Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL273894901M
Compliance #: HL273896098C

Date Concluded: August 5, 2024

Name, Address, and County of Licensee Investigated:
Beacon Home of Rosemount
12591 Shannon Parkway
Rosemount, MN 55068
Dakota County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Peggy L Boeck
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):
Allegation 1: The facility neglected to supervise resident #1 when the police found the resident wandering down the road in his non-motorized wheelchair on a hot day, and the facility staff did not know that he had left the building.

Allegation 2: The facility also neglected to supervise the three remaining residents (#2, #3, and #5) the next day when two staff working followed the resident outside and left the three remaining residents alone in the building for 45 minutes to an hour.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined allegation 1-neglect was substantiated. The facility was responsible for the maltreatment. Staff reported it was common knowledge some of the exit door alarms did not work. Resident #1 had an increase of exit seeking behavior in the weeks prior to the incident and the facility made no changes to the resident's observation level, staff interventions, nor did the facility explore medical rationale for the increased behaviors.

Resident #1 wheeled out into a busy road during a hot day and staff were not aware the resident was gone until law enforcement called them 42 minutes after Resident #1 left the facility.

The Minnesota Department of Health determined allegation 2-neglect was substantiated. The facility was responsible for the maltreatment. The only two staff working left three residents (#2, #3, and #5) unattended while they both followed resident #1 outside in his wheelchair going up and down the road.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement and the resident's guardian. The investigation included review of the resident record, hospital records, facility internal investigation, facility incident reports, personnel files, staff schedules, related facility policy/procedures, and law enforcement reports. Also, the investigator observed staff/resident interactions onsite and photographed the open garage door, driveway, and roads surrounding the facility.

Resident #1 lived in an assisted living facility. Resident #1's diagnoses included traumatic brain injury, dementia, and epilepsy. Resident #1's service plan included assistance with bathing, grooming, dining, escorts, transfers with a gait belt, bed mobility, fall prevention, and behavior management. The resident also received hospice care from an outside agency.

Resident #1's service plan indicated in the event of a fall where staff observed the resident on the floor, staff were to use a full mechanical lift (a Hoyer) and two staff to get the resident off the floor. The service plan directed staff to call Emergency Medical Services (911) if a second staff member was not available. The service plan directed staff to conduct hourly face to face wellness checks.

Resident #2 lived in the assisted living facility due to a history of stroke with left side paralysis/weakness, cognitive impairment, and visual impairment. Resident #2 received services that included safety checks, behavior management, medication administration, transfers with a mechanical lift, toileting, and incontinence cares.

Resident #3 lived in the assisted living facility due to weakness, a history of falls, and respiratory failure. Resident #3 received services that included medication administration.

Resident #5 lived in the assisted living facility due to dementia, hearing loss, stroke, and cortical blindness. Resident #5 received services that included turning/repositioning, behavior management, brace assistance, medication administration, toileting, transfers with a mechanical lift, and incontinence care.

A law enforcement report indicated a community member called 911 one morning for a welfare check on a wheelchair bound male who was in the road. Police responded to a residence (approximately 450 feet away from the facility) and identified the male as a resident of the facility (Resident #1). The report noted the weather at the time was full sun and over 90 degrees. The report indicated the officer called the facility and staff were unaware of the resident's absence. The officers brought the resident back into the facility and met with the two staff working. Both staff stated the facility had alarms on the doors, but the alarm on the patio sliding door was not working, so they assumed that was how he got out. The report indicated the officers recommended staff call maintenance to fix the alarm.

The law enforcement report further indicated staff called 911 later that afternoon to assist with resident #1 who wheeled himself away from the facility (with a staff following behind him) and onto the road. Officers had concerns resident #1 was having a medical incident, due to his deteriorated condition (described as scattered thoughts mumbled speech, and inability to make sense), and called paramedics, who transported resident #1 to the hospital.

Hospital records indicated resident #1 returned to the facility in the evening.

A law enforcement report from the next morning indicated police responded to a staff crisis call for resident #1, who wheeled himself from the facility up to the road again with a staff following behind. The staff had called 911 for assistance with getting resident #1 back into the building from his location north of the facility as he was aggressive. The report indicated staff had followed behind resident #1 after he exited the facility and tried to get ahold of his wheelchair. The report indicated resident #1 was aggressive and was trying to hit the staff. When officers arrived two staff members were present and stated maintenance had fixed the patio door alarm, but the alarm for the service door between the facility and the garage was not working, the garage doors were open, and the resident exited from there. Officers suggested to get the service door alarm fixed and keep the garage doors closed. The report indicated one of the staff told officers resident #1 had been escalating over the past weeks and they were frustrated no one could provide them a solution.

During an interview staff #1 stated during the first incident, resident #1 was fine and she thought the other staff was watching him. She received a call from law enforcement who stated they had resident #1 at a neighbor's house. Staff #1 stated she left the facility, ran up there, and he came back just fine. Staff #1 stated she knew the patio door alarm did not work but did not think he had the strength to get the door open and wheel himself out. Staff #1 stated she called the on-call and was told to give him as needed (PRN) medications.

Staff #1 stated the second incident happened around 1 p.m. when resident #1 had been trying to leave and she finally agreed to go outside with him. Staff #1 stated as soon as they got outside, he headed for the road and went "about two blocks." Staff #1 stated she walked behind him, and cars had to drive around them. Staff #1 stated she called the on-call who tried to speak with resident #1. When he would not speak with the on-call, staff #1 was told to call

911. Staff #1 stated the incident lasted over an hour, and when police arrived, they decided to take resident #1 to the hospital.

Staff #1 stated the third incident happened the next morning. Resident #1 wanted to go out and immediately went to the road. Staff #1 stated he was angry she wanted him to go back so he got up and pushed his wheelchair over into the bushes. Staff #1 stated she called staff #2, who came outside, retrieved his wheelchair, and resident #1 got in the wheelchair. Staff #1 stated resident #1 then wheeled up the road and back down toward a busier road, so eventually she told staff #2 to call 911. Staff #1 stated they were both outside with the resident for 45 minutes to an hour until the police arrived. There was no additional staff monitoring resident #2, resident #3, or resident #5 inside the facility.

During an interview, staff #2 stated she was in training and observed resident #1 liked to wander around the facility in his wheelchair. Staff #2 stated no one told her he might try to get out the door. Staff #2 stated during the first incident she was cleaning resident rooms and thought staff #1 was watching resident #1. Staff #2 stated after police returned resident #1 to the facility, a maintenance person fixed the patio door alarm, however, they did not know the door to the garage alarm was not working.

Staff #2 stated she did not know much about the second incident other than resident #1 went outside with staff #1 and came back with the police.

Staff #2 stated during the third incident, resident #1 got out the garage door and staff #1 followed behind him. He was aggressive and staff #1 called her to come out. Staff #2 stated resident #1 was fighting them, so she had to call 911. Staff #2 stated that while they were outside with him, resident #2 (who was inside the facility) had put on her call light, but they never got to her. Staff #2 stated she was scared that resident #1 was going to get run over one day.

During interview, another staff member stated resident #1 was more agitated and had more elopement attempts in the previous two weeks. The staff stated it was confusing at the facility because staff did not know who was in charge. The administrative staff were gone or at other facilities. The staff member stated the facility provided a phone number for an on-call nurse, but when no one answered that number staff were to call the scheduler (a person who created the schedules at all the facilities).

During an interview, resident #1’s guardian stated the facility never informed her of the three incidents and she learned of them when police called her. The guardian stated the facility did not update her on his recent increased behaviors. The guardian expressed concerns about lack of staff education of the residents’ diagnoses and how to interact with residents to prevent these types of incidents.

During a review of the facility surveillance video of the first incident, the investigator observed resident #1 propelling his wheelchair around the kitchen, dining, and living rooms (which were all connected and open). In the video staff #2 was collecting cleaning supplies from the kitchen, coming, and going toward resident bedrooms. In the video staff #1 was sitting on the couch in the living room looking at her phone, with a small child next to her looking at an I-Pad, and the television on. In the video resident #1 is observed opening the patio door, getting out of his wheelchair to step out of the building, lifting his wheelchair over the door threshold, shutting the patio door, getting into his wheelchair, and wheeling out of camera view. He was wearing a sweatshirt, long pants, and black footwear. The time stamps on the video indicated resident #1 was outside for 42 minutes.

Requested surveillance video from the facility of the third incident was not received at the time this report was filed.

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 replaced the sliding door alarm, investigated the incidents, added a tsk for staff to check door alarms twice per shift, education provided in staff communication log, added staff task to make sure garage doors are always closed, requested hospice do a medication review of resident, reached out to county case manager for new placement, obtained a urine sample, and began antibiotic for urinary tract infection.

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 emai.l

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 07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON HOME OF ROSEMOUNT	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 ******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: #HL27389C/#HL273894901M On July 31, 2024 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 4 residents receiving services under the provider's Assisted Living license. The following correction order is issued/orders are issued for #HL273896098C/#HL273894901M, tag identification 2320 and 2360.	0 000		
02320 SS=I	144G.91 Subd. 4 (b) 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	02320		

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02320	Continued From page 1 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. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to provide health care, assisted living services, and supervision for four of four residents (R1, R2, R3, and R5) reviewed when R1 eloped from the facility in 90 degree weather onto a busy road without staff awareness for over 40 minutes, and when staff left three residents (R2, R3, and R5) alone in the facility for an extended period of time. 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 moved into the facility on March 22, 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 inability to cooperated with medical decision making.	02320		

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02320	Continued From page 2 R1's service agreement dated July 27, 2024, directed staff to monitor for refusals in care and to report these to the nursing department via the communication log for further nurse follow-up. The service agreement directed staff to offer to take R1 outside twice daily for a total of 30 minutes. The service agreement did not include interventions for staff to use when he would not return. The service agreement directed staff to complete safety checks every hour and report to "director" if exit seeking or exits community, and "the community to provide assistance to manage wandering or exit seeking behaviors in a supportive environment". The service agreement directed nursing staff to review and document resident behaviors weekly including wandering or attempts to leave the building and nursing to add addition interventions as necessary to ensure safety of resident. The service agreement directed staff to call a nurse immediately if R1 did not respond to redirection. R1's vulnerability assessment/abuse prevention plan document dated June 20, 2024, indicated R1 was a wandering/elopement risk due to decreased safety awareness. The assessment indicated R1 attempted to get out of building doors "on occasion" and directed staff to monitor R1 closely throughout the day and night. The plan indicated the facility had alarms present on doors to alert staff when doors were opened. The plan failed to identify increase of exit seeking behavior, incidents of elopement, or updated interventions for staff to use when R1 was exit seeking. R1's progress note dated June 27, 2024 at 12:54 p.m. indicated staff monitored R1 for attempts at elopement and needed no additional interventions.	02320		

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02320	Continued From page 3 R1's assessment dated July 11, 2024, indicated R1 had exit seeking behavior and responded to redirection, frequently wandered, and required redirection. A document in the staff communication binder titled "A few updates on residents!!" dated July 12, 2024, indicated "[R1] got out tonight while the aid was vacuuming. She did not hear him open the door. Staff, please be sure that you are diligently keeping [R1] nearby, I know we are not perfect, but he is quick. If you need to go out of sight for more than 5 minutes, make sure you ask the other aide to watch him." The residents progress notes, abuse prevention plan, and service plan lacked evidence of documentation of the incident, updates to plans, or an incident report of the event. A document (undated) in the staff communication binder titled "Attention Rosemount Staff" indicated R1 was not to be outside by himself. The document indicated there was a lack of supervision of R1. The document indicated the writer observed R1 outside without direct supervision twice in the last week. The document indicated "If something happens to him it will be on the individual that was responsible for him." A document titled Communication log dated beginning night shift July 22, 2024, indicated R1 was agitated and "wanted to be outside all day". A document dated July 24, 2024, in the staff communication binder titled "Updates from the nurse" indicated R1 had no new concerns or updates.	02320		

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02320	Continued From page 4 A document titled Communication log dated beginning night shift July 26, 2024, indicated R1 "got away" (during day shift on July 27, 2024) and staff called police. The document indicated staff called hospice, interim assisted living director (ALD)-F and interim ALD-G. The document indicated R1 eloped a second time (in the afternoon of July 27, 2024), and staff called police who took him to the hospital. The document indicated R1 returned the same evening. The document indicated "other residents complained about their cares" because staff were tending to R1. A police report dated July 27, 2024, indicated Rosemount police department received a call for a welfare check of a wheelchair bound male in the roadway. The report indicated a neighbor of the facility observed R1 north of his residence on the road and wheeled him off the road and into the shade (due to temperature in the 90's). The report indicated the officers responded to the neighbor's driveway, interviewed the neighbor and attempted to interview R1, who was unable to answer any questions due to confusion/disorientation. The report indicated the officers brought R1 to the facility where unlicensed personnel (ULP)-B and ULP-C both reported they did not know R1 was outside. The report indicated ULP-B and ULP-C told officers that the facility alarm on the kitchen sliding glass door had not been working and assumed that was how R1 got out. The officers suggested the staff call facility maintenance to get the alarm fixed. The police report further indicated ULP-B called 911 at 2:14 p.m. to report R1 eloped again from the facility. The report indicated officers found R1 with a staff (ULP-B) on the road. The report	02320		

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02320	Continued From page 5 indicated R1 appeared confused, but not hostile. The report indicated staff told officers maintenance had fixed the door alarm, they heard it go off as R1 exited the building, but they were not allowed to prevent him from leaving, so ULP-B followed him outside. The report indicated officers contacted R1's guardian and spoke with onsite staff (ULP-B and ULP-C), who wanted R1 sent to the hospital, medics were called, and medics transported R1 to the hospital. A police report dated July 28, 2024, indicated that officers responded to the facility for a mental health/crisis incident. The report indicated a male left the facility in a wheelchair and when staff tried to intervene, he would hit them. The report indicated the officers were familiar with the male (R1) as they had issues with him twice on the previous day. The report indicated R1 was disorganized in thoughts and could not explain why he left. The report indicated officers arrived to find R1 in his wheelchair on the sidewalk across the road and north of the facility with two staff (ULP-B and ULP-C). R1 told officers that staff were mean to him and hit him, but there was no evidence. The officers and two staff then returned to the facility where it was discovered that the alarm for the service door between the residence and the garage was not working and the garage doors were both open. Officers recommended the garage doors remain closed until the alarm to the service door was fixed. The report indicated the staff were frustrated with lack of solutions as R1 had escalating behaviors over the past week. A document (undated) in the staff communication binder titled "Attention staff, Please Read, You should always know where [R1] is???????" indicated R1 had multiple incidents trying to get	02320		

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02320	Continued From page 6 out of the building, staff should use interventions, leave the garage door closed at all times, give snacks, television, and movies, PRN Ativan (after calling the nurse), and as a last resort "call 911 if no other interventions are working, resident is lashing out verbally or physically. Call the on-call nurse and they will assist with calling 911." During an interview on July 31, 2024, at 10:47 a.m., ULP-A stated R1 showed frustration with new staff and got frustrated when he forgot things. ULP-A stated that he typically did not have problems with R1. During an interview on July 31, 2024, at 11:08 a.m., ULP-B stated staff were supposed to always have eyes on R1, and when he tried to get out the doors to offer him snacks, soda, and Michael Jackson videos on television. ULP-B stated her efforts to redirect R1 with snacks, soda, or videos did not work with R1 once he was outside. ULP-B stated the incidents outside with R1 each lasted almost an hour. ULP-B stated she thought ULP-C was watching R1 at the time of the first incident. During an interview on July 31, 2024, at 11:38 a.m., ULP-C stated she was in orientation on the weekend of the incidents with R1. ULP-C stated she read a binder that said to redirect R1 with snacks, soda, and chips. ULP-C stated no one told her he might try to get out the doors. ULP-C stated she heard that the patio door alarm was not working. ULP-C stated that as soon as staff were out of R1's sight he would try to get out the door. ULP-C stated she thought ULP-B was watching R1 at the time of the first incident. During an interview on July 31, 2024, at 1:23 p.m. licensed practical nurse (LPN)-D stated she did	02320		

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02320	Continued From page 7 not know R1 was more exit seeking recently but heard that he had more "incidents". LPN-D stated staff are to redirect R1 with snacks and Michael Jackson videos. LPN-D stated the on-call during the weekend of the incidents was the assisted living director of another campus, and the manager on call was a scheduler, and that LPN-D was not on call, but did get a call about the incidents. LPN-D stated when she returned to work on Monday, she got a urine sample from R1, as she felt something medical was going on with him. (The results of the urinalysis were not available at the time of the investigation) During a review of facility surveillance video from Saturday July 27, 2024, the investigator observed R1 propelling his wheelchair around the kitchen, dining, and living rooms (which were all connected and open). In the video ULP-C was collecting cleaning supplies from the kitchen, coming, and going toward resident bedrooms. In the video ULP-B was sitting on the couch in the living room looking at her phone, with a small child next to her looking at an I-Pad, and the television on. In the video (at time stamp 10:23) R1 opened the patio door, got up out of his wheelchair, stepped out of the building, lifted his wheelchair over the door threshold, shut the patio door, got back into his wheelchair, and moved away from camera view. He was wearing a sweatshirt, long pants, and black footwear. In the video (at time stamp 11:05) ULP-B got up, answered the landline, gestured excitedly, and ran out the front door. At time stamp 11:06 ULP-B returned and at timestamp 11:07 ULP-B and ULP-C went out the front door. At time stamp 11:11 ULP-C wheels R1 into the dining area. R1 is wearing a red t-shirt, long gray pants, black footwear, and his sweatshirt is off and tucked along side his leg. At time stamp 11:13 two police	02320		

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02320	Continued From page 8 officers entered the facility. Review of website https://www.timeanddate.com/weather/@5043779/historic indicated the weather at the facility location on Saturday July 27, 2024, was between 88 and 91 degrees Fahrenheit. R2, R3, R5 R2 moved into the facility on September 1, 2022, due to diagnoses that included a stroke with left side weakness/paralysis, cognitive impairment, and impaired vision (left eye sewn shut). R2 received services that included safety checks, behavior management, brace assistance, medication administration, transfers with a mechanical ceiling lift, toileting, and incontinence care. R3 moved into the facility on November 22, 2022, due to diagnoses that included weakness, history of falls, and history of acute respiratory failure. R3 received services that included medication administration. R5 moved into the facility on June 18, 2019, due to diagnoses that included dementia, bilateral hearing loss, stroke, and cortical blindness. R5 received services that included turning/repositioning, behavior management, brace assistance, medication administration, toileting, transfers with a mechanical lift, and incontinence care. A document titled Communication log dated beginning night shift July 27, 2024, indicated R1 refused to come back from outside (during the day shift on July 28, 2024), went up the street again, both staff (ULP-B and ULP-C) intervened, he was aggressive, got out of wheelchair and laid	02320		

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 07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02320	Continued From page 9 down on ground in traffic and would not get out of the street, so staff called police to bring him home. A facility incident report dated July 31, 2024, at 8:41 a.m. indicated on July 28, 2024, at approximately 9:00 a.m. R1 wanted to go outside, and one staff (ULP-B) went with, walking behind R1's wheelchair as he headed up the hill. The report indicated staff attempted to turn R1's wheelchair around, R1 stood up, and pushed the wheelchair into the bushes. ULP-B called ULP-C who exited the facility to retrieve R1's wheelchair, R1 sat back down, and he wheeled up the hill away from the facility. The report indicated R1 was resistive and "belligerent" with staff, hitting both as they followed behind. The report indicated ULP-B called licensed practical nurse (LPN)-D, who instructed ULP-B to provide R1 with an as needed medication (PRN). The report indicated R1 accepted the PRN, but kept wheeling away from the facility, so ULP-B called LPN-D again, who instructed her to call 911. The report indicated police officers arrived and escorted R1 back into the facility. During an interview on July 31, 2024, at 11:08 a.m. ULP-B stated during the (above noted) incident both staff were outside with R1 for 45 minutes to an hour. ULP-B stated R1 had been trying to get out doors for about a week. During an interview on July 31, 2024, at 11:38 a.m. ULP-C stated she thought ULP-B told the other residents they would be outside. ULP-C stated R2 had put on her call light for assistance when ULP-B and ULP-C were outside with R1, and "we never got to her". ULP-C stated it was scary working at the facility and expressed concerns that "one day [R1] is going to get run	02320		

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02320	Continued From page 10 over." During an interview on July 31, 2024, at 1:23 p.m. LPN-D stated both staff left the remaining three residents alone in the facility, which was "not typical". Video for the incident on Sunday July 28, 2024, was requested but not received at the time of submission of the citation. 2023 Minnesota Statue 144G.91 Assisted Living Bill of Rights indicates 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. Time Period for Correction: Two (2) days.	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 four of four residents reviewed (R1, R2, R3, and R5) were free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred,	02360		

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02360	Continued From page 11 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		