance with stretching R2's left side, behavior interventions, and toileting. The service plan did not indicate how staff should transfer R2. R2's change in condition assessment following a hospital stay, dated February 10, 2024, indicated R2 was at a high risk falls with cognitive impairment. The assessment indicated R2 required one assist for transfers with the sit to stand lift and was unable to ambulate. There were no changes made to the service plan to indicate R2's updated transfer status. R2's Physical Therapy (PT) notes dated October 29, 2024, indicated nursing reported they had been using assist of three staff for transfers, but it was very difficult and used an EZ stand (sit to stand lift) earlier in the day. Nursing staff were present during the PT session and R2's change in ability to complete transfers were discussed. Nursing was going to contact R2's family and provide an update. R2 was unable to ambulate at that time. R2's medical record did not include additional therapy notes. No changes were made to R2's service plan following the PT notes and discussion on October 29, 2024. On February 28, 2025, at 9:50 a.m., the investigator observed R2 sitting in the memory care (MC) unit in a recliner with a gait belt around his waist. The recliner leg rest was up, and R2's feet were hanging over the leg rest. R2 had food on his face and clothes. Unlicensed personnel	01640		

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01640	Continued From page 3 (ULP)-J and ULP-K pivot transferred (2 staff assist transfer) R2 from the recliner to the wheelchair. R2 was unsteady and did not bear his own weight during the transfer and R2's left arm hung down and left leg dragged on the floor as the staff assisted and completed the transfer. On February 28, 2025, at 10:00 a.m., ULP-J stated R2 required two staff to assist for transfers. The investigator asked ULP-J if she had R2's service plan available to show where R2's transfer status was located but ULP-J stated she was responsible for activities and did not have R2's services on her task list. On February 28, 2025, at 10:07 a.m., ULP-K was asked to show the investigator R2's transfer status located on the taks list. ULP-K stated the task list indicated R2 could use his walker, EZ stand or his cane for transfers but did not say how many staff were required for transferS. On February 28, 2025, at 12:40 p.m., ULP-J and ULP-K transferred R2 with the EZ stand an noted they used the EZ stand since he was not helping to stand during their earlier transfer. R2's service check-off list dated February 2025, indicated R2 required hands on assist of one for toileting with the EZ stand for the night shift, but did not include how R2 should be transferred during the day and evening shifts. On February 28, 2025, at 2:45 p.m., licensed practical nurse (LPN)-L stated R2 was to be transferred with assist of one using the EZ stand. LPN-L stated R2 also had an ambulation task identified on the service list as the daughter was not ready to have that service removed. Physical therapy (PT) recommended the hoyer lift due to	01640		

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01640	Continued From page 4 left sided hemiplegia and noted that the EZ stand should not be used long term. LPN-L acknowledged that they did not document that conversation with PT. LPN-L stated ULPs should follow what was on the service plan when providing care to residents and there was not a separate service which described how the resident transferred and that transfer status would be included under toileting assistance. LPN-L stated if the service plan needed to be updated she could make the changes and then let the nurse know a change in condition assessment would need to be completed. On February 28, 2025, at 3:35 p.m., RN-I confirmed there was not a separate transferring service identified on R2's service list and that transfer status would be included under toileting. RN-I acknowledged R2's service plan did not include a description of how R2 should be transferred during the day and evening. RN-I stated she could see the inconsistencies identified by the investigator and would update resident's service plans to include transfer status. The licensee's Initial, Ongoing, and Change in Condition Assessment-Evaluation of Residents, dated February 7, 2025, indicated the RN is responsible for monitoring residents for a change in condition. If a resident's care needs have changed warranting aspects of the comprehensive assessment to be changed or has changes to service needs for more transfer assistance would require new comprehensive assessments completed. The licensee's Delegation of Nursing tasks, dated February 7, 2025, indicated prior to delegating a nursing task included completion of a nursing assessment of the resident's functional status	01640		

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01640	Continued From page 5 and need for nursing services; developing a service plan for providing the services according to the resident's needs and preferences; determining the unlicensed person is trained and competent and has been instructed in the proper methods to perform the procedures with respect to the specific resident; including written instruction for performing the procedure for the resident in the resident's record; and orienting the staff to the resident either in writing, in person or orally. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	01640		
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications	01760	Minnesota Department of Health is documenting the State Correction Orders	

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01760	Continued From page 6 were administered as prescribed and documented in the resident record for one of one resident (R1). In addition, the licensee failed to implement a system to identify, document, track, and evaluate medication errors and failed to document procedures provided to meet resident needs when medication was not administered as prescribed in accordance with resident medication management plans. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1's face sheet indicated R1 admitted to the facility on August 25, 2020, with diagnoses of dementia, depression, and hypertension (high blood pressure). R1's comprehensive assessment dated November 22, 2024, indicated R1 resided in memory care and was cognitively impaired. The assessment indicated R1 was depressed, had mental health concerns and received Sertraline (antidepressant). R1's Individualized Medication Management Plan, dated November 22, 2024, indicated R1 was dependent on staff to ensure correct medications were administered. Unlicensed staff were instructed to contact the licensed nurse with questions or problems such as missing doses or	01760	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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01760	Continued From page 7 medication. Licensed staff ordered medications for direct care staff to administer. R1's service plan, dated December 27, 2024, included R1 required assistance with meals, dressing, grooming, medication administration, safety checks at night, skin condition monitoring twice daily and showers twice weekly. R1's August 30, 2024. physician orders included an order for Sertraline 100 milligrams (mg) two tablets daily. R1's December 2024, medication administration record (MAR) indicated Sertraline was not administered 31 out of 31 days. R1's medical record did not include a rationale for the omitted medication. R1's January 2024, MAR indicated Sertraline was not administered 28 out of 31 days. R1's medical record did not include a rationale for the omitted medication. R1's progress notes dated January 17, 2025, indicated R1 had not received Sertraline for the last week. The registered nurse (RN) requested a hold order from the primary care physician (PCP) until the medication became available. The note to the PCP did not indicate R1 had been out of Sertraline since December 1, 2024. There were no additional interventions implemented following the abrupt discontinuation of Sertraline. The medical record did not include immediate notification of the resident's family and PCP of R1 not being administered the medication for December 2024 through January 17, 2025. In response to the January 17, 2025 fax, an emergency hold order for Sertraline was provided	01760		

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01760	Continued From page 8 on January 22, 2025, and R1's Sertraline was re-started on January 29, 2024. Facility documentation included no identification of R1's Sertraline medication error despite being identified by staff on January 17, 2025. There was no documentation of why the medication was not administered and documented as prescribed and no documentation of follow-up procedures following identification of the error. On February 28, 2025, at 2:45 p.m., licensed practical nurse (LPN)-A stated since the Sertraline had not been given for so long it would be considered a medication error and a medication incident report should have been completed. LPN-A stated at that time the registered nurse (RN) was responsible for ordering medications. LPN-A stated unlicensed staff should have notified the RN the medication was out. The electronic medical record had a feature were omitted medications were listed and the RN should have been checking the list. LPN-A was not aware of any facility wide training conducted following the medication error. On February 28, 2025, at 3:35 p.m., RN-I stated if the medication was out for that long it would be considered a medication error and at that time the RN was responsible for ordering medications. RN-I was not the RN at the time of the incident and had no knowledge of the medication error. RN-I stated the unlicensed staff should have told the nurse every time the medication was not available. On March 7, 2025, at 12:05 p.m., RN-C stated he was the director of health services (DHS) until January 24, 2025. RN-C stated he noticed Sertraline was missing on January 17, 2025.	01760		

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01760	Continued From page 9 RN-C was not aware a medication error report was required. RN-C stated he could not recall the specifics of the omitted Sertraline, and did not know why the medication was circled on the electronic medical record (EMAR) indicating the medications was not administered. On March 11, 2025, at 4:09 p.m., family member (FM)-G stated he was not aware R1 had not received the scheduled antidepressant for December 2024 and January 2025. FM-G stated this was "extremely upsetting, he did not get his medicine." On March 27, 2025, at 11:00 a.m., RN-I stated correct information regarding the medication error should have been shared with R1's PCP, and family. There should also have been a medication error incident report completed. RN-I stated an antidepressant should not have been discontinued abruptly. Medication information regarding the antidepressant Sertraline from www.drugs.com indicated abruptly stopping antidepressant treatment, or tapering your dose down too quickly, can result in withdrawal side effects which are usually mild but can be severe in some people. Do not discontinue Sertraline treatment on your own and should be reduced over at least two to four weeks to help reduce symptoms. If taking a higher dose or taking the antidepressant for an extended period of time, the provide may decide to decrease your dose even more slowly, in some cases over six to 12 weeks. The licensee's Medication Administration policy dated March 5, 2024, indicated medication errors will be reported to the licensed nurse who will determine the appropriate action. The resident's	01760		

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01760	Continued From page 10 physician and family will be notified in a timely manner. The information will be documented in the resident record. A medication error form must be completed. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
02310 SS=G	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 record review, the licensee failed to ensure assisted living services were provided based on resident needs according to an up-to-date service plan and accepted healthcare standards for one of one resident (R1) who had a change in condition. Nursing staff failed to assess, monitor, and implement interventions for R1 following a hospital return with a diagnosis of influenza and ongoing decline in condition. 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 an isolated scope (when one or a limited number of residents are affected or one or	02310		

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02310	Continued From page 11 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's face sheet indicated R1 admitted to the facility on August 25, 2020, with diagnoses of dementia, depression, and hypertension (high blood pressure). R1's comprehensive assessment dated November 22, 2024, indicated R1 resided in memory care and was cognitively impaired. R1 required assistance with toileting, supervision or one assist for transfers, walking, and bed mobility. R1's service plan, dated December 27, 2024, included R1 required assistance with meals, dressing, grooming, medication administration, safety checks at night, skin condition monitoring twice daily and showers twice weekly. The service plan did not indicate the resident required assistance with bed mobility, transfers, food/fluids. R1's progress notes dated January 31, 2025, indicated unlicensed personnel (ULP) notified a registered nurse (RN) that R1 had increased weakness, loss of appetite, low oxygen saturations and a fever. Staff were instructed to call emergency medical services (EMS). R1 was diagnosed with influenza A, prescribed medications, and was sent back to the facility. R1's February 2025, service check off list (documentation of service provided) indicated staff monitoring of skin condition twice daily. The service check off list also indicated R1 received a shower on February 4, 2025.	02310		

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02310	Continued From page 12 R1's progress notes dated February 3, 2025, ULP notified the RN that R1 fell, denied pain and had no change in range of motion. R1's oxygen saturation was 87% (normal range 90-100) blood pressure 177/78 (normal range 120/70) and temperature of 99 (normal range 97-98). The RN directed staff to assist R1 off of the floor, complete safety checks on the resident, and report any change in cognition or pain level. Vital signs and reassurance checks were also initiated for three days following the fall. Following the February 3, 2025 fall, R1's medical record did not indicate that an assessment was completed and no updates were made to the service plan to include the safety checks or monitoring of cognition, pain level, vital signs or reassurance checks. R1's progress note dated February 4, 2025, (late entry written February 11, 2024), indicated R1 was unable to stand or transfer from the recliner to a stable position due to weakness related to a new diagnosis of Influenza A. Staff were to continue monitoring R1 for changes in condition or further complications related to Influenza A and notify nurses of any changes. R1's medical record did not include an updated assessment, an updated service plan and additional interventions implemented following R1's increased needs identified on February 4, 2025. R1's progress note dated February 7, 2025, at 3:57 p.m., indicated R1 had a decline in functional status and ULP's were using an EZ stand for transfers for the past two days. R1 was not unable to use the EZ stand and required three	02310		

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02310	Continued From page 13 person assist off of the toilet. ULP's also reported R1 had minimal to no intake for the past two to three days and minimal to no urine output. R1 was now displaying aggressive and combative behaviors when staff attempted to complete cares or transfers. Staff were instructed to contact EMS for evaluation. R1 was sent to the ER. R1's medical record did not include evidence R1 was assessed, no updates were made to the service plan, and no new interventions were identified related to R1's noted change in condition indicated in the February 7, 2025 progress note of R1's change in condition over the past two days. R1's hospital records indicated R1 was seen in the ER on January 31, 2025, and diagnosed with Influenza A and was discharged back to the licensee. The hospital records indicated on February 7, 2025, R1 returned to the emergency room (ER) due to weakness and requiring a higher level of care than the facility could provide. Upon return to the ER, R1 still had electrocardiogram (EKG) patches on his chest, had dried food on his clothing but had not eaten in the last two days. R1 also had dried on feces on his inner thighs and abdominal creases. Hospital notes indicated a concern for skin break down and lack of care provided by the facility. R1's progress note dated February 7, 2025, at 11:06 p.m., indicated the hospital ER notified the RN that R1 was being discharged back to the facility as there was nothing else wrong with the resident besides the previously diagnosed influenza A. R1 was to remain on contact isolation precautions.	02310		

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02310	Continued From page 14 R1's medical record did not include an updated assessment, service plan or additional interventions implemented following R1's increased needs and changes to services including isolation precautions following R1's February 7th, 2025 ER visit and return to the facility. R1's progress note dated February 8, 2025, at 8:38 a.m., indicated R1 refused breakfast, wanted to stay in bed and his skin was clean and dry. Staff were directed to monitor and report any changes of the resident's current baseline. R1's progress note dated February 9, 2024, at 11:22 a.m., indicated R1 continued to refuse oral liquids and food and did not have any urine output. R1 refused vital sign checks and became agitated with staff and wanted to stay in bed. Staff were instructed to contact EMS services for evaluation. R1 was transferred to the ER. R1's progress notes dated February 10, 2025, at 2:11 p.m., indicated hospital staff contacted the facility nurse and reported R1 was a max of two assist with activities of daily living and were looking to discharge R1 to a higher level of care. R1's progress notes dated February 17, 2025, at 3:25 p.m., indicated R1 passed away at the hospital on February 14, 2025. On March 7, 2025, at 10:00 a.m., licensed practical nurse (LPN)-A stated if a resident had a change in condition and required additional services, the residents may or may not be allowed to return to the facility after hours or on a weekend after an ER visit. LPN-A stated staff should have notified nursing right away about a change in condition. LPN-E stated if a change in	02310		

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02310	Continued From page 15 condition assessment and updated service plan was not completed, the ULP would not know how to care for R1. On March 7, 2025, at 10:40 a.m., RN-B stated her first day as the interim DHS was February 4, 2025. RN-B stated on February 7, 2025, facility staff notified her of R1's functional decline. RN-B stated she was a contracted employee and was not required to be on call or work weekends so she would not have been responsible to go onsite after hours or on the weekend. RN-B stated a RN should have been notified immediately of R1's changes and a change of condition assessment should have been completed. On March 7, 2025, at 2:00 p.m., Licensed Assistive Living Director (LALD)-E stated, unlicensed staff should have notified a nurse immediately if there was a change in condition. If there was a significant change in condition the RN would be expected to come in to complete an assessment and update the service plan. At the time of this incident there was a contracted interim DHS that would not have been responsible to be onsite after hours or on the weekend. LALD-E stated if an assessment or updated service plan was not completed, unlicensed staff would not know how to care for the resident. On March 27, 2025, at 11:00 a.m., RN-H (regional RN) stated unlicensed staff should notify nursing right away when a change of condition was noticed. The RN stated if there was a change in condition the nursing staff should have attempted to have the resident return on a weekday so a nurse could have re-evaluated the resident if a nurse was not available on the weekend or after hours. RN-H stated the	02310		

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02310	Continued From page 16 unlicensed staff would not know what service the resident required if an assessment or updated service plan was not complete. The licensee's Initial and Ongoing Change in Condition Assessment- Evaluation of Residents policy dated February 7, 2025, indicated the RN is responsible for monitoring resident for a change in condition. If a resident's care needs have changed or has changes to service needs such as a new pressure wound, new addition to medication management services, need for more transfer assistance or admission to hospice would require a new comprehensive assessment. Upon return from the hospital, emergency department, skilled nursing facility or transitional care unit all residents will have their service care needs reassessed by a registered nurse. If care needs have changes, or their aspects of their comprehensive assessment needs updating the RN will complete all the comprehensive assessment in the medical record. The licensee's initial and ongoing assessment-observation of clients dated February 7, 2025, the licensed nurse will reassess/re-observe the client and update the service plan based on client's needs. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment	02360		

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02360	Continued From page 17 covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R1) 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		