DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL273891802M
Compliance #: HL273893432C

Date Concluded: October 20, 2022

Name, Address, and County of Licensee Investigated:
Hometown Senior living
12591 Shannon Parkway
Rosemount, MN 55068
Dakota County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Peggy Boeck, RN
Special Investigator

Finding: Substantiated, facility responsibility

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

Initial Investigation Allegation(s):
The facility neglected a resident when the facility failed to provide enough staff or training for managing the resident's agitation and directed staff to call law enforcement, who responded 33 times to the facility.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to ensure an adequate number of staff who were trained and educated to provide individualized care, supervision, and ensure the residents safety, were available. The facility relied on law enforcement to intervene when the resident experienced agitation and aggression.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's guardian and law enforcement. The investigation included review of the resident's hospital records, facility

records, facility incident reports, police reports, policies, and procedures related to admission of residents, changes in condition, training of staff, abuse prevention planning, service plans, assessments, orientation to residents, nurse availability, staffing, and maltreatment of vulnerable adults. Also, the investigator observed staff interactions with residents.

The resident lived in the assisted living facility due to diagnoses that included traumatic brain injury, dementia, and epilepsy. The resident's service plan included assistance with transportation, assistance with bathing, assistance with meals, cues for dressing/grooming, medication administration, stand-by assistance with toileting and/or continence cares, and hourly safety checks.

The facility web site advertised the facility provided behavioral management in coordination with medical and contracted psychiatric services.

Upon admission the resident's service plan directed staff to reorient the resident to time and place, monitor the resident's whereabouts, monitor the resident for statements of wanting to leave, redirect the resident, walk away from the area if the resident became aggressive or physical, and call law enforcement.

Staff documented in the resident's chart when the resident had behaviors such as aggression, irritability, "sundowners", frustration, combativeness, swearing, and slamming doors. Documentation by several staff indicated the resident had increased behaviors in the early evening and through the night shift, however, the service plan provided no new interventions for staff.

Law enforcement reports indicated the facility staff called for assistance with the resident on 22 occasions. The reports indicated staff stated the resident was a threat to staff, himself, or other residents. The staff often requested law enforcement take the resident away from the facility to a hospital for a mental health evaluation. Several reports indicated law enforcement questioned the number of staff, staff training, staff tools, or if staff had resources to manage the resident who had mental health issues. The reports indicated concern for the resident and the five other vulnerable adults living at the facility with two staff on days/evenings, and only one staff on overnights.

Facility records indicated the five other residents at the facility diagnoses included degenerative muscle disease with reliance on a wheelchair, Down's syndrome, dementia, blindness, and brain injury with inability to speak.

The nurse assessed the resident each time he returned from the hospital. The nurse made no changes to the resident's service plan and gave staff no new interventions to attempt prior to or when the resident became agitated or angry. Although the assessments indicated that a behavior management plan was indicated, none was provided for staff.

The resident's nursing assessments all indicated the facility met the resident's needs, and services were appropriate.

During an interview, a police detective stated the facility staff said management instructed them to call law enforcement if they were unable to redirect the resident. The detective stated the facility staff called law enforcement 22 times in a six-month period for this resident. The detective stated the facility had made no effort to do anything different with or for the resident.

During interviews, multiple staff members stated the facility relied on law enforcement to intervene with the resident. Staff interviewed stated they had received no education or training on how to interact with the resident beyond redirect, reorient, and medicate the resident.

During an interview, the nurse stated it would have been beneficial for the staff to have direction on managing the resident's behaviors. The nurse stated she thought staff had received some training from the facility corporation but could not provide evidence of the training.

During an interview, a management staff stated the nurse was responsible for training staff and making changes to the resident's service plan, which provided direction for staff for preventing and managing the resident's behaviors. The management staff stated the nurse did not have time to address all the residents' behaviors as she provided nursing coverage for seven facilities.

During an interview, the resident's guardian stated the facility called law enforcement rather than work with the resident. The guardian stated she did not feel the facility staff were tolerant of the resident. The guardian stated the hospital would send the resident back to the facility within two hours as there was no reason to keep him at the hospital.

In conclusion, neglect is 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:
No action taken

Action taken by the Minnesota Department of Health:

The responsible party will be notified of their right to appeal the maltreatment finding.

The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:
https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

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

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Dakota County Attorney
Rosemount City Attorney
Rosemount Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27389	A. BUILDING: _____ B. WING _____	C 09/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMETOWN SENIOR LIVING OF ROSE	12591 SHANNON PARKWAY ROSEMOUNT, MN 55068

(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 Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING 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: #HL273893432C/#HL273891802M/#HL273894681C/#HL273892804M On September 21, 2022, 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 6 residents receiving services under the provider's Assisted Living license. The following correction order is issued for #HL273894681C/#HL273892804M, tag identification 2360. The following immediate correction orders are issued for #HL273893432C/#HL273891802M, tag identification #0470 and #2320.	0 000	Minnesota Department of Health is documenting the State Licensing 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.	

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0 470	Continued From page 1	0 470		
0 470 SS=I	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the licensee failed to ensure sufficient staffing to meet the scheduled needs of six of six residents (R1, R2, R3, R4, R5, and R6). The licensee failed to ensure staff was scheduled according to the residents assessed needs; and ensure staff were able to respond promptly and	0 470		

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0 470	Continued From page 2 effectively to residents emergencies and/or behaviors. Staff were instructed to call law enforcement for behavior management and resident lift assistance as the licensee scheduled only one staff between the hours of 11:00 p.m. and 8:00 a.m. This resulted in multiple,ongoing calls to law enforcement for assistance with dealing with resident behaviors or lifting a resident. The facility was notified of the immediate correction order on October 25, 2022. 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: R1 R1 admitted to the facility on March 2, 2022, due to diagnoses that included traumatic brain injury, dementia, and epilepsy. R1's Hennepin County court guardianship order dated November 12, 2021, indicated R1 experienced poor memory and a deteriorating mental state with confusion, impulsivity, and an inability to cooperate with medical decision making. R1's Vulnerability Assessment/Abuse Prevention Plan dated March 2, 2022, included the following interventions: staff to provide cues and reminders regarding orientation, staff to monitor whereabouts of resident while up and about, staff to monitor for statements of wanting to leave, staff to redirect R1 and walk away if becoming	0 470		

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0 470	Continued From page 3 aggressive/physical, and staff to call law enforcement if unable to redirect. R1's Monthly Behavior Summary document dated April 28, 2022, indicated R1 was sleeping more during day, wandering house at night. R1 was often agitated and verbally aggressive towards staff. The document indicated R1's combative and aggressive behaviors were observed in early evening through night shift. R1's Service Agreement dated June 14, 2022, indicated R1 received services from the licensee that included assistance with self-directed activities, assistance with transportation, assistance with bathing, frequent redirection, assistance to manage orientation, assistance with meals, escorts to meals, meal preparation, cues for dressing, cues and prompting for grooming, assistance with nail care, assistance with shaving, medication administration, hourly safety checks, monitoring of reactive behaviors, redirection to manage wandering/elopement prevention, cueing and stand-by assistance with toileting and/or continence cares. R2 R2 admitted to the assisted living facility on July 26, 2022, due to diagnoses that included anoxic brain injury, aphasia (inability to speak due to brain injury), and diabetes. R2's Service Plan dated July 28, 2022, indicated R2 received services from the licensee that included assistance with use of the telephone, assistance with transportation, assistance with bathing, assistance with escorts to meals, assistance with meal preparation, assistance with grooming, nursing assistance with nail care, assistance with shaving, nursing coordination of	0 470		

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0 470	Continued From page 4 cares with a home health agency, weekly vital signs and weights, daily enema, medication set-ups, medication administration, ambulation with a gait belt, transfer assistance with a gait belt, bed mobility, turning/repositioning in bed, bed rail safety checks, redirection when wandering, wellness checks every one to two hours and as needed, documentation of bowel output, daily wound cares, physical assist of two staff for toileting (a.m., p.m., and nights) and behavior management. An e-mail dated August 23, 2022, at 10:42 a.m., from facility RN-A sent to hospital RN-L indicated R2 had difficulty in the mornings when pressing his call light, trying to self-transfer, and displaying impulsive behaviors. RN-A indicated in the e-mail that "it has been hard to monitor him with one staff on site." R3 R3 admitted to the facility on March 1, 2014, due to diagnoses that included stroke, cognitive impairment, and impaired vision (left eye sewn shut). R3's service plan dated September 14, 2021 indicated R3 received services from the licensee that included assistance to use the phone, physical assist of one staff for bathing, behavior management, orientation, dining stand-by assistance due to history of choking, physical assist of one staff for dressing/grooming/shaving/repositioning/bed mobility, assist of 1-2 staff for transfer using a full mechanical lift, bed rail safety checks, total assist of staff for toileting, check and change every two hours, and medication administration. R4	0 470		

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0 470	Continued From page 5 R4 admitted to the facility on June 29, 2020, due to diagnoses that included Spinocerebellar degeneration, dysphagia, and impaired coordination. R4's service plan dated November 23, 2021, indicated R4 received services from the licensee that included assistance to use the phone, physical assist of one staff for bathing, behavior management, physical assist of one staff for dressing/placing hearing aids/grooming, breathing treatments via nebulizer, bed mobility, transfers using a total body ceiling lift or sit to stand lift, bed rail safety checks, physical assist of one staff for toileting, and medication administration. R5 R5 admitted to the facility on April 1, 2019, due to diagnoses that included Down's syndrome and dementia. R5's service plan dated September 14, 2021, indicated R5 received services from the licensee that included assistance to use the phone, physical assist of one staff for bathing, behavior management, physical assistance of one staff for dressing/grooming/oral cares, breathing treatments via nebulizer, two-hour face-to-face safety checks, physical assist of one staff for toileting, and medication administration. R6 R6 admitted to the facility on June 18, 2019, due to diagnoses that included dementia, bilateral hearing loss, stroke, and cortical blindness. R6's service plan dated September 14, 2021, indicated R6 received services from the licensee that included assistance to use the phone,	0 470		

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0 470	Continued From page 6 physical assist of two staff for bathing, behavior management, physical assist of one staff for meals/dressing/grooming/oral care/shaving, assistance of staff for passive range of motion, transfers with gait belt or sit-to-stand lift, turning and repositioning every two hours, bed rail safety checks, assistance of one or two staff for toileting every two hours, and medication administration. During an interview on September 21, 2022, at 10:48 a.m. registered nurse (RN)-A stated staff documented R1's behaviors and the team reviewed the documentation. RN-A stated staff interventions were to reapproach and to redirect R1. RN-A stated R1 had increased behavioral difficulty at night. RN-A stated the "agreement to keep [R1] here is to keep him safe and call law enforcement" when he was agitated or aggressive. During an interview on September 21, 2022, at 11:28 a.m. executive director (ED)-B stated staff tried to redirect R1 but needed to call police multiple times. During an interview on September 23, 2022, at 10:20 a.m. law enforcement detective (D)-G stated the facility staff told her that management instructed them to call 911 if unable to redirect R1. D-G stated the facility had made no effort to do anything different. D-G stated the facility staff called law enforcement 22 times from March 1, 2022, through September 21, 2022, related to R1. During an interview on October 4, 2022, at 10:39 a.m., ULP-M stated the facility plan for R1 upon admission was to call the police if he became aggressive. During an interview on October 25, 2022, at 8:46	0 470		

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0 470	Continued From page 7 a.m., law enforcement detective (D)-G stated the facility staff called 911 two times related to R1's behavior on October 22, 2022. D-G stated the responding officers found R1 across the road from the facility. The responding officers assisted back to the facility into his room. D-G stated officers were later dispatched back to the facility and staff requested law enforcement place R1 on a hold and take him to the hospital due to behaviors. D-G stated the facility staff also called on October 25, 2022, requesting officers come to help a staff get a resident off the floor. A law enforcement report dated October 22, 2022, indicated (at 2:20 p.m.) officers responded to a mental health call and found R1 sitting across the street from the facility, despite the fact that R1 demonstrated limited mobility and used a wheelchair. The report indicated officers assisted R1 with deep breathing exercises (which calmed him down) and escorted R1 back to the facility. The report indicated R1 stated staff treated him poorly, laughed at him, shoved him, and R1 stated he wanted to die. The report indicated R1 admitted to throwing small rocks at staff, and knew it was wrong. The report indicated officers got R1 settled in his room and left the facility. The report indicated at 3:00 p.m. officers were again dispatched to the facility and upon entering, observed R1 in the hallway with his wheelchair. The report indicated R1 was known to have a traumatic brain injury and dementia. The officers indicated R1 seemed angry and talkative, but non-sensicle. The report indicated the officers spoke to the nurse, who expressed worry that R1 would escalate and wanted law enforcement to take him to the hospital. The report indicated based on conversation with staff it was obvious that R1 needed more care than available at the facility.	0 470		

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0 470	Continued From page 8 A law enforcement Incident Detail report dated October 25, 2022, at 7:08 a.m. indicated staff called requesting assistance getting a resident up into a chair. The report indicated the resident was on the floor on their knees, weighed 186 pounds, and the staff wanted lift assistance. Facility schedules indicated one staff scheduled from 11:00 p.m. to 8:00 a.m. on August 28, 2022, through September 8, 2022, September 10, 2022, September 12-18, 2022, September 20-23, 2022, and September 25,2022, through October 1, 2022. The schedules indicated one staff scheduled from 7:00 a.m. to 8:00 a.m. on September 9, 11, 19, and 24, 2022. The Staffing and Scheduling policy dated August 1, 2021, indicated the licensee would assure that qualified employees would be scheduled to meet operational requirements and the needs of the residents. The licensee provided no evidence of any staffing metrics used to determine appropriate staffing levels and no evidence that staffing levels had been reviewed. TIME PERIOD FOR CORRECTION: IMMEDIATE	0 470		
02320 SS=I	144G.91 Subd. 4 Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan.	02320		

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02320	Continued From page 9 This MN Requirement is not met as evidenced by: Based on observation, interviews, and document reviews the licensee failed to ensure properly trained staff in sufficient numbers provided appropriate care and services for two of two residents (R1 and R2) reviewed when the licensee failed to provide all staff with orientation to R1 and R2's service plans and failed to ensure R1 and R2's service plans included behavior management interventions for staff. Staff contacted police 22 times for crisis intervention related to R1 and and once for "lift assist" when the staff on duty was unable to get a resident off the floor. This had the potential to affect all 6 residents residing in the facility. The facility was notified of the immediate correction order on October 25, 2022. 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: R1 R1's medical record indicated the resident moved into the assisted living facility on March 2, 2022, due to diagnoses that included traumatic brain injury, dementia, and epilepsy. R1's County court guardianship order dated November 12, 2021, indicated R1 experienced poor memory and a deteriorating mental state with confusion,	02320	Minnesota Department of Health is documenting the State Licensing 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.	

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HOMETOWN SENIOR LIVING OF ROSE	12591 SHANNON PARKWAY ROSEMOUNT, MN 55068

(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
02320	Continued From page 10 impulsivity, and an inability to cooperate with medical decision making. R1's Vulnerability Assessment/Abuse Prevention Plan dated March 2, 2022, included the following interventions: staff to provide cues and reminders regarding orientation, staff to monitor whereabouts of resident while up and about, staff to monitor for statements of wanting to leave, staff to redirect R1 and walk away if becoming aggressive/physical, and staff to call law enforcement if unable to redirect. R1's Monthly Behavior Summary document dated April 28, 2022, indicated R1 was sleeping more during the day and wandering the house at night. The document indicated R1 was often agitated and expressed verbal aggression towards staff. The document indicated R1 had combative and aggressive behaviors in the early evening through night shift. R1's Master Assessments dated May 3, 20, and 24, 2022, indicated the reason for the assessment included emergency department visits. The assessments noted that a behavior management plan was indicated, however, R1's record lacked evidence of a behavior management plan. R1's Monthly Behavior Summary document dated May 31, 2022, indicated R1 was easily agitated in the early evening hours. R1 had trouble timing bathroom visits and the registered nurse (RN) suggested adaptive clothing, a bedside commode, and a toileting schedule. R1's service plan lacked evidence of any of the suggested interventions.	02320		

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02320	Continued From page 11 R1's assessment dated May 31, 2022, indicated the facility met R1's needs, registered nurse (RN)-A reviewed R1's service plan, services were appropriate, and RN-A made no changes to R1's service plan. R1's Service Agreement dated June 14, 2022, indicated R1 received services from the licensee including assistance with self-directed activities, assistance with transportation, assistance with bathing, frequent redirection, assistance to manage orientation, assistance with meals, escorts to meals, meal preparation, cues for dressing, cues and prompting for grooming, assistance with nail care, assistance with shaving, medication administration, hourly safety checks, monitoring of reactive behaviors, redirection to manage wandering/elopement prevention, cueing and stand-by assistance with toileting and/or continence cares. R1's Master Assessments dated June 17, 2022, and September 7, 2022, indicated a reassessment was completed of R1 after he was hospitalized for combative behaviors, and behaviors with physical aggression/agitation. The assessments indicated a behavior management plan was indicated. R1's record lacked evidence of a behavior management plan. R1's Monthly Behavior Summary document dated June 30, 2022, indicated R1 had behaviors of agitation/aggression that started after 3:00 p.m. The summary indicated police were called to assist with de-escalating R1 and to support staff. R1's 14/90 Day Assessment dated September 14, 2022, indicated the facility met R1's needs,	02320		

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02320	Continued From page 12 RN-A reviewed R1's service plan, indicated that services were appropriate, and RN-A made no changes to R1's service plan. R1's Verification of staff Orientation document (undated) indicated by signing the document staff acknowledged "I have been oriented to the care of this resident by the Registered Nurse and I have read through and reviewed the Care Plan and understand the level of assistance the resident will need with his/her activities of daily living also described on the ADL and Flow Sheets". The document lacked evidence that unlicensed personnel (ULP)-C and ULP-N received orientation to the cares of R1. R1's Service Received documents reviewed on September 21, 2022, indicated the following: May 29, 2022, AM (morning) cares note written by ULP-C, indicated "no behaviors just lots of confusion and unsteady". June 17, 2022, NOC (overnight) cares note written by ULP-N indicated "agitated when spoken to or redirected" June 23, 2022, AM cares note written by ULP-C indicated "some cursing in the early AM, but walked away ad [sic] he mellowed out" June 30, 2022, NOC cares note written by ULP-N indicated "won't allow me to put clothes on him and he can't get them on himself, has also peed all over himself". July 2, 2022, PM (evening) cares note written by ULP-N indicated "swearing at staff, racial slurs, slamming doors repeditively [sic], screaming" July 7, 2022, PC cares note written by ULP-N indicted "slamming and kicking his door for almost an hour and had been going in other resident's rooms and locking himself in their room	02320		

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02320	Continued From page 13	02320		

then would come out throwing stuff or attempting to hit staff as well as speaking to the staff in a vulgar and disrespectful manner".
July 12, 2022, AM cares note written by ULP-C indicated "mild behaviors after lunch, digging in fridge and throwing food".
July 14, 2022, NOC cares note written by ULP-N indicated "woke up agitated at 5:48".
July 16, 2022, PM cares note written by ULP-N indicated "was taking other resident's things and mistreating their belongings refusing to return the items".
July 16, 2022, AM cares note written by ULP-C indicated "he has more issues starting at 3 pm or later".
July 17, 2022, AM cares note written by ULP-C indicated "some up and down outburst of swearing. Trying to ignore or redirect".
July 18, 2022, AM cares note written by ULP-C indicated "many different type of redirection agitations this afternoon".
July 21, 2022, AM cares note written by ULP-C indicated "offer snacks and it sometimes helps during the day".
July 22, 2022, NOC note written by ULP-N indicated "resident woke up and was hanging out by his door and when he seen me he started getting angry and then started swearing at me and approaching me so he could swing at me and when we were by the picture frames he picked them up and threw them at me, continued making his way back to his afterwards and started to slam and kick doors"
July 25, 2022, AM cares note written by ULP-C indicated "some redirecting. He was starting to get upset but I offered him a snack".
July 28, 2022, AM cares note written by ULP-C indicated "some redirecting".
July 30, 2022, AM note written by ULP-C indicated "he got combative and we PRNed him".

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02320	Continued From page 14 August 3, 2022, PM cares note written by ULP-N indicated "after he ate dinner and wandered around, he became frustrated with everything around him". August 24, 2022, AM cares note written by ULP-C indicated "midafternoon sundowners starting". August 28, 2022, AM cares note written by ULP-C indicated "Had a bad morning. Started to get aggressive". September 19, 2022, AM cares note written by ULP-C indicated "Had some issue when he saw [another resident] today I PRNed him and it seemed to help somewhat". During an interview on September 21, 2022, at 10:48 a.m. registered nurse (RN)-A stated staff documented R1's behaviors and the team reviewed the documentation. RN-A stated staff interventions were to reapproach and to redirect R1. RN-A stated R1 had increased behavioral difficulty at night. RN-A stated the "agreement to keep [R1] here is to keep him safe and call law enforcement" when he was agitated or aggressive. RN-A stated she reached out and a corporate nurse trained some staff on strategies and techniques. RN-A stated the strategies and techniques should be in R1's service plan but acknowledged they were not. RN-A could not provide documentation of the training. During an interview on September 21, 2022, at 11:28 a.m. executive director (ED)-B stated staff tried to redirect R1 but needed to call police multiple times. ED-B stated R1 received one on one attention for a time and a "behavioral person" trained a couple of staff on behaviors but did not know what was in the service plan. ED-B stated she was several layers above the day-to-day operations of the facility and deferred to the onsite assisted living director (ALD-E).	02320		

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02320	Continued From page 15 During an interview on September 21, 2022, at 2:33 p.m. house manager-ULP-D stated the registered nurse provided training to staff working on the day of a new resident's admission and after that staff were told to read the residents' care plans and sign off on the Verification of RA Orientation document. During an interview on September 21, 2022, at 3:02 p.m. onsite assisted living director (ALD)-E stated she tried to be at the facility once per week but also had responsibility of two additional facilities in Minnesota and one in Wisconsin. ALD-E stated the nurse was responsible for training staff and the house manager (ULP-D) was responsible for the day-to-day operations of the facility. ALD-E stated RN-A handled incidents, but due to providing nursing coverage for seven facilities, she did not have time to address all the behaviors. ALD-E stated it would probably be helpful to staff if they had information about specific behavioral interventions. During an interview on September 23, 2022, at 10:20 a.m. law enforcement detective (D)-G stated the facility staff told her management instructed staff to call 911 if unable to redirect R1. D-G stated the facility had made no effort to do anything different. D-G stated the facility staff called law enforcement 22 times from March 1, 2022, through September 21, 2022, related to R1. During an interview on October 4, 2022, at 10:39 a.m., ULP-M stated the facility plan for R1 upon admission was to call the police if he became aggressive. ULP-M stated R1's guardian did not like the plan, so the facility instructed staff to give R1 as needed (PRN) medication to calm him down. ULP-M stated there were no interventions	02320		

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02320	Continued From page 16 to use with R1's behaviors. During an interview on October 25, 2022, at 8:46 a.m., law enforcement detective (D)-G stated the facility staff called 911 two times related to R1's behavior on October 22, 2022. D-G stated the responding officers found R1 across a road from the facility . The responding officers assisted R1 back to the facility and into his room. D-G stated officers were dispatched back to the facility and staff requested law enforcement place R1 on a hold and take him to the hospital. R1 was taken by ambulance to the hospital. Law enforcement report dated October 22, 2022 indicated (at 2:20 p.m.) officers responded to a mental health call and found R1 sitting across the street from the facility, despite the fact that R1 demonstrated limited mobility and used a wheelchair. The report indicated officers assisted R1 with deep breathing exercises (which calmed him down) and escorted R1 back to the facility. The report indicated R1 stated staff treated him poorly. laughed at him, shoved him, and R1 stated he wanted to die. The report indicated R1 admitted to throwing small rocks at staff, and knew it was wrong. The report indicated officers got R1 settled in his room and left the facility. The report indicated at 3:00 p.m. officers were again dispatched to the facility and upon entering, observed R1 in the hallway with his wheelchair. The report indicated R1 was known to have a traumatic brain injury and dementia. The officers indicated R1 seemed angry and talkative, but non-sensicle. The report indicated the officers spoke to the nurse, who expressed worry that R1 would escalate and wanted law enforcement to take him to the hospital. The report indicated based on conversation with staff it was obvious that R1 needed more care than available at the	02320		

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02320	Continued From page 17 facility and transported R1 to the hospital. R2 R2's medical record indicated the resident admitted to the assisted living facility on July 26, 2022, due to diagnoses that included anoxic brain injury, aphasia (inability to speak due to brain injury), and diabetes. R2's Vulnerability Assessment/Abuse Prevention Plan dated July 26, 2022, directed staff to provide cues and reminders regarding orientation (familiarity with surroundings), indicated R2 was non-verbal but made his needs known with yes/no questions he answered with thumbs up/thumbs down, directed staff to allow resident time to respond, and directed staff to use R2's communication board (a folder with letters laid out like a keyboard that R2 would point at one by one to spell). R2's Service Plan dated July 28, 2022, indicated R2 received services from the licensee that included assistance with use of the telephone, assistance with transportation, assistance with bathing, assistance with escorts to meals, assistance with meal preparation, assistance with grooming, nursing assistance with nail care, assistance with shaving, nursing coordination of cares with a home health agency, weekly vital signs and weights, daily enema, medication set-ups, medication administration, ambulation with a gait belt, transfer assistance with a gait belt, bed mobility, turning/repositioning in bed, bed rail safety checks, redirection when wandering, wellness checks every one to two hours and as needed, documentation of bowel output, daily wound cares, physical assist of two staff for toileting (a.m., p.m., and nights) and	02320		

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02320	Continued From page 18 behavior management. R2's Service Plan lacked evidence of interventions for staff related to behavior management. R2's record lacked evidence of staff orientation to R2's care plan and level of assistance needed with activities of daily living. R2's 14/90 Day Assessment dated August 9, 2022, indicated registered nurse (RN)-A reviewed R2's service plan and determined R2's needs were met, services were appropriate, and no changes in services were made. An e-mail dated August 23, 2022, at 10:42 a.m., from facility RN-A sent to the hospital RN-L indicated R2 had difficulty in the mornings when pressing his call light, trying to self-transfer, and displaying impulsive behaviors. RN-A indicated in the e-mail that "it has been hard to monitor him with one staff on site." An e-mail dated August 23, 2022, at 12:38 a.m., from hospital RN-L to facility RN-A indicated it was helpful [in the hospital] to have R2 get up in his wheelchair when he was on the call light a lot in the mornings. The e-mail also suggested offering R2 breakfast or a snack. R2's service plan lacked evidence of suggested changes. R2's hospital progress note dated September 14, 2022, indicated facility RN-A reached out to hospital registered nurse (RN-L) to discuss R2's interventions. The progress note indicated the writer (RN-L) reviewed previously discussed strategies for R2's anxious and impulsive	02320		

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02320	Continued From page 19 behaviors to include: answering R2's call light right away (even if to acknowledge R2's call), offer toileting assistance, offer pain assessment/treatment, offer repositioning, offer a blanket adjustment, offer fluids/food, encourage staff to perform bowel assessment, encourage staff to administer daily enema per orders, utilize as needed medications (PRN's) if R2 pressed his call light frequently, encourage daytime wakefulness/activity (turn lights on, turn on TV/music, encourage R2 to get out of bed). R2's service plan lacked evidence of recommended interventions. During an interview on September 21, 2022, at 12:00 p.m., registered nurse (RN)-A stated the nurse or management staff reviewed the resident care plan with staff. RN-A stated the staff would sign a document that acknowledged they received training on the resident care plan. During an interview on September 21, 2022, at 2:33 p.m., house manager- unlicensed personnel (ULP)-D stated when a new resident was admitted staff are to review the service plan, abuse prevention plan, face sheet, and medications to get to know what is needed for the resident. ULP-D stated the behavior management plan consisted of documenting a time frame of a behavior and a description of the behavior. ULP-D stated there was no plan for what staff should do about the behaviors. During an interview on September 29, 2022, at 12:40 p.m. hospital registered nurse (RN)-L stated she reviewed with the facility RN (RN-A) and two staff, R2's behavior triggers and specific interventions to minimize those behaviors at the time of R2's admission to the facility. RN-L stated	02320		

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she informed staff R2 intermittently refused cares, had impulsivity, restlessness, mood fluctuations, anxiety, and an unconventional preference to not wear clothes. RN-L stated she reviewed with staff R2's bowel program, as constipation led to retention, which lead to anxiety, which lead to impulsive behaviors. RN-L stated she reviewed how to communicate with R2 using a calm voice and telling R2 what you were going to do before touching him. RN-L stated she informed staff that R2's biggest trigger to behaviors was anxiety. RN-L stated she explained to staff how to ask questions using yes/no options, or thumbs up/thumbs down, or giving R2 time to type on his communication board. RN-L stated she informed them that other needs R2 experienced were related to hunger, thirst, or wanting an adjustment to his blanket. RN-L stated RN-A was supposed to educate the remaining staff on the recommended interventions.

During an interview on September 29, 2022, at 8:22 a.m., ULP-J stated the service plan directed staff to give R2 PRN's to keep him from getting up and to keep R2 in a calm state.

The Individual Abuse Prevention Plan policy dated August 1, 2021, indicated all residents would have an individual abuse prevention plan that included statements of the specific measures to be taken to minimize the risk of abuse (including self-abuse) to that person and other vulnerable adults.

The Orientation and Training policy dated August 1, 2021, indicated staff providing assisted living services must be oriented specifically to each individual resident on the services to be provided.

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02320	Continued From page 21 The Service Plan policy dated August 1, 2021, indicated all residents receiving assisted living services would have a service plan in place, based on outcomes of assessments, monitoring, and review of the resident's needs. The Staffing Requirements policy dated August 1, 2021, indicated all staff providing assisted living services must be trained and competent in the provision of services consisted with current practice standards appropriate to the resident's needs. The Vulnerable Adult Maltreatment Prevention and Reporting policy dated August 1, 2021, indicated during orientation, all staff will be trained on the identification of incident of maltreatment including abuse, financial exploitation, and neglect, and an explanation that any act that constitutes maltreatment is prohibited. TIME PERIOD FOR CORRECTION: IMMEDIATE	02320		
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 two of two residents reviewed (R1 and R2) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH)	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	

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02360	Continued From page 22 issued a determination maltreatment occurred, and the facility and an individual staff person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		