



Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL253803962M
Compliance #: HL253804620C

Date Concluded: August 2, 2024

Name, Address, and County of Licensee

Investigated:

Diamond Willow Assisted Living
1558 Randolph Road
Detroit Lakes, MN 56501
Becker County

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

Evaluator's Name:

Jana Wegener, RN, Special Investigator

Finding: Substantiated, facility responsibility
Not Substantiated

Nature of Investigation:

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

Initial Investigation Allegation(s):

The resident was abused when facility staff restrained the resident using chemical restraints, bed railings, and other objects. Then, staff forced dentures into the resident's mouth causing the resident to cry and be visibly shaken.

In addition, the resident was neglected when staff failed to provide the resident assistance with cares and the resident was observed wearing food encrusted clothing and smelling of urine with a saturated brief.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the neglect. The facility failed to ensure toileting and incontinence care was consistently provided. The resident was observed multiple times over several months in soiled clothing with a saturated incontinence brief.

The allegation of abuse was not substantiated. The residents medications, side rails, and body pillow was reviewed and no restraints were identified.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family members, and hospice providers. The investigation included review of the resident record(s), facility incident reports, complaints, grievances, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed the resident and staff at the facility.

The resident resided in an assisted living facility memory care unit with diagnoses including dementia with behavioral disturbance, cognitive deficits, delusional disorder, and hallucinations.

The resident's assessment, service plan, and care plan indicated the resident required full assistance from staff with dressing, grooming, and assistance from 2 staff with transfers, toileting, incontinence care, and repositioning every 2-3 hours and PRN. The resident assessment indicated the resident utilized a hospital bed with half side rails for mobility and repositioning which met FDA guidelines to prevent entrapment.

The resident's individual abuse prevention plan (IAPP) identified the resident was at risk to be abused, and indicated staff were trained to identify and report abuse and neglect.

The resident's medication administration record (MAR) was reviewed and indicated the resident was prescribed lorazepam 0.5 mg every 4 hours PRN. The resident record showed the medication was utilized appropriately 1-2 times a day, 12 out of 30 days, for resistance of cares, aggression with cares, anxiety, restlessness, repeatedly yelling out for help, and indicated the medication was effective.

The facility complaints and grievances indicated the resident's family had reported staff refused to provide toileting when the resident requested to use the bathroom. The report indicated the resident was to be toileted every 2 hours, but staff told the resident that was what his brief was for.

The resident's toileting service recap report from April to June indicated the resident's every 2-hour toileting service was scheduled only one time each 8-hour shift, and instructed staff to check, change, and reposition the resident every 2 to 3 hours, assist the resident with incontinence cares, and take the resident to the bathroom as he requested. The documentation indicated staff had not consistently provided toileting or incontinence care as indicated in the resident's service plan/agreement. The report identified the resident was either not provided any toileting or incontinence care, or the service was only provided one time during an 8-hour shift 48 out of 90 shifts in April, 40 out of 93 shifts in May, and 36 out of 90 shifts in June. In addition, multiple staff on numerous occasions documented completing the toileting service at the beginning of their shift, and prior to providing the service.

When interviewed a unlicensed personnel (ULP) staff stated she observed the resident in his bed saturated through his brief, soaker, and bedding. The staff stated it appeared the resident had not received cares for some time. The staff stated recently the facility had implemented change of shift rounding and if the resident was found soaked like that on rounds the previous staff had to stay and clean him up and change his bedding. The ULP staff stated some staff refuse to do the rounding, but she reported the concern to nursing.

Another ULP staff stated the resident was saturated with urine in his bed a few days ago, appeared uncomfortable, and his blankets were soaked, and all messed up. The ULP staff stated it appeared as though staff had not provided care to the resident "for a while." The ULP staff indicated she had repeatedly observed the resident soaked like that several times in the last month. The ULP staff indicated she observed the resident left in food crusted soiled clothing from the previous day. The ULP stated she reported the concerns to facility leadership.

Another ULP staff stated she had concerns staff were not toileting or changing the resident as they should and had found the resident soaked in urine. The staff stated the facility implemented a new system recently and if the resident was found soaked in urine the previous shift had to stay and change the resident. The ULP staff indicated the resident was frequently observed soaking wet with urine at the start of her shift.

Another ULP staff stated the resident had not been toileted or changed and was soaked when she came on shift in the evening. The staff indicated she reported the concern to leadership.

Another ULP staff stated the resident was not being toileted, checked, or changed every 2-3 hours, and stated some staff are not good about changing the resident as often as he should be.

When interviewed leadership staff stated the resident received frequent checks and scheduled toileting. Leadership staff indicated the facility had implemented a change of shift walk through to ensure cares were provided to resident's the end of April.

Although the facility implemented a process for staff to complete change of shift rounding, there was no indication the process ensured services were provided to the resident. Staff reported the resident continued to be soaked at the start of their shift, and documentation indicated the resident continued to not receive toileting or incontinence cares as indicated on his service plan. Multiple staff stated they reported ongoing concerns to the facility, but no action was taken to ensure the resident received toileting services needed.

When interviewed the resident's hospice staff indicated the resident had been observed on numerous occasions uncared for by facility staff, soaked in urine through his brief, clothing, soaker, and bedding, with food encrusted clothing unchanged from the previous day, and a strong smell of urine.

When interviewed the resident's family stated the resident was not toileted, checked, or changed as he should be. The family indicated they had observed the resident soiled, saturated, and smelling of urine on numerous occasions. The family stated some staff do not want to toilet the resident and told the resident to go in his brief when he had asked to use the toilet. The family indicated the care the resident received varied day to day depending on which staff was working. The family denied any concerns with restraints at this time.

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

"Not Substantiated" means:

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

Abuse: Minnesota Statutes section 626.5572, subdivision 2.

"Abuse" means:

(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:

- (1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
- (2) the use of drugs to injure or facilitate crime as defined in section 609.235;
- (3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
- (4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.

A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.

(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:

- (1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
- (2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening;
- (3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult; and
- (4) use of any aversive or deprivation procedures for persons with developmental disabilities or related conditions not authorized under section 245.825.

Vulnerable Adult interviewed: Yes

Family/Responsible Party interviewed: Yes

Alleged Perpetrator interviewed: Yes

Action taken by facility:

No action was 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

Becker County Attorney

Detroit Lakes City Attorney

Detroit Lakes Police Department

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25380	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/24/2024
NAME OF PROVIDER OR SUPPLIER DIAMOND WILLOW ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 1558 RANDOLPH ROAD DETROIT LAKES, MN 56501		
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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>#HL253803962M/#HL253804620C</p> <p>On June 24, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 28 residents receiving services under the provider's Assisted Living with Dementia Care license.</p> <p>The following correction orders are issued for #HL253803962M/#HL253804620C, tag identification 0620, 0630, 0730, and 2360.</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>	
0 620 SS=D	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma	0 620		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 620	<p>Continued From page 1</p> <p>(a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported.</p> <p>The requirement in Minnesota Statute section 626.557, Subd. 3 is:</p> <p>(a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless:</p> <p>(1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or</p> <p>(2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4).</p> <p>(b) A person not required to report under the provisions of this section may voluntarily report as described above.</p> <p>(c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point.</p> <p>(d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.</p>	0 620		

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0 620	<p>Continued From page 2</p> <p>(e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to report an allegation of abuse to the Minnesota Adult Abuse Reporting Center (MAARC) for one of one resident's (R1) when it was reported an unlicensed staff (ULP)-C was observed forcefully putting in R1's dentures which caused the resident to cry and appear visibly shaken.</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) 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>Findings include:</p>	0 620		

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0 620	<p>Continued From page 3</p> <p>R1 was admitted to the licensee on January 31, 2022, with diagnoses including dementia with behavioral disturbance, cognitive deficits, delusional disorder, and hallucinations.</p> <p>A common entry point Minnesota Adult Abuse Report #560462628 indicated a staff member abused R1 when they were observed forcing R1's dentures into his mouth which caused R1 to cry and be visibly shaken.</p> <p>A review of staff notes provided from January 1, 2024, to June 24, 2024, included a note dated June 4, 2024 indicated Registered Nurse, Director of Nursing, Licensed Assisted Living Director (RN, DON, LALD)-D spoke with unlicensed personnel (ULP)-C regarding a complaint from hospice ULP-B who reported she was not gentle putting R1's dentures in. The note indicated ULP-C stated she was not rough with residents "I know how to treat these people". The documentation indicated ULP-C was talked to her about how she appeared frustrated and her tone of voice being loud which may be perceived in a different way. The note indicated education was given to ULP-C to ask for assistance or re-approach R1 later.</p> <p>The facility incident report and investigation of the abuse allegation on June 4, 2024, involving R1 and ULP-C was requested, none was provided. In addition, the facility failed to report the abuse allegation incident to the common entry point MAARC.</p> <p>On June 24, 2024, at 12:51 p.m. Registered Nurse, Director of Nursing, Licensed Assisted Living Director (RN, DON, LALD)-D and Licensed Practical Nurse (LPN)-E stated a incident</p>	0 620		

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0 620	<p>Continued From page 4</p> <p>involving unlicensed personnel (ULP)-C putting in R1's dentures was reported, but ULP-C denied the allegation, education was provided to ULP-C on her approach and tone of voice, and no incident report or formal investigation of the incident was completed.</p> <p>On July 9, 2024, at 9:08 a.m. ULP-C denied any wrongdoing and stated R1 was not crying or upset when she put his dentures in.</p> <p>A facility policy and procedure titled "Vulnerable Adult and Maltreatment Communication, Prevention, and Reporting", and dated August 17, 2023, indicated any vulnerable adult report must be sent to the Minnesota Adult Abuse Reporting Center (MAARC) within 24 hours of the allegation. The procedure indicated a mandated reporter if known or suspected maltreatment of a vulnerable adult must report immediately from the time initial knowledge of the incident is received. The procedure indicated the LPN, RN, or Executive Director should begin and investigation into the allegation concerns.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	0 620		
0 630 SS=D	<p>144G.42 Subd. 6 (b) Compliance with requirements for reporting ma</p> <p>(b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the</p>	0 630		

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0 630	<p>Continued From page 5</p> <p>person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse.</p> <p>This MN Requirement is not met as evidenced by:</p> <p>Based on interview and record review the licensee failed to develop and implement an individualized abuse prevention plan (IAPP) to include and assessment of the residents susceptibility to abuse, and statements of specific measures to be taken to minimize the risk of abuse for one of one resident's (R1) reviewed. R1's IAPP failed to identify individual vulnerabilities with interventions to reduce the risk of abuse and failed to update the IAPP after an incident occurred to prevent recurrence.</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) 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>Findings include:</p> <p>R1 was admitted to the licensee on January 31, 2022, with diagnoses including dementia with behavioral disturbance, cognitive deficits, delusional disorder, and hallucinations.</p> <p>A Minnesota Adult Abuse Report indicated a staff member abused R1 when they were observed forcing R1's dentures into his mouth which</p>	0 630		

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0 630	<p>Continued From page 6</p> <p>caused R1 to cry and be visibly shaken.</p> <p>A review of staff notes provided from January 1, 2024, to June 24, 2024, included a note dated June 4, 2024 indicated Registered Nurse, Director of Nursing, Licensed Assisted Living Director (RN, DON, LALD)-D spoke with unlicensed personnel (ULP)-C regarding a complaint from hospice ULP-B who reported she was not gentle putting R1's dentures in. The note indicated ULP-C stated she was not rough with residents "I know how to treat these people". The documentation indicated ULP-C was talked to her about how she appeared frustrated and her tone of voice being loud which may be perceived in a different way. The note indicated education was given to ULP-C to ask for assistance or re-approach R1 later.</p> <p>The facility incident report and investigation of the abuse allegation on June 4, 2024, involving R1 and ULP-C was requested, none was provided.</p> <p>R1's individual abuse prevention plan (IAPP) dated June 6, 2024, identified R1 was at risk to be abused, and indicated staff were trained to identify and report abuse and neglect. The IAPP failed to include R1's individual risks for abuse. In addition, R1's IAPP was not updated following the allegation of abuse (denture incident) to reflect R1's difficulty with provision of oral care and denture placement, and had no specific interventions for staff to reduce the risks for R1 to be abused.</p> <p>On June 24, 2024, at 12:51 p.m. Registered Nurse, Director of Nursing, Licensed Assisted Living Director (RN, DON, LALD)-D and Licensed Practical Nurse (LPN)-E stated a incident involving unlicensed personnel (ULP)-C putting in</p>	0 630		

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0 630	<p>Continued From page 7</p> <p>R1's dentures was reported, but ULP-C denied the allegation, education was provided, and no incident report or formal investigation of the incident was completed.</p> <p>On June 24, 2024, at 3:58 p.m. ULP-N stated R1 was resistive with oral cares, refused to have them removed, and had tired to bite staff. ULP-N stated she would reapproach if R1 was being resistive with dentures or oral care.</p> <p>On June 24, 2024, at 3:27 p.m. ULP-K stated R1 refused to have his dentures removed or place and would sometimes have his teeth in the following day. ULP-K stated if R1 was resistive she would pass it on to the next shift.</p> <p>On July 9, 2024, at 9:08 a.m. ULP-C denied any wrongdoing and stated R1 was not crying or upset when she put his dentures in.</p> <p>A facility policy and procedure titled "Vulnerable Adult and Maltreatment Communication, Prevention, and Reporting", and dated August 17, 2023, indicated the licensee would develop individualized abuse prevention plans to identify risks and develop measures to minimize maltreatment based on identified information. The policy indicated any vulnerable adult report must be sent to the Minnesota Adult Abuse Reporting Center (MAARC) with in 24 hours of the allegation. The procedure indicated a mandated reporter if known or suspected maltreatment of a vulnerable adult must report immediately from the time initial knowledge of the incident is received. The procedure indicated the LPN, RN, or Executive Director should begin and investigation into the allegation concerns.</p> <p>No further information was provided.</p>	0 630		

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0 630	Continued From page 8 TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care	0 730		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25380	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/24/2024
NAME OF PROVIDER OR SUPPLIER DIAMOND WILLOW ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 1558 RANDOLPH ROAD DETROIT LAKES, MN 56501		
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0 730	<p>Continued From page 9</p> <p>professional;</p> <p>(11) documentation that services have been provided as identified in the service plan;</p> <p>(12) documentation that the resident has received and reviewed the assisted living bill of rights;</p> <p>(13) documentation of complaints received and any resolution;</p> <p>(14) a discharge summary, including service termination notice and related documentation, when applicable; and</p> <p>(15) other documentation required under this chapter and relevant to the resident's services or status.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record had the required contents including documentation services provided as identified in the resident's assessment of needs, frequency of services to be provided on the resident's service plan, incident's involving the resident and actions taken in response to the needs of the resident, and failed to document complaints and resolution of concerns reported for one of one residents (R1) with records reviewed.</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) 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>Findings include:</p> <p>R1 was admitted to the licensee on January 31,</p>	0 730		

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0 730	<p>Continued From page 10</p> <p>2022, with diagnoses including dementia with behavioral disturbance, cognitive deficits, delusional disorder, and hallucinations.</p> <p>R1's assessment dated April 11, 2024, indicated R1 required full assistance from staff with dressing, grooming, and assistance from 2 staff with transfers, toileting, incontinence care, and repositioning every 2-3 hours and PRN.</p> <p>R1's care plan dated June 6, 2024, indicated R1 was cognitively impaired and required assistance from one staff with dressing bathing grooming, and 2 staff with toileting, incontinence cares, and repositioning every 2-3 hours.</p> <p>R1's service plan dated April 11, 2024, indicated R1 required toileting assistance 3 times daily. R1's service plan failed to include the frequency of toileting assistance needed as identified in R1's assessment and care plan every 2-3 hours.</p> <p>A facility complaints and grievances dated April 8, 2024, indicated R1's family member had reported staff refused to provide toileting when R1 requested to use the bathroom. The report indicated R1 was to be toileted every 2 hours, but staff told R1 that was what his brief was for. The document indicated a message was sent to staff, and person centered care was reviewed at a staff meeting. R1's record failed to indicated the families specific complaint regarding R1's lack of toileting service being provided was addressed.</p> <p>R1's toileting service recap report from April 2024, to June 2024, was reviewed and indicated R1's every 2-hour toileting service was scheduled only one time each 8-hour shift, and instructed staff to check, change, and reposition the resident every 2 to 3 hours, assist R1 with</p>	0 730		

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0 730	<p>Continued From page 11</p> <p>incontinence cares, and take R1 to the bathroom as he requested. The documentation indicated staff had not consistently provided toileting or incontinence care as indicated in R1's assessment and plan of care. The report identified R1 was either not provided any toileting or incontinence care, or the service was only provided one time during an 8-hour shift 48 out of 90 shifts in April, 40 out of 93 shifts in May, and 36 out of 90 shifts in June 2024. In addition, the document showed multiple staff on numerous occasions had documented completing the toileting service at the beginning of their shift, and prior to providing the service.</p> <p>On July 9, 2024, at 9:59 a.m. during email correspondence Registered Nurse Cooperate Clinical Director (RNCCD)-O confirmed the numbers column on the toileting service recap report indicated the number of times the service was provided during that 8 hour shift.</p> <p>On June 24, 2024, at 2:24 p.m. unlicensed personnel (ULP)-H stated she had observed R1 in his bed saturated through his brief, soaker, and bedding. ULP-H stated it appeared R1 had not received cares for some time. ULP-H stated recently the facility had implemented change of shift rounding and if R1 was found soaked like that on rounds the previous staff had to stay and clean him up and change his bedding. ULP-H stated some staff refuse to do the rounding, but she reported the concern to nursing.</p> <p>On June 24, 2024, at 1:57 p.m. ULP-I stated R1 was saturated with urine in his bed a few days ago, appeared uncomfortable, with his blankets soaked, and all messed up. ULP-I staff stated it appeared as though staff had not provided care to R1 for a while. ULP-I indicated she had</p>	0 730		

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0 730	<p>Continued From page 12</p> <p>repeatedly observed R1 soaked like that several times in the last month. ULP-I stated she observed R1 left in food crusted soiled clothing from the previous day. ULP-I stated she reported the concerns to facility leadership.</p> <p>On June 24, 2024, at 1:32 p.m. ULP-J stated she had concerns staff were not toileting or changing R1 as they should and had found R1 soaked in urine. The staff stated the facility implemented a new system recently and if the resident was found soaked in urine the previous shift had to stay and change the resident. The ULP staff indicated the resident was frequently observed soaking wet with urine at the start of her shift.</p> <p>On June 24, 2024, at 3:27 p.m. ULP-K stated R1 had not been toileted or changed and was soaked when she came on shift in the evening. The staff indicated she reported the concern to leadership.</p> <p>On June 24, 2024, at 3:58 p.m. ULP-N stated R1 was not being toileted, checked, or changed every 2-3 hours, and stated some staff are not good about changing R1 as often as he should be.</p> <p>On June 24, 2024, at 12:51 p.m. Registered Nurse, Director of Nursing, Licensed Assisted Living Director (RN, DON, LALD)-D and Licensed Practical Nurse (LPN)-E stated R1 received frequent checks and scheduled toileting. RN, DON, LALD-D, and LPN-E stated the facility had implemented a change of shift walk through to ensure cares were provided to residents the end of April. Staff stated when the denture incident with R1 was reported ULP-C denied the allegation, education was provided to ULP-C on her approach and tone of voice, and no incident</p>	0 730		

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0 730	<p>Continued From page 13</p> <p>report or formal investigation of the incident was completed.</p> <p>A review of staff notes provided from January 1, 2024, to June 24, 2024, failed to show any communication was provided to staff regarding R1's toileting complaint. One note dated June 4, 2024 indicated RN, DON, LALD -D spoke with ULP-C regarding a complaint from hospice ULP-B who reported she was not gentle putting R1's dentures in. The report indicated ULP-C stated she was not rough with residents "I know how to treat these people". The documentation indicated ULP-C was talked to her about how she appears frustrated in her tone of voice and is sometimes loud which may be perceived in a different way. The report indicated education was given to ULP-C.</p> <p>The facility incident report and investigation of the abuse allegation involving R1 and ULP-C was requested, none was provided.</p> <p>Although the facility implemented a process for staff to complete change of shift rounding, there was no indication the process ensured services were provided to R1. Staff reported R1 continued to be soaked at the start of their shift, and documentation indicated R1 continued to not receive toileting or incontinence cares as indicated in his assessment and care plan. Multiple staff stated they reported ongoing concerns to the facility, but R1's record failed to show any action was taken to ensure R1 received toileting and incontinence care services needed.</p> <p>On July 9, 2024, at 3:03 p.m. hospice RN-A stated hospice staff reported R1 had been observed on numerous occasions uncared for by facility staff, soaked in urine through his brief,</p>	0 730		

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0 730	<p>Continued From page 14</p> <p>clothing, soaker, and bedding, with food encrusted clothing unchanged from the previous day, and a strong smell of urine. RN-A stated hospice staff ULP-B reported an observed incident with facility staff ULP-C putting in R1's dentures and felt like ULP-C was more aggressive with R1 than she should have been, but did not intervene. RN-A stated later that day another hospice staff reported R1 was crying and appeared shaken, but it was unknown if R1 was upset as a result of the incident.</p> <p>On June 24, 2024, at 11:40 a.m. hospice staff ULP-B stated facility staff do not assist R1 as they should, but did not mention any concerns of abusive conduct or forced cares from staff.</p> <p>On July 9, 2024, at 9:08 a.m. ULP-C denied any wrongdoing and stated R1 was not crying or upset when she put his dentures in.</p> <p>On July 9, 2024, at 9:24 a.m. and 11:14 a.m. R1's family members stated R1 was not toileted, checked, or changed as he should be. The family indicated they had observed R1 soiled, saturated, and smelling of urine on numerous occasions. The family stated some staff do not want to toilet R1 and told R1 to go in his brief when he had asked to use the toilet. The family indicated the care R1 received varied day to day depending on who was working, and indicated some staff did not take the time to provide care in a gentle, kind, and caring manner.</p> <p>A facility policy and procedure titled "Complaints and Grievances", dated November 5, 2023, indicated a facility complaint form should be filled out. When possible and reasonable, the complaint will be resolved immediately involving others as needed. If needed, an investigation</p>	0 730		

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0 730	<p>Continued From page 15</p> <p>surrounding the facts of the complaint shall be initiated. During the investigation process, and when possible, residents, resident representatives, or employees will be asked to participate in determining the solution and bring about resolution of the complaint. After an investigation is complete, a prompt response to the resident, resident representative, or employee complaint or concern will be provided verbally and, if desired, in writing. Residents or employees will be given a reasonable explanation for the action taken on their behalf. In a case where maltreatment was identified (abuse, neglect, or exploitation), a staff will promptly contact the Minnesota Adult Abuse Reporting Center (MAARC) to make a report. If the resolution of a complaint results in a system or procedure change, the change shall be made and communicated appropriately to employees or residents.</p> <p>A facility policy and procedure titled "Vulnerable Adult and Maltreatment Communication, Prevention, and Reporting", and dated August 17, 2023, indicated the licensee would develop individualized abuse prevention plans to identify risks and develop measures to minimize maltreatment based on identified information. The policy indicated any vulnerable adult report must be sent to the Minnesota Adult Abuse Reporting Center (MAARC) with in 24 hours of the allegation. The procedure indicated a mandated reporter if known or suspected maltreatment of a vulnerable adult must report immediately from the time initial knowledge of the incident is received. The procedure indicated the LPN, RN, or Executive Director should begin and investigation into the allegation concerns.</p> <p>A facility policy and procedure titled "Resident</p>	0 730		

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0 730	<p>Continued From page 16</p> <p>Record Documentation", dated November 12, 2023, indicated staff will document, on a daily basis services provided to resident. When are not performed per the service agreement and as schedule, staff must document the reason why it was not performed or administered. Staff will document in the electronic record the completion of the administered services, treatment or therapies as soon as reasonable. The exception to timely documentation would be if there is an electronic device failure or Internet failure that may prevent timely documentation. In this case staff should complete documentation as soon as able and include a note as to the time that the service was provided. Tasks not performed or administered must be reported and followed up on to meet the resident's needs.</p> <p>A facility policy and procedure titled "Service Plans/Care Plans", dated December 8, 2023, indicated the service plan must include all of the following required elements including: A description of the services to be provided, and the frequency of each service, according to the resident's current review or assessment and resident preferences. The policy indicated services are expected to be completed timely according to direction given by nursing. The policy indicated staff should take the electronic charting devices with them while providing cares for residents for easy reference and document as soon as able after completion of the services.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	0 730		

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