Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL265858202M
Compliance #: HL265854350C

Date Concluded: March 12, 2025

Name, Address, and County of Licensee Investigated:
Edgewood Assisted Living
673 Brianna Dr.
Sartell, MN 56377
Stearns County

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

Evaluator's Name:
Jana Wegener, RN, Special Investigator

Finding: Inconclusive

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

Initial Investigation Allegation(s):
The resident was abused when Alleged Perpetrator 1, (AP1), AP2, and AP3 forcibly restrained the resident while assisting the resident with cares causing bruising on the resident's forearms, wrists, and hands.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. AP1, AP2, and AP3 attempted to assist the resident with toileting and the resident was resistive and became combative. Instead of reapproaching the resident, the AP's continued to attempt to provide cares. After the incident occurred, bruising was noted on the residents' hands, wrists, and forearms. However, AP1 and AP2 denied holding/restraining the resident, or seeing anyone do so. There were no other witnesses to the incident. It could not be determined if abuse occurred.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record(s),

facility internal investigation, facility incident reports, personnel files, staff schedules, related facility policy and procedures, video surveillance, and bruise photographs. Also, the investigator observed resident's and staff in the secure memory care unit.

The resident resided in an assisted living memory care unit with diagnoses including Alzheimer's Disease. The resident's assessment prior to the incident indicated the resident had moderately impaired cognition and was confused, anxious, agitated, resistive, combative, and paranoid. The assessment indicated the resident required assistance with toileting, and dressing.

The resident's care plan identified the resident had impaired cognition and communication vulnerabilities and indicated staff should not raise their voices or shout at the resident, should speak to the resident as an adult, avoid carrying on more than one conversation at a time, keep a quiet atmosphere, and not rush the resident. The assessment identified the resident had a history of verbal/physically aggressive behaviors related to increased anxiety and indicated staff should explain what they want to do before completing a task. If the resident refused or if behavior escalated staff were directed to back away, allow the resident space, re-approach later, and document the behavior with attempted interventions.

The resident's service delivery record indicated AP3 documented the resident had physically aggressive behavior the day of the incident. The note indicated the resident was incontinent of stool and AP1, AP2, and AP3 tried to change the resident in his bathroom, but the resident became aggressive by grabbing staff's hair and punching staff in the face and head. Following the incident AP3 documented the resident remained agitated and was calling care staff, "stupid hoe's and bitch's, " as well as calling residents and other care staff "stupid idiots."

Leadership staff stated the resident's family reported finding bruises on the resident, then reviewed recorded video from the resident's room and observed the 3 staff (AP1, AP2, and AP3) were rough with the resident while providing incontinence cares. Leadership stated they were not aware of any bruising or skin issues prior to the incident. The nurse who assessed the resident following the incident described the bruises appearing like hand and thumb prints on the resident's hands and arms. Leadership staff stated when the APs were interviewed AP3 reported they had to "put hands," on the resident to get him to sit down on the toilet. Leadership stated they did not clarify with AP3 what it meant to "put hands" on the resident. Leadership stated AP1, AP2, and AP3 did not follow the residents plan of care related to responding appropriately to the residents aggressive behavior. The staff should have walked away and approached the resident at a later time.

The resident's progress notes indicated the resident's family reported concerns with the way staff assisted the resident with incontinence cares. Another progress note indicated the APs attempted to assist the resident to the bathroom when the resident became resistive/combative towards staff. A nurse assessed the resident following the incident and noticed discolored areas on his right and left forearms. The progress notes lacked documentation of the discolored areas including size/description.

A facility investigation indicated leadership interviewed AP1 about the incident who stated she tried to get the resident to sit on the toilet, but he became combative and harder to work with. When leadership interviewed AP2 about the incident, she stated AP3 called for help to change the resident's soiled pants, but the resident became agitated and hit AP2 in the head. AP2 stated the resident did not want to sit on the toilet, but they finally got him to sit down and cleaned him up. When leadership interviewed AP3 about the incident, AP3 stated she took the resident to get his pants changed and clean up. AP3 stated the resident became frustrated, so AP3 called AP1 and AP2 for assistance. AP3 stated the resident started to push staff but they were able to get the resident to sit down on the toilet. AP3 indicated they had to, "Put hands" on the resident to get him to sit. The facility investigation had no further documentation to clarify AP3's statement regarding putting hands on the resident.

A 12-minute-long recorded video of the incident was reviewed, and the resident was observed entering his room with AP1, AP2, and AP3. The staff could be heard on video but could not be seen when they were in the bathroom. The AP's (unknown) were heard repeatedly telling the resident "Let's go potty", "you have poop on your butt." At one point the resident was observed trying to leave the bathroom, then appeared to return to the bathroom willingly with the 3 APs. A few moments later the resident and staff voices were heard escalating higher, louder, as all 3 APs attempted to redirect the resident at one time. One AP (unknown) was heard say in a scolding tone, "I am so disappointed…" After approximately 12 minutes, the resident and AP1, AP2, and AP3 leave the bathroom, and the video ended.

A review of family provided time and date stamped pictures following the incident showed the resident had a large dark purple bruise on his left hand spanning the webbed space between his thumb and index finger, a quarter size dark purple bruise on the back of his right hand, a small dot the size of a thumb on the inner aspect of his right forearm above the wrist, and a large bruise on one of his forearms.

When interviewed AP1 stated if a resident had aggressive resistive behaviors she would step back and re-approach later. AP1 stated the resident had a history of verbally and physically aggressive behaviors toward residents and staff and indicated only one staff normally provided cares to the resident. AP1 indicated having 3 staff in the bathroom the day of the incident was unusual and likely made the resident's behaviors worse. AP1 indicated they did not stop, re-approach, or ask the nurse/family for help when the resident's behavior escalated because she thought they would be in trouble if they left the resident in incontinence. AP1 denied hearing or saying anything to the resident in a scolding manner. AP1 denied holding/grabbing or forcing the resident to sit on the toilet for incontinence care or seeing anyone else do so either.

When interviewed AP2 stated the resident required assistance with toileting and incontinence cares with one staff. AP2 stated the resident was verbally and physically aggressive toward staff and residents, would hit, swear, and hit people with his walker. AP2 stated if the resident was resistive or refused cares staff should redirect/re-approach, switch staff, and indicated they

would sometimes use 2 staff or call the nurse or family for help, however, they did not do any of those things the day of the incident. AP2 stated 3 staff assisting the resident with cares at one time could have been overwhelming for the resident. AP2 denied holding/grabbing or forcing the resident to sit on the toilet for incontinence care or seeing anyone else do so either.

When interviewed the resident's family members stated every evening around 6:00 p.m. they went to the facility to assist with bedtime cares and showers. The family indicated the resident had no bruising prior to the day the incident occurred. The family members stated they were upset to see 3 staff assisting the resident with incontinence care the day of the incident, and indicated the resident likely would have felt attacked, overwhelmed, and overstimulated in that situation.

Multiple attempts to interview AP3 were made with no response

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

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

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; or
(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 unless authorized under applicable licensing requirements or Minnesota Rules, chapter 9544.

Vulnerable Adult interviewed: No, deceased
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes, AP1/AP2. No, AP3 did not respond to interview attempts.

Action taken by facility:
The facility held a care conference with the resident's family following the incident. Reviewed the video provided, suspended the staff involved, reported the concern to the Minnesota Adult Abuse Reporting Center (MAARC), and re-educated staff involved on dementia challenging behaviors. AP3 is no longer employed by the facility.

Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26585	A. BUILDING: _____ B. WING _____	C 02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD SARTELL LLC	677 BRIANNA DRIVE SARTELL, MN 56377

(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: #HL265858202M/# HL265854350C On February 14, 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 84 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL265858202M/# HL265854350C, tag identification 0730, and 1640.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the	0 730		

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0 730	Continued From page 1 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 professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution;	0 730		

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0 730	Continued From page 2 (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure resident records had the required content including documentation of incidents involving the resident, and accurate documentation of assessment of bruising injuries following an allegation of abuse for one of one resident (R1) reviewed for maltreatment. 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). Findings include: R1 was admitted to the licensee secure memory care unit on December 14, 2021, with diagnoses including Alzheimer's Disease. R1 assessment dated December 24, 2024, indicated R1 had moderately impaired cognition and was confused, anxious, agitated, resistive, combative, and paranoid. The assessment indicated R1 required assistance with toileting, and dressing.	0 730		

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0 730	Continued From page 3 R1's care plan identified R1 had impaired cognition and communication vulnerabilities and indicated staff should not raise their voices or shout at R1, should speak to R1 as an adult, avoid carrying on more than one conversation at a time, keep a quiet atmosphere, and not rush R1. The assessment identified R1 had a history of verbal/physically aggressive behaviors related to increased anxiety and indicated staff should explain what they want to do before completing a task, if R1 refused or if behavior escalated staff were to back away and allow R1 space and re-approach later, then document the behavior with attempted interventions. R1 service delivery record indicated on December 29, 2024, at 1:35 p.m. unlicensed personnel (ULP)-C documented R1 had physically aggressive behavior. The note indicated R1 had incontinent feces on the back of his pants and ULP-A, ULP-B, and ULP-C were trying to change R1 in his bathroom, but R1 became physical and tried grabbing staff's hair and punching staff in the face and head. At 1:50 p.m. (following the incident) ULP-C documented R1 was calling care staff "stupid hoe's and bitch's " as well as walking around the pod and calling residents and other care staff "stupid idiots." The note indicated staff tried redirecting but that would only further R1's agitation. The documentation indicated R1 remained agitated and upset following the incident with the 3 staff and was unable to be redirected. On February 14, 2025, at 11:20 a.m. during an entrance conference with Licensed Practical Nurse (LPN)-G, Executive Director (ED)-F, Registered Nurse Clinical Services Director (RNCSD)-L, and RN-D stated R1's family reported finding bruises on R1, then reviewed	0 730		

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0 730	Continued From page 4 video footage also shared with leadership, which indicated 3 staff were rough with R1 while providing incontinence cares on December 29, 2024. Leadership stated R1 had no bruises or skin issues, then after the incident had bruising that looked like someone had grabbed R1. RN-D described R1's bruises as having visible hand and thumb prints on R1's hands and arms. Leadership staff stated when the 3 staff were interviewed about the incident unlicensed personnel (ULP)-C reported "they" (ULP-A, ULP-B, and ULP-C) "had to put hands on R1" to get him to sit down on the toilet. Leadership indicated they did not know what ULP-C meant by put hands on R1, and indicated they did not ask any further questions to identify who or how staff had put hands on R1. Leadership indicated staff did not follow R1's plan of care for how to respond to resistive aggressive behavior. An incident report, complaint/grievance, and skin/wound assessment prior to and following the incident were requested but none were provided. On February 25, 2025, at 4:32 p.m. during email communication RNCSD-L indicated there were no measurements or descriptions for the bruising other than what was documented in nursing notes. On February 26, 2025, at 1:46 p.m. during email communication RNCSD-L indicated there was no incident report completed for the incident involving (R1) and 3 staff on December 29, 2024, resulting in bruising injuries. R1's progress note on December 30, 2024, at 11:50 a.m. indicated LPN-G documented family reported concerns with R1's services provided on December 29, 2024. The note indicated a care	0 730		

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0 730	Continued From page 5 conference was held for concerns with the way staff provided R1 with incontinence cares.. At 2:39 p.m. RN-D documented she had assessed R1 following the incident and noticed discolored areas on R1's right and left forearms. The note indicated staff attempted to assist R1 to the bathroom when R1 became resistive/combative towards staff. R1's progress notes lacked documentation of injuries caused following the incident including size/description of R1 bruises. A review of family provided time and date stamped pictures following the incident showed R1 had a large dark purple bruise on his left hand spanning the webbed space between R1's thumb and index finger, a quarter size dark purple bruise on the back of R1's right hand, a small dot the size of a thumb print on the inner aspect of R1 right forearm above the wrist, and a large bruise on one of R1's forearms. On February 27, 2025, at 2:31 p.m. during email communication RNCSD-L indicated an incident report should have been completed following the incident with R1 on December 29, 2024, with the 3 staff but was not. On February 28, 2025 at 8:15 a.m. during email communication RNCSD-L indicated documentation of R1's bruising injuries following the incident should have included documentation of bruising location, color, and description, pain, drainage (if any), and surrounding tissue but did not. A facility policy and procedure titled "Resident Record Documentation" dated January 2025, Section 9. indicated the resident record would include documentation of issues involving the resident and actions taken in response to the	0 730		

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0 730	Continued From page 6 needs of the resident including reporting to the appropriate supervisor or health care professional. Section 12. indicated the resident record would include complaints received and resolutions will be documented and stored per state regulation. Staff will also document other important and pertinent information relating to each resident. A facility policy and procedure titled "Skin Care Policy" dated January 2025, indicated at the time of admission a skin assessment would be completed to identify any bruises, lacerations, puncture wounds, rashes, and abrasions and indicated the documentation would include the location, color, surrounding tissue, and pain. Section B indicated ongoing skin integrity monitoring would be completed when personal care was provided, and indicated a formal skin assessment would be completed annually and with any change of condition. The policy and procedure indicated when a wound was identified, the skin care protocol would be implemented, progress toward healing is monitored and documentation is noted in the resident record under wound assessment, at a minimum weekly. Section C. indicated 1. Documentation of a change in skin integrity should include a. Location. b. Description.c. Degree of pain if present.d. Drainage, amount and appearance. 2. The resident record reflects notifications, care provided, and if applicable interventions taken to prevent re-occurrence. Section 3. When any lesion, bruise, skin tear, etc. was identified it would be noted in the resident record. A facility policy and procedure titled " Incident Management" dated January 2025, indicated all incidents or adverse events occurring in the community or on community property must be	0 730		

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0 730	Continued From page 7 reported immediately. An incident report is to be completed when there is any unexpected event or near-miss involving a resident or a visitor or when a situation occurs that varies from established policy or procedure and may lead to an undesired effect. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 730		
01640 SS=G	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 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	01640		

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01640	Continued From page 8 by: Based on interview and record review, the licensee failed to ensure the plan of care was implemented for one of one resident's (R1) reviewed with dementia behaviors. Harm occurred for R1 after he was incontinent of stool, and resisted/refused cares, 3 staff failed to follow R1 plan of care and forced cares on R1 for approximately 12 minutes. The incident caused R1 distress, agitation, and likely provoked R1 to respond to staff in an aggressive manner. R1 was observed with multiple bruises on his hands, wrists, and forearms following the incident. 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 was admitted to the licensee secure memory care unit on December 14, 2021, with diagnoses including Alzheimer's Disease. R1's assessment dated December 24, 2024, indicated R1 had moderately impaired cognition and was confused, anxious, agitated, resistive, combative, and paranoid. The assessment indicated R1 required assistance with toileting, and dressing. R1's care plan identified R1 had impaired cognition and communication vulnerabilities and indicated staff should not raise their voices or	01640		

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	26585	A. BUILDING: _____ B. WING _____	C 02/14/2025

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01640	Continued From page 9 shout at R1, should speak to R1 as an adult, avoid carrying on more than one conversation at a time, keep a quiet atmosphere, and not rush R1. The assessment identified R1 had a history of verbal/physically aggressive behaviors related to increased anxiety and indicated staff should explain what they want to do before completing a task. Staff were directed if R1 refused or if behavior escalated staff were to back away and allow R1 space and re-approach later, then document the behavior with attempted interventions. R1's service delivery record indicated on December 29, 2024, at 1:35 p.m. unlicensed personnel (ULP)-C documented R1 had physically aggressive behavior. The note indicated R1 had incontinent feces on the back of his pants and ULP-A, ULP-B, and ULP-C were trying to change R1 in his bathroom, but R1 became physical and tried grabbing staff's hair and punching staff in the face and head. At 1:50 p.m. (following the incident) ULP-C documented R1 was calling care staff "stupid hoe's and bitch's, " as well as walking around the pod and calling residents and other care staff "stupid idiots." The note indicated staff tried redirecting but that would only further his agitation. The documentation indicated R1 remained agitated and upset following the incident with the 3 staff and was unable to be redirected. On February 14, 2025, at 11:20 a.m. during an entrance conference with Licensed Practical Nurse (LPN)-G, Executive Director (ED)-F, Registered Nurse Clinical Services Director (RNCSD)-L, and RN-D, they stated R1's family reported finding bruises on R1, then reviewed recorded video footage also shared with leadership, which indicated 3 staff were rough	01640		

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01640	Continued From page 10 with R1 while providing incontinence cares on December 29, 2024. Leadership stated R1 had no bruises or skin issues, then after the incident had bruising that looked like someone had grabbed R1. RN-D described R1's bruises as having visible hand and thumb prints on R1's hands and arms. Leadership staff stated when the 3 staff were interviewed about the incident unlicensed personnel (ULP)-C reported "they" (ULP-A, ULP-B, and ULP-C) "had to put hands on R1 to get him to sit down on the toilet". Leadership indicated they did not know what ULP-C meant by "put hands on R1," and indicated they did not ask any further questions to identify who or how staff had put hands on R1. Leadership staff indicated staff did not follow R1's plan of care for how to respond to resistive aggressive behavior, because staff did not want to be in trouble for leaving R1 in incontinent stool. R1's progress note on December 30, 2024, at 11:50 a.m. indicated LPN-G documented family reported concerns with R1's services provided on December 29, 2024. The note indicated a care conference was held for concerns with the way staff provided R1 with incontinence cares, but the note failed to provide any details of the concern reported by family. At 2:39 p.m. RN-D documented she had assessed R1 following the incident and noticed discolored areas on R1's right and left forearms. The note indicated staff attempted to assist R1 to the bathroom when R1 became resistive/combative towards staff. R1's progress notes lacked documentation of injuries caused following the incident including size/description of R1 bruises. A facility investigation template dated December 30, 2024, indicated when ED-F and LPN-G interviewed ULP-A about the incident, ULP-A	01640		

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01640	Continued From page 11 stated she tried to get R1 to sit on the toilet, but R1 became combative and harder to work with. A facility investigation template dated December 30, 2024, indicated when ED-F and LPN-G interviewed ULP-B about the incident, ULP-C stated she was called for help to change R1's soiled pants, and indicated R1 became agitated and hit ULP-B in the head. ULP-B indicated ULP-A tried to keep R1 from hitting ULP-B. ULP-B indicated staff (unknown) tried to get R1 to sit on the toilet, R1 did not want to, but they finally got him to sit and cleaned R1 up. A facility investigation template dated December 30, 2024, indicated when ED-F and LPN-G interviewed ULP-C about the incident, ULP-C stated she took R1 into his room to get his pants changed and cleaned up. The template indicated R1 became frustrated so ULP-C called for help, to which ULP-A and ULP-B responded, but indicated R1 began pushing staff. The interview template indicated ULP-C stated they did "finally get R1 to sit down on the toilet, but we did have to put hands on him to sit him down." Review of the recorded 12 minute video from R1's room during the incident indicated R1 entered his room with 2 staff. The staff were heard repeatedly telling R1, "lets go potty", to which R1 responded, "no". One staff (unknown) repeated "No? "We gotta get you changed you have some poop on you." Another staff (unknown) was also heard telling R1 he had poop on him, and told R1 to "be cooperative" because he had an accident. Then, a third staff entered the room and told the resident, "You pooped your pants, you have poop on you butt." R1 was heard swearing at the staff. R1 was observed trying to leave the bathroom. Shortly after R1 returned to	01640		

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01640	Continued From page 12 the bathroom with the 3 staff. Then, voices are heard escalate higher, louder, and more than one trying to redirect R1 at once, then a few seconds later unknown staff are heard telling R1 they needed to change his pants and R1 was yelling, "No!". Staff (unknown) continued to loudly and repeatedly tell R1 to sit down, they needed to clean him up, and ask the resident to, "stop, stop!" A (unknown) staff was heard saying to R1, "please your mother is here we need to get dressed, I got to wipe your butt...!" Approximately 7 minutes later one staff (unknown) left the bathroom looking at her arm and said, "oh my gosh, I am going to stand over here, holy cow!" Shortly after the staff and R1 left R1's bathroom, one staff was observed shaking her head as she exited the room. The video ended. A review of family provided time and date stamped pictures following the incident showed R1 had a large dark purple bruise on his left hand spanning the webbed space between R1's thumb and index finger, a quarter size dark purple bruise on the back of R1's right hand, a small dot the size of a thumb print on the inner aspect of R1 right forearm above the wrist, and a large bruise on one of R1's forearms. On February 26, 2025, at 1:23 p.m. ULP-A stated if a resident had aggressive resistive behaviors she would step back and re-approach later. ULP-A stated R1 had verbally and physically aggressive behaviors toward residents and staff and indicated only one staff normally provided cares to R1. ULP-A indicated having 3 staff in the bathroom was very unusual and likely increased R1's behaviors the day of the incident. ULP-A indicated despite R1 striking out and being resistive to cares staff staff did not stop, re-approach, or ask the nurse/family for help	01640		

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01640	Continued From page 13 when R1's behavior escalated because she thought they would be in trouble either by leaving R1 in incontinence or by staff getting him changed. ULP-A stated R1 grabbed another staff's hair and she had to pry R1's hand off, then restated that she put her hand under R1's and R1 let go of the staffs hair. ULP-A denied hearing or saying anything to R1 in a scolding manner. ULP-A denied holding/grabbing or forcing R1 to sit on the toilet for incontinence care or seeing anyone else do so either. On February 26, 2025, at 11:39 a.m. ULP-B stated R1 required assistance with ADL's including toileting and incontinence cares with one staff. ULP-B stated R1 was verbally and physically aggressive toward staff and residents, would hit, swear, and hit people with his walker. ULP-B indicated if R1 was resistive or refused cares staff should redirect/re-approach R1 3 times, switch staff, and indicated they would sometimes use 2 staff or call the nurse or family for help, but stated they did not do any of those things. ULP-B stated 3 staff assisting R1 with cares at one time could have been overwhelming for R1. ULP-B stated no incident report was completed. ULP-B denied holding/grabbing or forcing R1 to sit on the toilet for incontinence care or seeing anyone else do so either. Multiple attempts to interview ULP-C were made with no response. On February 14, 2025, at 12:54 p.m. ULP-H stated R1 did not like certain people or things. ULP-H stated R1 had unpredictable behaviors, and indicated if R1 was in a swatting behavior she would step away and reapproach. ULP-H stated R1 was fairly cooperative with one staff, however, if multiple staff were assisting with	01640		

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01640	Continued From page 14 cares R1 could become overwhelmed resulting in behaviors. On February 14, 2025, at 1:27 p.m. ULP-I stated if a resident was resistive aggressive she would approach in a calm manner, tell them step by step what she was doing, and if the resident was still resistant she would give time/space, and re-approach by trying another care staff, calling family, or the nurse. ULP-I indicated family generally came in every night to assist R1 with cares, and would come in and help if needed. On February 26, 2025, at 3:44 p.m. R1's family member (FM)-E and FM-M stated every evening around 6:00 p.m. they went to the facility to assist R1 with bed time cares and showers and R1 had no bruising prior to the incident. FM-E stated R1 preferred order and structure in his routine and would yell, scream, lash out, and become physically/verbally aggressive when frustrated. FM-E indicated the facility had no incident report following the incident, and indicated nothing was followed on R1's plan of care. FM-E and FM-M stated they were appalled to see 3 people assisted R1 the day of the incident, and indicated R1 likely would have felt attacked when 3 staff at one time provided care to R1. FM-E stated 3 staff could have escalated behavior due to too much stimulation and being overwhelming for R1. A facility policy and procedure titled "Service Planning and Care Planning Coordination of Care" Dated January 2025, indicated as a basic health service tool, the Service Plan/Care Plan is used to identify resident care issues, how staff should monitor/observe for them, and interventions for each resident that staff can apply if necessary.	01640		

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01640	Continued From page 15 No additional information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	01640		