Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL273896564M
Compliance #: HL273892279C

Date Concluded: October 3, 2023

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 Alleged Perpetrator, (AP), unknown staff, financially exploited a resident when the AP stole the resident's narcotic medication for personal use.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The facility and unknown AP or APs were responsible for the maltreatment. The facility had no system in place to securely store narcotic medications and failed to ensure accountability of narcotic medications. The resident was missing 56 tablets of his narcotic medication (hydrocodone). The AP/APs who stole the narcotics could not be identified as the facility had disabled their cameras and documentation was missing.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement. The investigation included review of medical records, incident reports, personnel files, policies, and

procedures related to administration of medications, storage of medications, and maltreatment of vulnerable adults. Also, the investigator observed the medication storage set-up.

The resident lived in an assisted living facility. The resident's diagnoses included stroke with right side paralysis, cognitive impairment, and impaired vision. The resident's service plan included assistance with bathing, behavior management, meals, dressing, grooming, housekeeping, laundry, mobility, transfers, toileting, and medication administration. The resident's medication administration record indicated the physician had prescribed the resident a narcotic pain medication three months before the incident. The resident's medical record showed the resident received four doses in that time and the facility had 56 doses remaining.

A facility investigation indicated the resident requested a dose of the narcotic for pain one Tuesday morning. The investigation indicated the staff could not find the narcotic in either the lock box in the medication cart (where a card of 26 tablets was supposed to be) or the locked overflow supply in the locked office (where a card of 30 was supposed to be). The staff then looked to see if the narcotic book log indicated why the narcotic was missing, with no results. The investigation indicated they attempted to review the shift sign-off logbook to verify when and who verified the narcotic count, but the document was missing. The investigation indicated the staff verified the narcotic count the previous Thursday. The facility interviewed all staff working between Thursday and Monday.

A law enforcement report indicated the facility called to report the stolen narcotics and told law enforcement they would do their own investigation.

During an interview, the house manager stated she counted narcotics on Thursday and was off for the weekend. The house manager stated she became aware on Monday the shift sign-off sheet was missing but was too busy to report it to the nurse. The house manager suspected several staff. The house manager stated the registered nurse never participated in verifying narcotics.

During investigative interviews, staff who worked the weekend the narcotics went missing denied involvement, and several suspected each other including one staff who abruptly quit that weekend.

During investigative interviews, multiple staff reported the key to the lock box on the medication cart (where the facility stored most narcotics) hung on the wall in the medication room, which all staff had access to because the room contained the washer and dryer. Multiple staff reported the lock to the door to the office was easily pried open with a butterknife and several admitted to having done so to use the office. The staff also reported the location of the key for the overflow box (which contained narcotics) although "hidden" was known by most staff.

In conclusion, financial exploitation 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.

Financial exploitation: Minnesota Statutes, section 626.5572, subdivision 9
"Financial exploitation" means:
(b) In the absence of legal authority, a person:
(1) willfully uses, withholds, or disposes of funds or property of a vulnerable adult.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: An alleged perpetrator was not identified, although several staff were suspected.

Action taken by facility:
The facility retrained staff on the narcotic count process.
The facility filed reports.
The facility placed a padlock on the office door.

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 09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMETOWN SENIOR LIVING 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: #HL273895311C/#HL273898147M #HL273892279C/#HL273896564M On September 20, 2023, 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 orders are issued for #HL273895311C/#HL273898147M and #HL273892279C/#HL273896564M, tag identification 0115, 0250, 0470, 1290, 1690, 2310, and 2360.	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.	
0 115 SS=F	144G.10 Subd. 2 Licensure categories (a) The categories in this subdivision are	0 115		

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0 115	Continued From page 1 established for assisted living facility licensure. (1) The assisted living facility category is for assisted living facilities that only provide assisted living services. (2) The assisted living facility with dementia care category is for assisted living facilities that provide assisted living services and dementia care services. An assisted living facility with dementia care may also provide dementia care services in a secured dementia care unit. (b) An assisted living facility that has a secured dementia care unit must be licensed as an assisted living facility with dementia care. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the licensee failed to ensure an assisted living with dementia care license was in place to meet compliance with regulations, as the licensee advertised as providing memory care programming, the building was secured, and residents were not able to leave the building without assistance. This had the potential to affect all current and potential future residents. 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: Review of the Application for Assisted Living Licensed dated November 14, 2022, indicated the	0 115	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.	

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0 115	Continued From page 2 licensee agreed to an assisted living license category. Review of the facility web site (https://beaconspecialized.org/minn-sr-residence/rosemount/) on September 7, 2023, at 8:46 a.m. indicated the licensee advertised as providing memory care programming. During observation on September 20, 2023, from 10:00 a.m. to 5:00 p.m. the Minnesota Department of Health (MDH) investigator noted the front door to the building was locked and had an additional lock on the upper portion of the inside of the front door. The back door to the facility was also locked and opened into the closed garage area. During an interview on September 21, 2023, at 4:00 p.m. unlicensed personnel (ULP)-E stated R1 had a behavior of going outside and then not wanting to come back in, so that is why the licensee put extra locks on the doors, to prevent R1 from going outside. During an interview of September 26, 2023, at 2:44 p.m. executive director (ED)-G stated she had no comment on the advertisement of the facility, as she was not involved in marketing. During an interview on September 26, 2023, at 3:30 p.m. ULP-H stated the facility had a lock on the door to "keep them in" (residents) and it worked well. TIME PERIOD FOR CORRECTION: 7 (Seven) DAYS	0 115	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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0 250	Continued From page 3	0 250		
0 250 SS=I	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department;	0 250		

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0 250	Continued From page 4 (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and document review, the license failed to meet the requirements of licensure when the licensee performed acts detrimental to the health, safety, and welfare of six of six residents (R1, R2, R3, R4, R5, and R6) reviewed for implementation of policies. The licensee failed to provide staff adequate in numbers, training, and qualification for the assessed needs of the residents. The licensee abused community Emergency Response resources when they directed staff to call 911 for behavior interventions and lift assistance 26 times in 10 months. The licensee failed to conduct background studies of employees, failed to implement medication management policies, and failed to ensure staff did not chemically restrain a resident with narcotics. This practice resulted in a level three violation (a violation that harmed a resident's health or safety,	0 250	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	

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0 250	Continued From page 5 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: See tag 0470- Minimum Requirement 144G.41 Subdivision 1. See tag 1290- Background Studies Required-144G.60 Subdivision 1. See tag 1690- Medication Management Services-144G.71 Subdivision 1. See tag 2310- Appropriate Care and Services-144G.91 Subdivision 4 (a) TIME PERIOD FOR CORRECTION: SEVEN (7) DAYS	0 250	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.	
0 470 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	0 470		

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0 470	Continued From page 6 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 resident (R1, R2, R3, R4, R5, and R6). The licensee failed to schedule staff according to the resident's assessed needs and failed to ensure staff were trained and able to respond promptly and effectively to resident emergencies and/or behaviors. Staff were instructed to call law enforcement for behavior management and resident lift assistance due to the licensee's plan of staffing with one individual. This resulted in multiple ongoing calls to 911 for assistance with dealing with resident behaviors or lifting a resident off the floor. 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	0 470	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	

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0 470	Continued From page 7 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 Vulnerability Assessment/Abuse Prevention Plan dated April 1, 2022, included the following interventions: staff will work to have a calm and safe environment, redirect as needed and walk away if resident is safe while becoming aggressive/physical, staff will call EMS/law enforcement if noted any altercations begins without being able to redirect and resident will go to ED if a danger to himself or others. The plan indicated R1 could not ambulate safely without a device. R1's Service Plan dated October 26, 2022, indicated R1 received services from the licensee that included physical assist as needed during activities, physical assistance with bathing twice weekly in the morning, frequent redirection, time and place orientation, escort to dining room, cues and prompts for meals, cues for dressing/undressing/grooming, medication administration, hourly safety checks, stand-by assistance when getting in and out of bed, assistance of two staff ("one staff and a helper") for transfers, and interventions per behavior plan. R1's Behavior Management Plan dated October 28, 2022, indicated the following preventative interventions: toileting, checking for pain, asking if	0 470	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 8 hungry, asking if thirsty, asking to participate in activity. The plan indicated the following interventions for R1 throwing items: remove items, distance self from resident, remove other residents, give resident space (to go to room), do not leave items within resident reach. The plan included the following interventions for R1's physical combativeness: approach with a way to exit, do not raise voice, remove self for safety, reassure resident he is ok. R2 R2 admitted to the facility on March 1, 2014, due to diagnoses that included stroke, cognitive impairment, and impaired vision (left eye sewn shut). R2's service plan dated October 26, 2022, indicated R2 received services from the licensee that included assistance to use the phone, physical assistance of one staff for bathing, behavior management, orientation, dining stand-by assistance due to history of choking, physical assistance of one staff for dressing/grooming/shaving/repositioning/bed mobility, assistance of 1-2 staff for transfers using a full mechanical lift, bed rail safety checks, total assistance of staff for toileting, check and change every two hours, and medication administration four times per day. R3 R3 admitted to the facility on November 22, 2022, due to diagnoses that included weakness, history of falls, and acute respiratory failure. R3's service plan dated November 22, 2022, indicated R3 received services from the licensee that included stand-by assistance for bathing, cues for meals, cues for dressing/grooming, and	0 470		

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0 470	Continued From page 9 medication administration one to three times per day. R4 R4 admitted to the facility on June 29, 2020, due to diagnoses that included Spinocerebellar degeneration (a neurological disease that creates difficulty with walking, eating, dressing, bathing, etc), dysphagia, and impaired coordination. R4's service plan dated February 15, 2023, indicated R4 received services from the licensee that included physical assist of one staff for activities/phone use, physical assist of one staff for bathing, behavior management, physical assist of one staff for dressing/placing hearing aids/grooming, breathing treatment 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 one to three times per day. R5 R5 admitted to the facility on June 18, 2019, due to diagnoses that included dementia, bilateral hearing loss, stroke, and cortical blindness. R5's service plan dated October 26, 2022, indicated R5 received services from the licensee that included assistance to use the phone, physical assist of two staff for bathing, behavior management, physical assist of one staff for meals/dressing/grooming/oral cares/shaving, assistance of staff for passive range of motion (every other day in the morning), transfers with a gait belt or sit-to-stand lift or total body ceiling lift, turning and repositioning every two hours, bed rail safety checks, assistance of one staff for toileting every two hours, and medication administration	0 470		

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 09/20/2023

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

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0 470	Continued From page 10 one to three times per day. R6 R6 admitted to the facility on May 9, 2023, due to diagnoses that included multiple sclerosis, pressure ulcer of the sacral region, and sleep disorder. R6's service plan dated May 9, 2023, indicated R6 received services from the licensee that included physical assist of one staff for activities, skin checks weekly, physical assist of one staff for turning/repositioning in bed every two hours, meals, physical assist of one staff for dressing/grooming/nailcare/shaving/toileting, transfers with a total body ceiling lift, physical assist of one staff for toileting/incontinence care, and behavior management. During observation on September 20, 2023, the Minnesota department of Health (MDH) investigator observed unlicensed personnel (ULP)-B, ULP-I, and ULP-J providing care and services to residents including R1, R2, and R6. Review of R1's Behavior Plan dated October 28, 2022, provided no documentation that ULP-I and ULP-J were oriented to R1's behavior plan. Review of R6's facility document titled Verification of RA Orientation document indicated "I acknowledge 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 orientation document signatures did not include ULP-B or ULP-I, indicating they had not been oriented to the residents cares.	0 470		

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0 470	Continued From page 11 During an interview on September 20, 2023, at 2:03 p.m. registered nurse (RN)-A stated she was aware R1 had a behavior plan. RN-A stated the facility often resorted to sending R1 to the hospital. RN-A stated staff called the police when R1 was a risk to harm himself or others (such as "if [R1] broke glass and had no shoes on"), or if they could not de-escalate a situation. RN-A stated she told staff to call emergency medical services for lift assist for R1 on September 5, 2023, but the ambulance decided to take him to the hospital. RN-A stated the facility could not provide more staff for R1. RN-A stated she made no changes to R1's behavior plan in the previous year since its creation. During an interview on September 20, 2023, at 2:45 p.m. unlicensed personnel (ULP)-B stated she personally used music for calming with R1, but no one added music interventions to the behavior plan. ULP-B stated the facility was often short staffed which left little time for behavior plan interventions. ULP-B stated R1 was on hospice from May 19, 2023, through September 5, 2023, and hospice provided medication that helped keep R1 from acting out. ULP-B stated hospice gave the facility "more freedom" with frequency of medications, and she primarily used lorazepam (an antianxiety medication prescribed to R1 for anxiety every four hours as needed)) and oxycodone (a narcotic pain medication prescribed for shortness of breath or pain). ULP-B stated she gave R1 lorazepam right before a peer's (R5) family member came to visit every Monday, Wednesday, and Friday afternoon, because R1 did not get along with the person. ULP-B stated the company policy directed staff to call emergency medical services (EMS) to lift residents off the floor.	0 470		

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0 470	Continued From page 12 During an interview on September 21, 2023, at 2:14 p.m. hospice registered nurse (RN)-C stated a staff called her to the facility on September 4, 2023, at 4:30 p.m. for R1 as he had laid on the floor since 9:00 a.m. and staff (oncoming 4:00 p.m. shift) could not identify if he had fallen. RN-C stated she assessed R1 who had right side weakness, right side facial drooping, and was leaning to the right so EMS took R1 to the hospital. During an interview on September 21, 2023, at 2:58 p.m. R1's guardian (G)-D stated ULP-B told her that staff used the medication hospice provided to keep R1 subdued, and she had concerns they overmedicated R1 instead of adding more staff. During an interview on September 21, 2023, at 4:00 p.m. ULP-E stated when R1 enrolled in hospice, staff were directed to not bathe R1, as hospice would take care of that, and if R1 fell to call hospice to come and pick him up. ULP-E stated she worked alone often and when R1 was agitated she gave him as needed (PRN) medications such as oxycodone and made sure he got his trazodone (an anti-depressant medication prescribed to R1 at 11:00 a.m., 5:00 p.m., and 8:00 p.m. for insomnia) "every four hours". During an interview on September 25, 2023, at 10:06 a.m. law enforcement detective (D)-F stated law enforcement has received 26 calls from the facility since November 2022, 11 of which were for R1. D-F stated responding officers reported the facility was consistently understaffed and ill equipped to handle R1's behaviors.	0 470		

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0 470	Continued From page 13 The facility schedule provided on September 20, 2023, for the previous two months, indicated the licensee scheduled one staff from 7:00 a.m. to 8:00 a.m. on August 1, 2, 3, 4, 5, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 28, 29, and 30. September 3, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, and 20. The facility schedule provided on September 20, 2023, for the previous two months, indicated the licensee scheduled one staff from 7:00 a.m. to 3:00 p.m. on August 7 and 31. September 1, 2, 4, 5, 6, and 12. The facility schedule provided on September 20, 2023, for the previous two months, indicated the licensee scheduled one staff from 3:00 p.m. to 4:00 p.m. on August 4, 5, and 7. September 6, 8, and 12. The facility schedule provided on September 20, 2023, for the previous two months, indicated the licensee scheduled one staff from 8:00 p.m. 11:00 p.m. on August 1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, and 31. September 1,2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, and 20. The facility schedule provided on September 20, 2023, for the previous two months, indicated the licensee scheduled one staff from 11:00 p.m. to 7:00 a.m. on August 1, 3, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, and 31. September 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 111, 12, 13, 14, 15, 16, 17, 18, 19, and 20. The facility schedule provided on September 20, 2023, for the previous two months indicated the	0 470		

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0 470	Continued From page 14 licensee had no staff scheduled from 11:00 p.m. to 7:00 a.m. on August 1, 2, 4, and 5. The licensee did not provide documentation of who worked those shifts. An e-mail received by the MDH investigator dated September 22, 2023, at 8:54 a.m. from executive director (ED)-G indicated the schedule sent to the MDH investigator was accurate. 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 Staffing Plan document reviewed on July 1, 2023, indicated the staffing plan per two-week period required two ULP's for AM shift (assumed to mean 7:00 a.m. to 3:00 p.m.), two ULP's for PM shift (assumed to mean 3:00 p.m. to 11:00 p.m.), one ULP for NOC (assumed to mean 11:00 p.m. to 7:00 a.m.), and "0.1 FTE (assumed to mean 0.1 full time equivalent or 48 minutes per day)/ on-call 24/7 RN " . The document also indicated a "Minimum Staffing Plan per two-week period" required one ULP for AM, one ULP for PM, one ULP for NOC, and 0.1 FTE RN/on-call 24/7. 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. TIME PERIOD FOR CORRECTION: 7 (Seven) DAYS	0 470		

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01290	Continued From page 15	01290		
01290 SS=H	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interviews and document review, the licensee failed to conduct a background study for two of two unlicensed personnel (ULP-D2 and ULP-G2) reviewed for maltreatment. ULP-D2 and ULP-G2 provided direct services to residents while working independently. This had the potential to affect all 6 residents receiving services from the licensee as ULP-D and ULP-E both worked alone and were suspected of drug diversion. 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the	01290	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	

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01290	Continued From page 16 situation has occurred repeatedly; but is not found to be pervasive). Findings include: ULP-D2's personnel file indicated the licensee hired ULP-D2 on October 20, 2021, to provide direct care for residents. ULP-G2's personnel file indicated the licensee hired ULP-G2 on December 2, 2022, to provide direct care for residents. A review of the facility roster on September 19, 2023, at 3:17 p.m. on the Department of Human Services NETStudy 2.0 site (https://netstudy2.dhs.state.mn.us/Live/Employees/SearchRoster) found the facility roster did not include either ULP-D2 or ULP-G2. A search by name on September 19, 2023, at 3:36 p.m. on the Department of Human Services NETStudy 2.0 site on (https://netstudy2.dhs.state.mn.us/Live/PersonSearch) found no background study requested or completed for ULP-G2. A search by name on September 19, 2023, at 3:36 p.m. on the Department of Human Services NETStudy 2.0 site on (https://netstudy2.dhs.state.mn.us/Live/PersonSearch) found ULP-D2 was separated from employment of the licensee on November 24, 2021. The facility schedule dated April 27, 2023, through May 2, 2023, indicated: ULP-D2 worked alone on the following dates/times: April 27,2023, 8:00 p.m. through 7:00 a.m.; April 28, 2023, 8:00 p.m. through 7:00	01290	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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01290	Continued From page 17 a.m.; April 29, 2023, 8:00 p.m. through 11:00 p.m.; April 30, 2023, 8:00 p.m. through 7:00 a.m.; May 1, 2023 11:00 p.m. through 7:00 a.m.; May 2, 2023, 11:00 through 7:00 a.m. ULP-G2 worked April 27, 2023, 8:00 p.m. to 11:00 p.m. and failed to report for her shift on April 28, 2023 and resigned. A facility investigation document dated May 2, 2023, indicated 56 tablets of narcotic hydroco/apap 5-325 milligrams were discovered missing. The last time the tablets were counted was the morning of April 27, 2023. The investigation indicated the shift sign- off logbook was also missing since April 28, 2023. During an interview on September 20, 2023, at 3:16 p.m. unlicensed personnel-house manager (ULP)-B2 stated the licensee investigated the missing narcotics and ULP-D2 and ULP-G2 were suspected, but she did not know the conclusion of the investigation. During an interview on September 27, 2023, at 1:30 p.m. assisted living director (ALD)-J2 stated the licensee records indicated ULP-D2 was separated from the roster on November 24, 2021, when the new company (Beacon Specialized) took over. ALD-J2 stated the new company separated all employees, rehired them as Beacon employees and conducted new background studies. ALD-J2 stated they must have missed ULP-D2. ALD-J2 stated their records indicated ULP-G2 never got fingerprints taken, so her background study did not get completed, which the licensee missed. The licensee did not provide the background study policy.	01290		

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01290	Continued From page 18 TIME PERIOD FOR CORRECTION: 7 (SEVEN) DAYS	01290		
01690 SS=I	144G.71 Subdivision 1 Medication management services (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23.	01690		

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01690	Continued From page 19 This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to implement their medication management policy for two of two residents (R1 and R2) reviewed for controlled medications, storage of medications, monitoring of medications, and evaluation of medication use. The licensee failed to ensure accountability of controlled medications, which resulted in the use of medications to chemically restrain R1 (use of oxycodone to prevent agitation), failed to ensure accuracy of ordered medications which resulted in R1 having an active order for a medication R1 had an allergy to (morphine), failed to ensure security of controlled medications which resulted in the theft of 56 tablets of R2's controlled medication (hydrocodone). 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 22, 2022, due to diagnoses that included traumatic brain injury, dementia, and epilepsy. R1's Service Plan dated October 26, 2022, directed staff to follow R1's behavior plan, and provide R1 medications as per medication administration record (MAR).	01690	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.	

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01690	Continued From page 20 R1's MAR dated January 2023, indicated R1's allergies included morphine. R1's MAR dated February 2023, included medications and administration as follows: Acetaminophen 325 milligrams (mg) one to two tabs every six hours as needed (PRN) for pain., R1's MAR indicated the resident received no Acetaminophen in February 2023. R1's MAR dated March 2023 included medications and administration as follows: Acetaminophen 325 milligrams (mg) one to two tabs every six hours as needed (PRN) for pain, R1's MAR indicated the resident received no Acetaminophen in March 2023. R1's MAR dated April 2023, included medications and administration as follows: Acetaminophen 325 mg one to two tabs every six hours for pain. R1's MAR indicated the resident received no Acetaminophen in April 2023. R1's progress note dated May 19, 2023, indicated R1 had been enrolled in hospice. R1's MAR dated May 2023, included medications and administration as follows: ABH gel (a medication which contained a combination of Ativan (lorazepam) 1 mg, Benadryl 25 mg, and Haldol 1 mg) apply one milliliter (ml) topically on exposed skin every six hours as needed (PRN) for aggressive behaviors (must call hospice or registered nurse to okay use). No administration was documented for May 2023. Acetaminophen 325 milligrams (mg) two tablets twice daily PRN for pain level 1-4 (on a pain scale	01690		

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(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
01690	Continued From page 21 of 1 to 10, with 1 being least amount of pain and 10 being the worst amount of pain). , administered zero doses in May 2023. Morphine 7.5 mg every six hours PRN for pain. No administration was documented for May 2023. R1's MAR dated June 2023, included medications and administration as follows: ABH gel (which contained a combination of Ativan (lorazepam) 1 mg, Benadryl 25 mg, and Haldol 1 mg) apply one ml topically on exposed skin every six hours PRN for aggressive behaviors (must call hospice or registered nurse to okay use), administered zero doses in June 2023. Morphine 7.5 mg every six hours PRN for pain or shortness of breath. No administration was documented for June 2023. Oxycodone (a narcotic pain medication used for moderate to severe pain with drowsiness as a side effect and high risk of addition) 5 mg every four hours PRN for pain 5 or higher on pain scale (1-10), No administration was documented for June 2023. R1's progress note dated June 7, 2023, indicated registered nurse (RN)-A noted morphine should be discontinued due to R1's allergy to morphine. Morphine was not removed from R1's MAR. R1's MAR dated July 2023, included medication and administration as follows: ABH gel (which contained a combination of Ativan (lorazepam) 1 mg, Benadryl 25 mg, and Haldol 1 mg) apply one ml topically on exposed skin every six hours PRN for aggressive behaviors (must call hospice or registered nurse to okay use). No administration was documented for July 2023. Morphine 7.5 mg every six hours PRN for pain or shortness of breath, administered zero doses in July 2023.	01690		

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	27389	A. BUILDING: _____ B. WING _____	C 09/20/2023

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01690	Continued From page 22 Oxycodone 5 mg every four hours PRN for pain 5 or higher on pain scale (1-10). R1 was administered 22 doses of Oxycodone in July 2023. R1's MAR dated August 2023, included medication and administration as follows: ABH gel (which contained a combination of Ativan (lorazepam) 1 mg, Benadryl 25 mg, and Haldol 1 mg) apply one ml topically on exposed skin every six hours PRN for aggressive behaviors (must wear gloves to apply). No administration was documented for August 2023. Lorazepam 0.5 mg one tablet every four hours PRN for anxiety/agitation. R1 was administered two doses in August 2023. Morphine 7.5 mg every six hours PRN for shortness of breath or pain, administered zero doses in August 2023. Oxycodone 5 mg every four hours PRN for pain 5 or higher on pain scale (1-10). R1 was administered 38 doses in August 2023. R1's MAR dated through September 21, 2023, included medication and administration as follows: Lorazepam 0.5 mg every four hours PRN for agitation/anxiety. R1 was administered 14 doses from September 1, 2023, to September 21, 2023. Oxycodone 5 mg every four hours PRN for shortness of breath or pain. R1 was administered 11 doses from September 13 through September 21, 2023. During an interview on September 20, 2023, current registered nurse (RN)-A stated R1 did well on hospice due to the medications hospice provided. RN-A stated the medications slowed R1 down but was not clear on what medications R1 received.	01690		

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01690	Continued From page 23 During an interview on September 20, 2023, at 3:16 p.m. unlicensed personnel-house manager (ULP)-B stated R1 required assistance to keep calm. ULP-B stated she had more freedom with medications when R1 was on hospice, such as the lorazepam and oxycodone. ULP-B stated she requested hospice to order lorazepam for R1 when she determined a peer's family member agitated R1. ULP-B stated she regularly gave R1 lorazepam right before the peer's family member visited (every Monday, Wednesday, and Friday) so R1 would not get agitated. During an interview on September 21, 2023, at 2:58 p.m. R1's guardian (G)-D stated the facility nurse had suggested to enroll R1 in hospice. G-D stated she was told hospice would provide more cares for R1 but had concerns about her observations of R1 being "drugged" and ULP-B told her they [staff] "have to give him [R1] medication to keep him under control." G-D stated they crossed the line between medicating and sedating R1. During an interview on September 21, 2023, at 4:00 p.m. ULP-E stated staff give R1 oxycodone when he was getting agitated. The PRN Medications policy dated August 1, 2021, indicated properly trained staff must administer PRN medications according to the prescriber's orders. The procedure indicated staff were to confirm whether the reason for giving the medication matched the reason the medication was prescribed. The Vulnerable Adult Maltreatment-Prevention and Reporting policy dated August 1, 2021, indicated the licensee prohibited the maltreatment	01690		

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01690	Continued From page 24 of residents consistent with the Minnesota Vulnerable Adults Act. The Minnesota Vulnerable Adults Act 626.5572 subd 15, indicated residents shall be free from maltreatment including nontherapeutic chemical restraints. R2 R2 admitted to the facility on March 1, 2014, due to diagnoses that included stroke, cognitive impairment, and impaired vision. R2's Medication Management Plan dated April 16, 2018, indicated the licensee would securely store medications in the locked medication room. R2's plan indicated the resident had no medications that were at risk of diversion. R2's Medication Administration, Set-up, and Central Storage Review document dated April 16, 2019, indicated R2 required medication administration assistance due to right hand paralysis and visual impairment. R2's medication administration record (MAR) dated April 2023, indicated R2 was prescribed hydroco/apap (a schedule II narcotic pain medication) 5-325 milligrams (mg) twice daily as needed (PRN) for pain. R2's MAR indicated R2 received a dose of hydroco/apap on April 3, 2023. A facility investigation document dated May 2, 2023, indicated unlicensed personnel-house manager (ULP)-B notified the former registered nurse two cards of R2's hydroco/apap were missing. The investigation revealed a total of 56 tablets of hydroco/apap were unaccounted for. The report indicated the last confirmed count of	01690		

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01690	Continued From page 25 R2's hydroco/apap was by ULP-B2 and ULP-E2 on the morning of Thursday April 27, 2023. The investigation indicated the shift sign-off logbook was also missing since Friday April 28, 2023. The facility schedule indicated staff working April 27 through May 2, 2023, included ULP-B, ULP-C2, ULP-D2, ULP-E2, and ULP-G2. Page 104 of the Narcotic Log Book reviewed on September 20, 2023, indicated the facility should have had a card of 26 tablets of R2's hydroco/apap prescription # 23022550, which was last verified on April 3, 2026 by ULP-B. Page 105 of the Narcotic Log Book viewed on September 20, 2023, indicated the facility should have had a card of 30 tablets of R2's hydroco/apap prescription # 23022550, which was entered in the log book on March 24, 2023 by unknown staff. A request for the corresponding Narcotic Count Sheets for page 104 and page 105 was not provided, as they were missing. During an interview on September 20, 2023, at 1:28 p.m. registered nurse (RN)-A stated they stored R2's card of 26 tablets of hydroco/apap in the medication room, in a locked box within the medication cart. RN-A stated the facility kept "overflow" controlled medications (including R2's card of 30 hydroco/apap) in a portable handheld "safe" that had a keyed lock and kept in the locked office. RN-A stated the doors to the office was French-style and could be pried open by staff. RN-A stated ULP-B kept one key to the portable handheld "safe" on her person and "hid the other one in the office." RN-A stated oncoming and outgoing staff were supposed to	01690		

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01690	Continued From page 26 count all the controlled medications but did not. RN-A stated they suspected two staff who worked at the time of the missing medication. During an interview on September 20, 2023, at 3:16 p.m. ULP-B stated she discovered R2's hydroco/apap was missing. ULP-B stated R2 asked ULP-B for a pain pill and when ULP-B opened the locked box in the medication cart the card was gone. ULP-B stated she then went into the office to the portable handheld safe and saw R2's other card of 30 tablets of hydroco/apap was also missing. ULP-B stated she also suspected ULP-D2 and ULP-E2. ULP-B stated she was aware that staff pried open the office door with a butter knife and some staff knew where she hid the key for the portable handheld safe. ULP-B stated the staff were supposed to count controlled medications together at change of shift but did not always. ULP-B stated she and the lead (ULP-E2) verified the overflow medications located in the portable handheld safe weekly. ULP-B stated the RN never counted the controlled medications in either location (medication cart or the lock box). ULP-B stated she initially suspected ULP-G2 stole the narcotics, but later thought it was ULP-D2 and ULP-E2, because of their history of drug use and personal relationship. During an interview on September 26, 2023, at 1:14 p.m. ULP-C2 stated the facility did not have a system to make sure the controlled medications were accurate. ULP-C2 stated it could have been ULP-D2, ULP-E2, or ULP-G2 who stole the medications, but she did not see anything. During an interview on September 27, 2023, at 2:48 p.m. ULP-D2 stated the key to the locked box in the medication cart was just hanging in the	01690		

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01690	Continued From page 27 medication room. ULP-D2 stated everyone had access to the medication room because it held the washer and dryer. ULP-D2 stated he never counted controlled medications when ULP-G2 worked because she was always in a hurry to get out the door. He suspected ULP-G2 stole the narcotics. During an interview on September 27, 2023, at 3:41 p.m. ULP-E2 stated the facility had a locked box for storage of narcotics and one for overflow medications but everyone knew where the keys were and how to get into the office (using a butter knife). ULP-E2 stated she suspected ULP-G2 stole the narcotics. The Medication Storage policy dated August 1, 2021, indicated medications would be kept securely locked to prevent diversion and only authorized staff had access to medications. The policy indicated schedule II medications would be stored under a double lock system and counted at the beginning and end of every shift. TIME PERIOD FOR CORRECTION: 7 (SEVEN) DAYS	01690		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview and document review, the	02310	Minnesota Department of Health is	

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02310	Continued From page 28 licensee failed to provide appropriate care and services for 1 of 1 resident (R1) when staff called emergency medical services (EMS) for lift assistance and to intervene when R1 became agitated and used as needed (PRN) medication (oxycodone) to chemically restrain R1 in anticipation of negative behaviors. 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's medical record was reviewed. R1 admitted to 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 cooperate with medical decision making. R1's Vulnerability Assessment/Abuse Prevention Plan dated April 1, 2022, included the following interventions: staff will work to have a calm and safe environment, redirect as needed and walk away if resident is safe while becoming aggressive/physical, staff will call EMS/law enforcement if noted any altercations begins without being able to redirect and resident will go to ED if a danger to himself or others.	02310	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.	

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02310	Continued From page 29 R1's Behavior Management Plan dated October 28, 2022, provided staff with interventions for the following behaviors: Verbal Abuse-do not raise voice, practice active listening, ask R1 if there were any concerns to address, implement empathetic listening for understanding, and be aware of demeanor and approach to avoid triggers. Throwing items-remove items, put distance between self and R1, removed other residents, give resident space (go to room), do not leave unnecessary items within R1's reach. Physical combativeness-approach R1 with a way to exit (don't put self in corner), do not raise voice, remove self for safety, reassure R1 that he is OK and safe. R1's nursing assessment dated December 8, 2022, indicated R1's services were appropriate, R1's needs were being met, and R1 was pleased with his services. The assessment indicated the nurse made no changes to R1's service plan. R1's nursing assessment dated September 12, 2023, indicated R1's services were appropriate, R1's needs were being met, and R1 was pleased with his services. The assessment indicated the nurse made no changes to R1's service plan. R1's medication administration records (MARs) from January 2023 through September 20, 2023, indicated R1 received zero doses of acetaminophen ordered for pain during that time period. The MARS indicated R1 received oxycodone 5 milligrams (mg) (ordered for pain at a level of 5 or above (on a scale of 1-10 with one being least pain and ten being most pain) 22 doses in July 2023, 38 doses in August 2023, and 11 doses in September 2023 (1st through 20th).	02310		

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02310	Continued From page 30 During an interview on September 20, 2023, at 2:03 p.m. registered nurse (RN)-A stated the resident did better behaviorally when on hospice because hospice was more liberal with PRNs. RN-A stated she was aware of R1's behavior plan but had not made any changes in the last year. RN-A stated staff were directed to call the police when R1 was a risk to harm himself or others (such as "if [R1] broke glass and had no shoes on"), or if they could not de-escalate a situation. RN-A stated she told staff to call emergency medical services (EMS) for assistance lifting patients off the floor. RN-A stated the licensee did not train staff on physically lifting residents off the floor. During an interview on September 20, 2023, at 2:45 p.m. unlicensed personnel (ULP)- B stated R1 did well on hospice, not due to the extra attention received from hospice staff, but due to the amount of medication that ULP-B and staff were allowed to give R1. ULP-B stated hospice gave the facility "more freedom" with frequency of medications, and she primarily used lorazepam (an antianxiety medication prescribed to R1 for anxiety every four hours as needed)) and oxycodone (a narcotic pain medication prescribed for shortness of breath or pain). ULP-B stated she gave R1 lorazepam right before a peer's (R5) family member came to visit every Monday, Wednesday, and Friday afternoon, because R1 did not get along with the person. ULP-B stated the company policy directed staff to call EMS to lift residents off the floor. During an interview on September 21, 2023, at 2:58 p.m. guardian (G)-D stated the licensee recommended she enroll R1 in hospice and the licensee offered to have their provider sign off on	02310		

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02310	Continued From page 31 the certification of terminal illness. G-D stated the licensee overmedicated R1 in order to keep him from becoming agitated. G-D stated ULP-B told her that staff use the medication hospice provided to keep R1 subdued rather than wait for behaviors to start. During an interview on September 21, 2023, at 4:00 p.m. ULP-E stated staff were directed to give R1 PRN medication prior to a peer's family member regular visits (Monday, Wednesday, and Friday) so that R1 did not get into altercation with the family member. ULP-E stated she was directed to call hospice and then 911 for R1's behaviors. ULP-E stated on September 4, 2023, when she arrived at the facility, R1 was laying of the floor, the morning staff told her she was directed by ULP-B to leave R1 on the floor. ULP-E stated R1 may have been on the floor for seven hours. During an interview on September 25, 2023, at 10:06 a.m. detective (D)-F stated law enforcement has had multiple 911 calls from the facility (26 total since November 2022) and staff often wanted law enforcement to place R1 on an emergency hold and hospitalize him. D-F stated the hospital did not usually keep R1, but the staff have a 2-3-hour break from R1. Law enforcement records indicate the facility called 911 on the following dates for R1: January 5, 2023, at 10:32 a.m. February 8, 2023, at 12:46 p.m. February 10, 2023, at 12:5 p.m. March 25, 2023, at 8:51 p.m. April 2, 2023, at 4:36 p.m. April 5, 2023, at 4:12 p.m. June 9, 2023, at 2:23 p.m. September 4, 2023, at 5:22 p.m.	02310		

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02310	Continued From page 32 September 5, 2023, at 8: 11 a.m. 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. 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: 7 (SEVEN) DAYS	02310		
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	02360		

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02360	Continued From page 33 by: The facility failed to ensure two of two residents reviewed (R1 and R2) were free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	