Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL254607162M
Compliance #: HL254602162C

Date Concluded: May 27, 2025

Name, Address, and County of Licensee Investigated:

Cypress Manor
16770 Wren Street Northwest
Andover, MN, 55304
Anoka County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Jennifer Segal RN, BSN
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 resident was neglected when the facility failed to ensure staff administered the residents tube feeding formula and medications were given into the correct port. The resident was hospitalized with aspiration pneumonia.
In addition, the facility neglected the resident when they failed to monitor, provide treatment, or implement interventions to prevent pressure ulcers. The resident developed multiple pressure ulcers.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility staff administered the resident's tube feeding and medications in the wrong port of the residents feeding tube and failed to ensure the resident was in a safe position during and after tube feeding. The resident required multiple hospitalizations for aspiration pneumonia.

In addition, the facility failed to follow providers' orders to treat pressure ulcers. The residents pressure ulcers worsened. The resident was hospitalized for severe sepsis (body-wide response to infection). The resident required surgical intervention and several weeks of antibiotics for the pressure ulcer.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, unlicensed staff, and the resident's guardian. The investigator interviewed hospital staff, outside home care, and hospice agency staff. The investigation included a review of medical records from the facility, hospital, outside home care and hospice agencies, and the primary care provider. The investigation included a review of staff training records and related facility policies. Also, the investigator observed ULP provide tube feeding and other personal care, including repositioning, to the resident during the investigation.

The resident resided in an assisted living facility with diagnoses including Parkinson's disease, respiratory failure, dysphagia, recurrent aspiration pneumonia, diabetes, and dementia. The resident's assessment indicated the resident was nonverbal, had difficulty swallowing, and was unable to eat or drink by mouth. In addition, the assessment indicated the resident was bedbound and at risk for skin breakdown and pressure ulcers. The service plan included management of tube feeding for nutrition and medication administration, wound care as needed, a mechanical lift for mobility, and frequent repositioning.

The residents medical record indicated the resident had a feeding tube which had 2 ports referred to as a G tube port and a J tube port.

A facility progress note indicated the resident returned to the facility following hospitalization for aspiration pneumonia. The note indicated that during hospitalization, the resident's gastrostomy (G) tube [feeding tube] was replaced with a gastrojejunostomy (GJ) tube due to aspiration pneumonia. The nurse's note indicated "food and meds [medication] to be administered via GJ-tube". In addition, the note indicated the resident had wounds and required wearing foam heel boots when in bed. The resident's record did not include interventions for the new feeding tube or pressure ulcers.

One week later, the provider provided the facility a clarifying order regarding the resident's tube feeding. The order directed staff to administer medications via G tube and administer tube feeding via J tube. Although the provider notified the facility of specific directions for use of the resident's GJ tube, there was no indication that the facility implemented the changes to the resident's service plan, care card, or medication and treatment records. In addition, there was no indication that staff received individual training and competency testing by a registered nurse to provide food or medications via GJ tube. There was no indication the resident received the heel boots.

The residents progress notes indicated several weeks later facility staff discovered the resident was unresponsive and short of breath. The staff called 911.

Hospital records indicated paramedics observed the resident with liquid coming out of his mouth and the resident’s oxygen saturation was 70% (normal is 95%). The resident was hospitalized for acute respiratory failure and aspiration pneumonia. In addition, the resident's left heel pressure ulcer required surgical intervention and weeks of antibiotics.

Hospital discharge orders included a daily dressing change to the left heel and heel boots while in bed. In addition, the hospital record indicated the resident had multiple additional pressure ulcers on his lower body that required treatment.

Although the resident's record contained multiple new wound care orders, daily to three times weekly and as needed following hospitalization, there was no indication that the facility had implemented wound care or heel boots.

Four days later, a facility progress note indicated facility staff observed the resident lying on his back with "bubbly phlegm" coming out of his mouth, and staff heard audible wheezing. The resident was unable to clear his airway and cough. The facility called 911.

Hospital records indicate the resident presented to the emergency department (ED) with shortness of breath and the tube feeding solution coming out of the resident’s mouth. The resident required frequent suctioning and high-flow oxygen to stabilize his breathing. The ED provider noted familiarity with the resident from recent and recurrent hospitalizations with similar issues, including four days earlier.

The hospital record indicated the provider called the facility nurse to verify which port (the J or G port) staff used to administer food and which port was used to administer medication. The nurse indicated unlicensed personnel (ULP) were trained to administer food via J tube and stated a diagram was posted in the resident's room as a reminder for ULP. The provider requested the nurse confirm all ULP’s administered feeding via the J port. The provider requested the nurse call back with findings. When the nurse called back, she reported several staff members did not correctly implement the tube feeding order and administered the tube feeding solution in the wrong port.

In addition, the hospital record indicated the resident's left heel ulcer worsened, and the resident had, "multiple new wounds" compared to four days prior.

A facility note indicated the resident returned to the facility following hospitalization for aspiration pneumonia and noted the provider, "suspected" the resident received "feeding in the wrong port". The note indicated "food in gastric port [G tube] instead of jejunal [J tube]." The resident's record indicated some training was provided to the unlicensed staff following the resident’s hospitalization. The resident's overall health continued to decline, and the resident/representative elected home hospice.

Approximately two months later, one evening a ULP called a facility nurse to report that the resident's hospital bed was stuck in a flat position. Troubleshooting was ineffective, and the nurse instructed the ULP to call maintenance for further direction, but the issue was still unresolved. Maintenance directed the ULP to provide care while the resident lay flat in bed for over 12 hours. The following morning, the resident was observed short of breath, with gurgling sounds, and flat in bed. Staff observed that the bed was not plugged into power. After plugging in the bed and placing the resident in the correct position (head of bed elevated), the resident continued to have shortness of breath and difficulty breathing. The resident died a week later.

The resident’s death record indicated the resident died from adult failure to thrive and Lewy body dementia.

During interviews, multiple ULP’s reported when the resident's feeding tube changed from a G tube to a GJ tube, they could easily use the wrong port if they didn't pay close attention to the small writing on the ports.

During interview a ULP stated concern when the resident's bed was stuck in a flat position and high up (highest position from floor position). The ULP placed ten pillows behind the resident during and after tube feeding to ensure he was upright and checked on him frequently.

During interviews facility leadership stated all staff who could give medication were trained on tube feedings. However, the facility did not train staff on the resident’s specific tube feeding and medication administration.

During an interview with outside agency staff, they stated they instructed the facility several times not to administer the resident's tube feeding when he was unresponsive due to the risk of aspiration. Also, the outside agency nurse stated the agency would have replaced the resident's bed the same day if they were notified of any change in condition with the resident or his equipment.

During interview a facility nurse stated they did not assess the resident's pressure ulcers because they were covered with a dressing. In addition, the nurse stated the outside agency had primary responsibility for the resident's pressure ulcers, not the facility.

During interview an outside agency nurse reported that over months, there was frequent conversation about the facility's need to obtain heel boots. The outside agency staff reported they frequently and repeatedly educated facility staff to reposition the resident.

Another outside agency nurse stated if the resident's pressure ulcer dressings required changing between the agency nurse visits, the facility staff were expected to change the dressings. However, the nurse stated the resident's dressings were not changed because the dressings were soaked, or the dressing was hard to remove because it was stuck in the pressure ulcers. Other times, the nurse stated the agency nurses wrote their initials and date on the

pressure ulcer dressing and the same dressing was on when an agency nurse returned to the facility.

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

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
“Substantiated” means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
“Neglect” means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility called 911 and retrained staff

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
The Minnesota Board of Nursing
Anoka County Attorney
Andover City Attorney
Andover Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25460	A. BUILDING: _____ B. WING _____	C 02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CYPRESS MANOR	16770 WREN STREET NW ANDOVER, MN 55304

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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: #HL254602162C/#HL254607162M On February 12, 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 10 residents receiving services under the provider's Assisted Living License. The following correction orders are issued for #HL254602162C/#HL254607162M, tag identification 0590, 1950, and 2360	0 000	Assisted Living Provider 144G. Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 590 SS=D	144G.42 Subd. 3 Facility restrictions	0 590		

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0 590	Continued From page 1 (a) This subdivision does not apply to licensees that are Minnesota counties or other units of government. (b) A facility or staff person may not: (1) accept a power-of-attorney from residents for any purpose, and may not accept appointments as guardians or conservators of residents; or (2) borrow a resident's funds or personal or real property, nor in any way convert a resident's property to the possession of the facility or staff person. (c) A facility may not serve as a resident's legal, designated, or other representative. (d) Nothing in this subdivision precludes a facility or staff person from accepting gifts of minimal value or precludes acceptance of donations or bequests made to a facility that are exempt from section 501(c)(3) of the Internal Revenue Code. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee allowed a staff member, vice president (VP)-A, to serve as guardian (legal right and duty to care for another and make decisions related to medical, health and residential) for one of one resident (R1) 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:	0 590		

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0 590	Continued From page 2 R1 moved into the facility on December 11, 2023, due to dementia and diabetes. R1's Service Plan dated September 10, 2024, indicated the resident received assistance with tube feedings, medication administration, bathing, dressing, toileting, and behavior management. The service plan was signed by VP-A and indicated VP-A was the responsible party and guardian for R1. R1's "Order Appointing Guardian" dated October 12, 2023, indicated R1 was incapable of making informed decisions and required a guardian. The document indicated VP-A owned an organization that provided professional guardian services and therefore appointed VP-A to serve as R1's legal guardian. During an interview on February 12, 2025, at 11:00 a.m. licensed practical nurse (LPN)-B stated VP-A served as R1's guardian. During an observation on February 12, 2025, at 11:45 a.m. LPN-B called the licensees corporate office and asked to speak with VP-B. LPN-B discussed and planned a future medical appointment and transportation plan for another resident in the facility with VP-A. During entrance conference on February 12, 2025, at 12:30 p.m. registered nurse (RN)-C, assisted living director in residence (ALDIR)-D and licensed assisted living director (LALD)-E discussed the licensee's organizational chart. The licensees vice president (VP)-A is also known as R1's legal guardian. During an interview on March 24, 2025, at 4:45 p.m. R1's guardian stated she was the appointed	0 590		

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0 590	Continued From page 3 guardian for R1 and made all decisions related to R1's health, financial, and personal business. An email received from the licensee March 25, 2025, at 12:00 p.m. contained White Pines Assisted Living Organization Chart, VP-A/guardian was not listed on the chart as previous. An employee roster listed VP-A as current vice president of the organization. The licensee's Facility Restrictions policy, dated September 27, 2023, indicated" neither WPAL [Whispering Pines Assisted Living] or any of its staff may accept a power-of-attorney from residents for any purpose, accept appointments as guardians or conservators of residents, borrow funds from a resident, or borrow personal or real property from a resident. " No further information provided. Time period for Correction: Fourteen (14) days.	0 590		
01950 SS=G	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the	01950		

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01950	Continued From page 4 proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse provided training for unlicensed personnel (ULP) to provide delegated nursing tasks and determine competency of each ULP for one of one resident reviewed (R1) who required tube feedings for medications and nutrition. 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 a limited number of staff are involved or the situation has occurred only occasionally). Findings include: R1 admitted to the facility due to diagnoses including dementia and diabetes. R1 received assistance with, mobility, bathing and medication management. R1 had a regular diet and fed himself. R1's progress note dated August 5, 2024, indicated R1 was unresponsive, had difficulty breathing and oxygen saturation measured 82%. Facility staff called 911.	01950		

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01950	Continued From page 5 R1's hospital records indicated R1 was hospitalized from August 5, 2024, to August 26, 2024, for multiple changes in condition including aspiration pneumonia. R1's progress note dated August 26, 2024, indicated R1 returned to the facility following a three-week hospitalization for aspiration pneumonia. R1's changes in condition included the inability to eat or drink by mouth or swallow medication. R1 required all food, fluids and medications via gastrostomy tube (G tube). R1's record lacked documentation of specific training and competency requirements completed by RN for appropriate delegation of nursing tasks to ULP to ensure safe and appropriate G tube feeding and medication administration via G tube. R1's facility progress note dated September 1, 2024, indicated ULP discovered R1 was short of breath and unresponsive and called 911. R1's hospital record indicated R1 was hospitalized September 1, 2024, through September 5, 2024, for recurrent aspiration pneumonia. As a result, R1's G tube feeding was revised to a gastric jejunal (GJ) tube to decrease the risk of aspiration. R1's facility progress note dated September 5, 2024, indicated R1's G tube was revised during hospitalization and indicated food, and medications would "continue" to be administered via GJ tube. R1's care team included an outside skilled home care agency for intermittent and unrelated skilled needs. The skilled nurse (SN) visited R1 for Resumption of Care assessment on September	01950		

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01950	Continued From page 6 6, 2024. SN inquired with a facility nurse the instructions for R1's GJ tube and specifically asked about the use of the J port. The facility nurse indicated no changes. The SN determined clarification from R1's provider was required and contacted the provider for direction. R1's Service Plan dated September 10, 2024, indicated R1 received food and medication via G tube. There were no changes made to R1's plan. No indication of new GJ tube and no mention of purpose or direction for proper use of G port or J port. R1's facility record contained a clarifying order dated September 12, 2024, indicating R1's medications were administered via G port and food administered via J port. R1's record indicated no changes were made to R1's September 2024 facility plan of care, care card, service plan, medication record or treatment order for use of GJ tube. In addition, there was no record of required RN training or competency testing for ULP to administer food or medication via GJ tube. R1 was seen by provider on October 3, 2024, and the providers exam indicated R1 was recently twice hospitalized for aspiration pneumonia and determined R1 at high risk of recurrent aspiration pneumonia. The provider directed facility staff to continue to provide aspiration precautions. R1's Daily Reporting Sheet for the month of October 2024, instructed ULP administer R1's food and medication via G tube. The ULP initialed the report sheet multiple times daily for the month indicating ULP administered food and medication via G tube.	01950		

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01950	Continued From page 7 R1's facility record for the month of October 2024, contained no new or clarifying directions for ULPs to provide food or medication via GJ tube and lacked aspiration precautions. R1's facility record dated November 5, 2024, indicated ULP observed R1 had difficulty breathing and appeared to be drooling. ULP called the nurse on call then called 911. R1's hospital record dated November 5, 2024, indicated R1 arrived at the emergency department in respiratory distress with liquid coming out of his mouth. R1 required urgent interventions including high flow oxygen. R1 remained hospitalized through November 16, 2024, for aspiration pneumonia. R1's facility progress note dated November 16, 2024, indicated R1 returned from the hospital following an 11-day hospitalization for aspiration pneumonia. In addition, the note indicated R1 "still on tube/bolus feeding and all meds crushed via GT". R1's Individual Treatment Plan dated November 16, 2024, indicated R1 received tube feeding via GJ tube. The record lacked specific instruction indicating which port was used for feeding and which port for medication. R1's progress note dated November 20, 2024, indicated R1 was observed with bubbly phlegm from the mouth and unable to cough. Facility staff called 911 for assistance. The note indicated paramedics suctioned tube feeding formula from R1's mouth and throat. R1's hospital record dated November 20, 2024,	01950		

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01950	Continued From page 8 indicated hospital staff was familiar with R1 and indicated R1 returned to the hospital for the same issue, which included coughing, shortness of breath and required suctioning. The provider noted the fluid suctioned was consistent with tube feeding. The physician noted he contacted the facility to ensure staff used the correct port for feeding. Licensed practical nurse (LPN)-B informed the physician there was a sign in R1's room directing ULP that tube feedings were given via the J tube. LPN-B stated she would investigate further to confirm ULP used the correct port. The physician provided his cell phone number to LPN-B and requested a call back with the information as soon as possible to guide further testing and treatment. LPN-B completed investigation and discovered that "several staff did not comply with tube feedings". LPN-B noted staff provided food in the G tube instead of in the J tube. R1's progress note dated November 25, 2024, signed by RN-C indicated R1 was hospitalized for five days with aspiration pneumonia. RN-C noted the provider "suspected" that R1 received tube feeding in the wrong port, "food in gastric port instead of jejunal port". RN-C implemented interventions to prevent recurrence, including updated written instructions with color coding to distinguish the G port and J port. In addition, RN-C indicated all ULP were reeducated on the proper use of each port. R1's Daily Reporting Sheet for the month of November 2024, instructed ULP administer R1's food and medication via G tube. The instructions did not distinguish the G port from J port. ULP initialed the report sheet multiple times daily indicating they administered food and medication via G tube.	01950		

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01950	Continued From page 9 R1's Medication Administration Record (MAR) month of November 2024, indicated a handwritten edit in large print across the top of MAR "All meds go down Gastric Port only". In addition, each medication listed on MAR had a handwritten note clarifying the route of each medication was administered via G port. R1's record indicated no changes were made to R1's November 2024 facility plan distinguishing the ports. In addition, R1's record lacked RN training and competency testing for each ULP for G tube and GJ tube. R1's progress note dated December 11, 2024, indicated R1 had increased secretions and increased shortness of breath with wheezing. Facility staff called 911. R1 was seen in the emergency department and diagnosed with hypoxia. RN-C indicated R1 returned to the facility "back to baseline" and lungs were clear. R1's Care Card that directed ULP dated December 26, 2024, indicated R1 received food via G tube four times daily and medication via G tube. There was no mention of J port. R1's Daily Reporting sheet during the month of December 2024 indicated staff administer tube feeding via G tube although the J port was ordered. R1's progress note dated February 23, 2025, indicated ULP-K contacted LPN-B at approximately 4:30 p.m. to report R1's "bed was stuck up in the air won't come down." In addition, ULP-K reported the head of R1's bed was in a flat position. ULP-K reported checking the power source and the bed continued to be stuck in a flat	01950		

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	25460	A. BUILDING: _____ B. WING _____	C 02/12/2025

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01950	Continued From page 10 position. ULP-K requested a manual crank for the hospital bed, however LPN-B informed ULP-K there was only one bed crank in the facility and LPN-B uncertain if it would work for R1's bed. However, ULP-K could not locate the manual bed crank. LPN-B directed ULP-K to call maintenance for help. The RN was not informed of the incident. R1's progress note dated February 24, 2025, indicated an oncoming ULP and LPN-B observed R1's bed was not plugged into power. Staff plugged the bed in and reported it began to work as usual. There was no indication an RN was notified of the incident. In addition, no new interventions for power failure or swallow precautions. A facility report dated February 27, 2025, indicated during a meeting on February 25, 2025, LPN-B reported to RN-C and others on the management team that R1's bed was stuck in an elevated position and flat. The report indicated LPN-B attempted to troubleshoot however unsuccessful and instructed ULP-N to contact maintenance for assistance. ULP-N contacted maintenance staff for assistance however the bed remained stuck. Maintenance directed ULP-N to use a mechanical lift to assist R1 back into the bed although the bed was at an unsafe height and flat. The report indicated ULP-N placed ten pillows behind R1 to keep R1 in an upright position during and following feeding for the required time. The report noted R1's bed was stuck for greater than 12 hours. The following morning it was observed R1 had an exacerbation of symptoms and it was unknown if the exacerbation was related to R1 being fed and lying flat for over twelve hours. All staff were instructed to notify the RN for any changes or concerns.	01950		

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01950	Continued From page 11 During investigation on February 12, 2024, an undated facility document was provided to the investigator. The document indicated reeducation was provided to ULPs for proper use of R1's GJ tube. Six ULPs signed and dated the form November 26, 2024. One ULP noted training was provided on December 4, 2024, and another ULP indicated reeducation provided December 11, 2024. The form was unsigned by a facility nurse. Review of ULP-N training records dated November 17, 2023, and ULP-F training records dated November 21, 2023, indicated ULPs were trained weeks before R1 admitted to the facility. Review of facility training documentation included basic tube feeding skills, not specific to R1. The records included how to administer tube feeding via premeasured bag, run by gravity or set to pump. However, R1's tube feeding was administered via gravity and bolus fed. Facility training for medication administration included multiple routes of administration, however medication administration via tube was not included. During interview on February 12, 2025, at 12:30 p.m. LPN-B stated she provided training and retraining to all ULP to administer R1's tube feeding and medications via tube. In addition, LPN-B stated she provided all initial communication and follow up with R1's providers and ULP. In addition, LPN-B stated she investigated the incident and determined all staff required retraining. During interview on February 12, 2025, at 12:45 pm RN-C stated he provided training to all ULP for R1's tube feeding. RN-C stated the facility did	01950		

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01950	Continued From page 12 not keep formal record of individual training records for each ULP trained in each delegated tasks specific to each resident. The facility trained all staff at time of hire and once ULP demonstrated competency in one resident's delegated task that indicated the ULP was competent in providing the same task to another resident. The investigator requested supervisory visit documentation, RN-C stated the facility did not keep a record of each resident and each ULP specific training and competency. When the investigator requested supervisory visit documentation RN-C stated the facility did not have a formal document for a supervisory visit and stated he was unfamiliar with the required regulation. During interview February 12, 2025, at 4:45 p.m. ULP-H stated R1's G tube had two identical G ports. When R1's tube was revised to a GJ tube the ports looked the same however one port was labeled gastrostomy and the other port labeled jejunum. ULP-H stated staff had to look closely at the label to ensure the correct port was used. During interview on March 13, 2025, at 11:50 a.m. ULP-N stated she worried when R1's bed was stuck in flat position because she did not know how to keep R1 upright at 30-45 degrees. ULP-N stated she placed ten pillows behind R1 during and after feeding to ensure R1 was upright. ULP-N stated once feeding complete and R1 was safe to lay down with two pillows that ULP-N remained concerned because the bed was stuck at the tallest position, and it was difficult to reach R1. During interview on March 13, 2025, at 12:15 p.m. a [anonymous] leadership staff stated when R1's bed lost power a RN should have been	01950		

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01950	Continued From page 13 notified. In addition, leadership indicated that maintenance directed ULP-N to assist R1 back into bed and maintenance should not make any clinical decisions. Leadership stated concern that R1 was in an unsafe position for over twelve hours, and it was unknown if R1's positioning affected R1's change in condition. Leadership stated staff involved received discipline and all staff were reeducated on process for reporting a change in condition to the on-call nurse. Delegation of Assisted Living Services policy dated June 15, 2022, indicated a registered nurse delegates tasks to unlicensed personnel. The registered nurse will ensure prior to delegation the ULP is trained in task for each resident and able to demonstrate competency. The RN will document instruction and competency in the resident's record. Treatment and Therapy Management Plan policy dated April 17, 2023, indicated each resident record must contain an individualized plan that included specific instructions for task. Procedures for notifying a RN if a problem arises. Verification that task was administered as prescribed. In addition, the RN would monitor and prevent complications. The plan must be current. The RN retains final authority. Following emergencies the RN will follow up care coordination Nurse on Call policy dated June 6, 2022, and revised November 29, 2024, indicated RNs provide clinical oversight and must approve direct care decisions. RNs provide on call consultation for LPNs. LPNs provide guidance to ULPs based on established care plans. LPNs required to consult with RNs for a change in condition, abnormal vital signs, worsening symptoms, any situation requiring an updated plan of care.	01950		

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01950	Continued From page 14 No further information was provided. Time Period for Correction: Fourteen (14) days.	01950		
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 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		