

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL296246826M Date

Compliance #: HL296242903C

Date Concluded: August 16, 2023

Name, Address, and County of Licensee

Investigated:

Ultimate Care Assisted Living 5443 Logan Avenue North Brooklyn Park, MN 55430 Hennepin County

Facility Type: Assisted Living Facility (ALF) **Evaluator's Name:** Michele R. Larson, RN

Special Investigator
Holly German, RN
Special Investigator

Finding: Substantiated, facility and individual responsibility

Nature of Investigation:

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

Initial Investigation Allegation(s):

The facility and an alleged perpetrator (AP) neglected a resident when they failed to provide daily wound care for the resident's diabetic pressure ulcer on her right heel. The resident's foot became infected, filled with maggots, and required hospitalization.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was substantiated. The facility and the AP were responsible for the maltreatment. The facility and the AP failed to provide the resident with proper due care for her diabetic heel wound. The resident's podiatrist ordered daily wound care, yet her records lacked documentation daily wound care was provided. The AP failed to complete routine wound assessments and was the only staff performed wound care per documented records, in addition to not developing any instructions for unlicensed staff to

provide wound care. The AP only performed wound care one day after the podiatrist order wound care to be completed daily. The facility stated the resident routinely refused her bathing services, yet facility records lacked documentation the resident refused services. The unlicensed staff failed to identify any deterioration of the resident's heel wound although they documented bed baths and showers were completed. The resident's wound was severely infected with maggots at the time of hospitalization.

The investigators conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigators interviewed the resident and her family member. The investigation included review of the resident's facility records, hospital records, and clinic record. Also, the investigators observed resident cares during their onsite investigation.

The resident resided in an assisted living facility. The resident's diagnosis included type 2 diabetes mellitus. The resident's care plan included assistance with transfers, repositioning, showers, bed baths, and toileting. The resident's assessment indicated she was totally dependent on staff to complete her cares. The resident required a total body mechanical lift with the assist of two staff and used an electric wheelchair for mobility. The resident's record indicated the resident required bed baths daily and showers three times per week.

The resident's skin assessment, completed by the AP, indicated the resident had a right heel wound. The skin assessment lacked detailed wound assessment of her heel to include wound measurements, type of tissue present, drainage, and signs or symptoms of infection. The skin assessment failed to include rating of her pain level.

The resident's podiatrist note indicated the podiatrist ordered daily wound care for her right heel pressure ulcer 29 days before she was hospitalized. The daily wound care order consisted of dressing changes with betadine, 4 x 4 gauze, an absorbent gauze, and an off-loading shoe to relieve pressure on her heel wound. The podiatrist classified the resident's wound as an unstageable pressure ulcer with circulatory complication.

The resident's care plan lacked documentation the AP updated her care plan to include daily wound care and failed to implement the wound care orders on her treatment record. The AP failed to create an individualized treatment plan for the resident and create instructions for unlicensed personnel (ULP) to preform wound care to the resident's right heel.

The resident's record indicated the AP performed wound care six days after the podiatrist new order. The AP documented she changed the resident's heel dressing, changed her sock as the other one smelled bad and wrote the wound is "dry and healing". The assessment of the wound failed to include the wound status such as type of tissue present, any drainage, signs or symptoms of infection and wound measurements. The residents record failed to include further routine wound assessments to track the healing of her wound during the 22 days before the resident was hospitalized.

The resident's progress note indicated the resident woke up with her left leg swollen. ULP staff provided the resident a bed bath but failed to look at her heel. Staff administered over-the counter pain medication. Hours later the resident went to the hospital due to pain in her heels.

The resident's record lacked documentation the AP assessed the resident's swollen left leg.

The resident's hospital record indicated the resident reported her right heel wound burst with purulent (pus) drainage a few days before she was hospitalized. Her heel pain intensified and traveled up her right leg. At the hospital, staff found the resident's wound filled with maggots. Hospital staff debrided her wound and administered strong intravenous (IV) antibiotics and pain medication. The resident reported the AP assessed her wound once a week. During a phone call with a hospital RN, the AP stated the resident received wound care every other day but agreed to comply with daily wound care once the resident returned to the facility.

Upon return to the facility, there continued to be lack of documentation the AP assessed the resident's wound after her hospitalization and failed to transcribe the resident's daily wound care orders. There was no documentation the facility provided daily wound care after the resident returned from the hospital on the resident's treatment record.

During an interview, an ULP stated the AP never trained her on wound care stating, "the RN did not give me any directions on anything I should do for the wound."

During an interview, the resident stated the AP assessed her heel wound weekly and stated staff were not changing her dressings prior to her hospitalization. The resident stated her right heel wound burst open with pus about a week or so before she was admitted to the hospital. The resident stated, "I was in a lot of pain. Pain so bad I was in tears." The resident stated she was in disbelief when hospital staff told her she had maggots in her right heel wound. The resident stated staff started changing her bandages every other day after her discharge from the hospital.

During her initial interview, the AP stated she never implemented interventions related to the resident's refusals or updated the resident's doctors regarding her refusals but stated she "strongly encouraged" the resident to shower. The AP contradicted herself when she stated she unsure if assessments or wound care were provided to the resident prior to her hospitalization, but later stated she performed weekly assessments, and staff performed dressing changes on alternate days. The AP agreed ULP should have performed daily wound care, but stated she was unsure if that was being done since she was only there once a week. The AP stated she should have "laid eyes" on the resident more than once a week due to the resident's diagnoses of diabetes and obesity. The AP stated, "I'm doing that now, but I didn't before."

During a subsequent interview, the AP stated it was ULP's responsibilities to inform her of any changes and updates to the resident's change of condition but stated she was seldom informed

of the resident refusing services or updates in her condition. The AP stated she trained two ULP on the resident's wound care then it was their responsibility to train other ULP. The AP stated she was still unclear if she was the only nurse who worked for the facility, or if another registered nurse (RN) worked there too, stating the owner never told her anything. The AP stated although she worked for the facility for two years, she still did not understand the process of transcribing physician orders with the facility's electronic record system.

During an interview, the family member stated initially, the AP was not cleaning the resident's wound. The family member stated she told the resident to call 911 because the resident was diabetic and her wound could develop into something serious, but the resident told her she did not want to be a pest. The resident was in severe pain when she admitted to the hospital, stating the resident told her it felt like there was "something crawling on her." The family member stated she was furious with the facility for allowing the resident to deteriorate. The family member stated facility management tried to blame the resident, indicating the resident should have told someone.

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: Yes

Action taken by facility:

The facility sent the resident to the hospital when she complained of heel pain.

Action taken by the Minnesota Department of Health:

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

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

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

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

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

CC

The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Hennepin County Attorney
Brooklyn Park City Attorney
Brooklyn Park Police Department
Minnesota Board of Nursing

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	(X3) DATE SURVEY COMPLETED		
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	In accordance with 144G.08 to 144G.9 issued pursuant to a Determination of what requires compliance provided at the state When a Minnesota items, failure to combe considered lack INITIAL COMMENT #HL296242903C/#HOUSE A DOTATE OF THE SERVICES UNDER THE SERVICES	Minnesota Statutes, section 5, these correction orders are a complaint investigation. The ther a violation is corrected with all requirements ute number indicated below. Statute contains several apply with any of the items will of compliance. TS: HL296246826M The Minnesota Department of complaint investigation at the difference of the complaint were two residents receiving provider's Assisted Living ction orders are issued for HL296246826M, tag 30, 1390, 1500, 1530, 1620,		Minnesota Department of Health is documenting the State Correction using federal software. Tag number been assigned to Minnesota State Statutes for Assisted Living Facilitia assigned tag number appears in the left column entitled "ID Prefix Tag. state Statute number and the corresponding text of the state State of compliance is listed in the "Sum Statement of Deficiencies" column column also includes the findings are in violation of the state require after the statement, "This Minnesor requirement is not met as evidence Following the evaluators' findings in Time Period for Correction. PLEASE DISREGARD THE HEAD THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES THE FOURTH ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION STATUTES. THE LETTER IN THE LEFT COLUMN THE LETTER IN THE LEFT COLUMN USED FOR TRACKING PURPOS REFLECTS THE SCOPE AND LETTER IN THE LETTER IN THE LEFT COLUMN USED FOR TRACKING PURPOS REFLECTS THE SCOPE AND LETTER IN THE LET	Orders ers have es. The ne far "The atute out amary n. This which ment ota ed by." is the ON FOR TATE JMN IS ES AND VEL
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Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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(a) The assisted living facility must comply the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure the cases of suspected maltreatment are reported. This MN Requirement is not met as evided by: Based on interview and record review, the licensee failed to report suspected maltreat to the Minnesota Adult Abuse Reporting C (MAARC) for one of one residents (R1) were records reviewed. R1's foot (podiatrist) do ordered daily wound care for R1's right he wound yet R1's record indicated licensee performed only intermittent wound care. Fewound became infected. R1 was admitted hospital with severe right heel pain where staff discovered R1's wound was filled wit maggots. R1 spent a few days in the hospite received intravenous (IV) antibiotics and debridement for her wound. This practice resulted in a level two violation that did not harm a resident's heastety but had the potential to have harmer resident's health or safety, but was not like cause serious injury, impairment, or death was issued at an isolated scope (when on limited number of residents are affected of a limited number of residents are affected of a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's medical record was reviewed. R1 ad to the licensee's facility on January 25, 20 diagnoses included type 2 diabetes mellitic.	with on that all orted. enced eatment center ith octor el staff R1's I to the hospital h oital and on (a ely to n), and ne or a er one or ne mitted 22. R1's	20			

Minnesota Department of Health

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		acility filed a MAARC report, nning on taking care of R1's				

Minnesota Department of Health

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Minnesota Department of Health

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mobility. R1's assessment dated September 6, 2022, indicated R1 was totally dependent with personal cares, transfers, mobility, and self-preservation. R1's vulnerability assessment dated September 6, 2022, indicated R1 was vulnerable to	0 630	licensee failed to er prevention plan (IAI assessment of vuln be abused by other abuse for one of on reviewed. This practice results violation that did no safety but had the president's health or cause serious injury was issued at an iss limited number of realimited number of situation has occurr. The findings included R1's medical record to the licensee's fact diagnoses included R1's service plan daindicated R1 was to bed baths, showers diabetic meals, foot every two hours, two exercises, and toile standing mechanical lift for transfers and mobility. R1's assessment daindicated R1 was to cares, transfers, more R1's vulnerability as R1's vulnerabilit	risure an individual abuse PP) was developed based on erablities and identify risk to s with interventions to prevent e resident (R1) with record ed in a level two violation (a tharm a resident's health or otential to have harmed a safety, but was not likely to y, impairment, or death) and olated scope (when one or a esidents are affected or one or staff are involved, or the red only occasionally). Et al. was reviewed. R1 admitted cility on January 25, 2022. R1's type 2 diabetes mellitus. At was reviewed with daily at three times per week, a care, transfers, repositioning ice daily range-of-motion ting/peri-care. R1 used a sal lift or total body mechanical an electric wheelchair for eated September 6, 2022, otally dependent with personal obility, and self-preservation.				

Minnesota Department of Health

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	accurate information interest in environmentation, ensembles, and behavior physically abusive, behaviors, and was R1's vulnerability as documentation an inassessment was desusceptibility to abusincluding other vulnof specific measurerisk of abuse to R1 R1's vulnerability as interventions for here	on, anxiety and depression, nent/activities, ndurance, pain, walking, iors. R1 was not verbally or did not exhibit threatening a not sexually inappropriate. Seessment lacked ndividualized review or eveloped that assessed R1's use by another individual, nerable adults, and statement es to be taken to minimize the and other vulnerable adults. Seessment lacked specific or listed vulnerabilities.				
	(RN)-C stated she cresident IAPP's.	at 9:00 a.m., registered nurse developed and revised titled Vulnerable Adult, dated				
	were required to income determine vulnerab	indicated licensee employees dividually assess residents to sility to abuse or neglect and plan to minimize the risk of ent.				
	TIME PERIOD TO	CORRECT: Seven (7) days				
01390 SS=F		on 1 Availability of contact	01390			
	registered nurse av performing delegate have an appropriate	acilities must have a vailable for consultation by staff ed nursing tasks and must e licensed health professional ing other delegated services				

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	Based on interview licensee failed to ha available 24 hours (24/7) for consultation delegated nursing the affect all residents at the procession of the proc	and record review, the ave a registered nurse (RN) per day seven days per week on by staff performing asks. This had the potential to and unlicensed staff. ed in a level two violation (and tharm a resident's health or potential to have harmed a safety), and was issued at a (when problems are pervasive emic failure that has affected to affect a large portion or all				
	2023, at 9:50 a.m., Monday through Fright, as well as after stated she was availability was a "g	conference on June 14, RN-C stated she worked day, from 9:00 a.m. until 5:00 er hours and weekends. RN-C ilable 24/7 but stated her ray area." RN-C stated staff				
	reach her during after she would respond was not urgent. Ow	ext message if they needed to ter hours or weekends and the following business day if it ner (OW)-D stated RN-C was RN for the licensee's several				
	she was surprised was the only nu several facilities du	, at 9:00 a.m., RN-C stated when owner (OW)-D stated urse and RN for the licensee's ring the entrance conference partment of Health (MDH) ne 13, 2023. RN-C				

Minnesota Department of Health

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01390	Continued From pa	ige 8	01390			
	she was available be issues, but worked through Friday. RN-discharge residents hours" and weeken and staffing. RN-C a resident back on The licensee's Unifficiensed staff were attached building, of available to responding available to responding available to responding the RN on site.	f when she told investigators by phone 24/7 if staff had 9:00-5:00 p.m. Monday -C stated hospitals could not back to the licensee "after ids due to no nurse available stated, if hospitals ask to take weekends, she says no. Form Disclosure of Assisted Amenities (UDALSA), idicated the licensee's either in the building, an or within the campus and d to resident requests 24/7. The licensee had one full-time CORRECT: Seven (7) days.				
01500		equired annual training	01500			
SS=D	(a) All staff that per complete at least er for each 12 months may be obtained from source and must in provision of assiste training must include (1) training on reportulation of the assistent fresponsibilities exercise and protection (3) review of infection the home and implest and ards including techniques; the needs	form direct services must ight hours of annual training of employment. The training om the facility or another clude topics relevant to the d living services. The annual de: rting of maltreatment of nder section 626.557; sisted living bill of rights and serelated to ensuring the ction of those rights; on control techniques used in ementation of infection control a review of hand washing ed for and use of protective I masks; appropriate disposal				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		29624	B. WING		06/1) 3/2023
		23024			00/1	3/2023
NAME OF I	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
ULTIMAT	E CARE ASSISTED L	IVING LOGAN HC	AN AVENUE YN CENTER,			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
	Continued From partial of contaminated mass dressings, needs blades; disinfecting disinfecting environ reporting communic (4) effective approach when working with behaviors, and how residents who have disease, or related (5) review of the fact relating to the provision of the principles of and service delivery support services providing services to the annual training may providing services to the annual training on hear subdivision must be based, may include include training on topics: (1) an explanation of and how it manifest challenges it poses (2) the health impact age-related hearing incidence of demensional depression of the principles of and tactile alerting of an	ge 9 aterials and equipment, such les, syringes, and razor reusable equipment; mental surfaces; and cable diseases; ches to use to problem solve a resident's challenging to communicate with dementia, Alzheimer's disorders; cility's policies and procedures sion of assisted living services ent those policies and person-centered planning y and how they apply to direct ovided by the staff person. The topics in paragraph (a), y also contain training on o residents with hearing loss. Fing loss provided under this en high quality and research online training, and must one or more of the following of age-related hearing loss is itself, its prevalence, and to communication; cts related to untreated loss, such as increased itia, falls, hospitalizations, ession; or ut strategies and technology	01500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		29624	B. WING		06/1	3/2023
	PROVIDER OR SUPPLIER	IVING LOGAN HC 5443 LOG	DRESS, CITY, S AN AVENUE 'N CENTER,			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01500	by: Based on record relicensee failed to endicensee failed to endicense completed training on required employment for one registered nurse (Roman Failed nurse). This practice results violation that did not safety but had the president's health or cause serious injury was issued at an iselimited number of realimited number of realimited number of situation has occurred. The findings include RN-C was hired by 2021. RN-C's training recall and training for each annual training for each	ent is not met as evidenced view and interview, the asure a direct care staff at least eight hours of annual topics for each 12 months of e of three employees, N)-C with records reviewed. ed in a level two violation (a tharm a resident's health or otential to have harmed a safety, but was not likely to y, impairment, or death) and olated scope (when one or a esidents are affected or one or staff are involved, or the red only occasionally). e: the licensee on February 23, ord lacked eight hours of each 12 months of following topics: ng of maltreatment of moder section 626.557; ted living bill of rights and staff ted to ensuring the exercise	01500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
	29624	B. WING		06/1	; 3/2023
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED L	IVING LOGAN HO 5443 LOG	DRESS, CITY, STAN AVENUE YN CENTER,	NORTH	•	
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
disinfecting environment reporting community - effective approach when working with a behaviors, and how residents who have disease, or related or review of the facility relating to the provision and how to implement procedures; and the principles of perservice delivery and support services procedures are delivery and support services procedures. On July 20, 2023, and Department of Heal email to owner (OW) employee file, included the modern of the stated she was in cluther of the stated she	reusable equipment; mental surfaces; and cable diseases; nes to use to problem solve a resident's challenging to communicate with dementia, Alzheimer's				

Minneso	ta Department of He	ealth				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY
		29624	B. WING			C 3/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
ULTIMAT	E CARE ASSISTED L	IVING LOGAN H(GAN AVENUE LYN CENTER,			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
01500	Continued From pa	ge 12	01500			
	August 1. 2021.	to assisted living licensure in rect: Twenty-One (21) Days				
01530 SS=D		3 IN DEMENTIA CARE	01530			
	following training re (1) supervisors of deleast eight hours of the employment thereased to dementiate employment thereased (2) direct-care employment hours of the employment hours of the employment hours of the employment hours of the employment thereased to dementiate the employment hours of the employment hours of the employment hours of the employment hours of the employment thereased the employment hours of the employment hours o	lirect-care staff must have at initial training on topics agraph (b) within 120 working yment start date, and must ours of training on topics care for each 12 months of				

Minnesota Department of Health

by:

eight hours of training on topics related to

and assist if issues arise. A trainer of the

until the training requirement is complete.

each 12 months of employment thereafter;

Based on interview and record review, the

dementia care and who can act as a resource

requirements under paragraph (b) or a supervisor

meeting the requirements in clause (1) must be

Direct-care employees must have at least two

available for consultation with the new employee

hours of training on topics related to dementia for

This MN Requirement is not met as evidenced

licensee failed to provide evidence that one of

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Minnesota Department of Health

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING:		` '	COMPLETED	
		29624	B. WING			C I 3/2023
	PROVIDER OR SUPPLIER	IVING LOGAN HO 5443 LOG	DRESS, CITY, S AN AVENUE 'N CENTER,		•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUTH CROSS-REFERENCED TO THE APPROPRIES (EACH COSS-REFERENCE)	ULD BE	(X5) COMPLETE DATE
01530	completed two hour required topics for employment with real employment with real topics for employment with real topics are serious injury was issued at an isolimited number of real limited number of situation has occurred. The findings include RN-C hired by the IRN-C's training transport to dementia for each of the semail to owner (OV employee file, included on July 20, 2023, as a supervisor, unlicense of the stated she was in course of the	egistered nurse (RN)-C, as of dementia care training on each 12 months of ecords reviewed. ed in a level two violation (a tharm a resident's health or potential to have harmed a safety, but was not likely to y, impairment, or death), and polated scope (when one or a esidents are affected or one or staff are involved or the red only occasionally). e: icensee on February 23, 2021. ascript dated February 25, -C completed the initial 8	01530			

Minnesota Department of Health

	A. BUILDING:	(X3) DATE SURVEY COMPLETED	
29624	B. WING	C 06/13/2023	

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ULTIMATE CARE ASSISTED LIVING LOGAN HO BROOKLYN CENTER, MN 55430					
(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	
01530	Continued From page 14 investigator received an email from OW-D. The	01530			
	email had one attachment. The attachment contained RN-C's background clearance letter, her original training transcripts from February 25, 2021, and a certificate of completion for a course titled, "Calming an Overactive Brain", dated May 16, 2023.				
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days				
01620 SS=G	(),,	01620			
	(c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	` '	E SURVEY PLETED	
		29624	B. WING			C 13/2023
	PROVIDER OR SUPPLIER	IVING LOGAN HC 5443 LOG	DRESS, CITY, STAN AVENUE YN CENTER,			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
01620	Based on interview licensee failed to en performed routine was no pitalized wind wound and maggot. This practice result violation that harmone or a violation that harmone including serious or a violation that has serious injury, impaissued at an isolate limited number of real limited number of situation has occurred to the licensee's fact diagnoses included R1's service plan dindicated R1 was to be be baths, showers diabetic meals, transhours, twice daily ratioleting/peri-care, and an electric when goals were to ensure free from any abuse cares from licensee R1's skin assessments.	ent is not met as evidenced and record review, the nsure registered nurse (RN)-C wound care assessments for (R1) with record reviewed. R1 th an infected right heel s in her wound. ed in a level three violation (a ed a resident's health or safety, is injury, impairment, or death, as the potential to lead to airment, or death), and was ed scope (when one or a esidents are affected or one or staff are involved or the red only occasionally). d was reviewed. R1 admitted cility on January 25, 2022. R1's type 2 diabetes mellitus. ated March 25, 2022, or receive assistance with daily of three times per week, asfers, repositioning every two ange-of-motion exercises, and and medication management. And or Hoyer lift for transfers selchair for mobility. Facility are R1 was safe, clean, and e or neglect while receiving e's staff. ent dated September 6, 2022,				
		right heel wound with acute ndicate her pain level and				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	` ,	E SURVEY PLETED	
		29624	B. WING			C 13/2023
	PROVIDER OR SUPPLIER	IVING LOGAN HO	DDRESS, CITY, ST SAN AVENUE YN CENTER,	NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION OF CORRECTION OF COR	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
01620	R1's progress note 11:09 a.m., documer right heel wound ware RN-C indicated R1' R1's progress note 7:29 p.m., documer dressing was changed documented, "assefailed to measure a wound status (signstype of tissue exposed rissue expose	dated September 6, 2022, at ented by RN-C, indicated R1's as cleaned and redressed. In wound was "healing slowly." dated September 13, 2022, at ented by RN-C, indicated R1's ged by the ULP. RN-C ssed, looks good." RN-C and clinically described the sof infection, type of drainage, sed). clinic note dated September m., indicated R1's dressings kly by licensee staff. R1's R1 to receive daily wound care facility. Facility staff were to defor acute changes or signs of wound was documented as ssure injury of the right heel. dated September 20, 2022, at essing was changed. RN-C deforment R1's wound status document R1's wound status documen				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE COMP	MPLETED	
		29624	B. WING		06/1) 3/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ULTIMAT	E CARE ASSISTED L	IVING LOGAN HC	AN AVENUE IN CENTER,			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
01620	Continued From pa	ge 17	01620			
	daily wound care as	documentation R1 received ordered by her podiatrist.				
	5:09 p.m., indicated hospital emergency pain in her right heel wound burst of (pus) drainage. R1 intensified and trave she was hospitalize wound was infected maggots. Her wound administered intrave medication. R1 indicated hospital RN, RN-C icare every other da	I dated October 12, 2022, at IR1 was admitted to the department (ED) with severe el wound. R1 reported her right pen days before with purulent indicated her heel pain eled up her leg the day before d. ED hospital staff found R1's with a large number of id was debrided, and she was enous (IV) antibiotics and pain cated RN-C assessed her c. During a phone call with a indicated R1 received wound y, but agreed to have licensee yound care after R1's				
	On October 14, 202 discharged back to	22, at 3:00 p.m., R1 was the facility.				
	assessed R1's right	documentation RN-C theel wound after she was the licensee's facility.				
	assessed R1's wou she did reassess R	at 9:00 a.m., RN-C stated she nd once a week. RN-C stated 1's right heel wound after she could not explain why it was				
		t 1:30 p.m. RN-C stated she or 12 residents who resided in facilities.				
	The licensee policy	titled Comprehensive Nursing				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	E CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
		/ \. Boilbiivo.			С	
	29624	B. WING			13/2023	
NAME OF PROVIDER OR SUPPLIE	R STREET AD	DDRESS, CITY, S	STATE, ZIP CODE			
ULTIMATE CARE ASSISTED	LIVING LOGAN H(GAN AVENUE				
	BROOKL	YN CENTER,				
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
01620 Continued From	page 18	01620				
the licensee's RN assessment dele unlicensed perso	ted February 17, 2022, indicated assess a resident and from that gate appropriate tasks to nnel (ULP). CORRECT: Seven (7) days.					
01640 144G.70 Subd. 4 SS=D implementation a	•	01640				
that services are facility shall finali (b) The service pinclude a signature facility and by the agreement on the service plan must resident reassest facility must provabout changes to and how to contain Long-Term Care for Mental Health (c) The facility must be entered including notice of when applicable. (e) Staff providing the current writte This MN Require by: Based on interviews	first provided, an assisted living to a current written service plantan and any revisions must be or other authentication by the resident documenting to services to be provided. The to be revised, if needed, based on the services if needed, based on the facility's fee for services of the Office of Ombudsman for and the Office of Ombudsman and Developmental Disabilities. The service plantan and the revised service plantan and the revised service plantan and the resident record, if a change in a resident's fees a service plantan and the revised service plantan and the resident record, if a change in a resident's fees a service plantan and the revised service plantan and the revised service plantan and the resident record, if a change in a resident's fees a service plantan and record review, the ensure a resident's service plantan and record review, the ensure a resident's service plantan and record review, the ensure a resident's service plantan and record review, the ensure a resident's service plantan and record review, the ensure a resident's service plantan and record review, the ensure a resident's service plantan and record review, the ensure a resident's service plantan and record review, the ensure a resident's service plantan and the revised review, the ensure a resident's service plantan and record review, the ensure a resident's service plantan and the revised review, the ensure a resident's service plantan and the revised review, the ensure a resident's service plantan and the revised review, the ensure a resident's service plantan and the revised review, the ensure a resident's service plantan and the revised review.					
included all the s	ensure a resident's service planervices to be provided as record for one of one resident					

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE COMP			
	20004	B WING		C	
	29624	D. WING		06/13	3/2023
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING	S LOGAN HC 5443 LOG	ORESS, CITY, S AN AVENUE 'N CENTER,			
(X4) ID SUMMARY STATEMEN PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDE	T BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION (PROVIDENCY)	D BE	(X5) COMPLETE DATE
R1's foot (podiatrist) doc care for a chronic pressulted. This practice resulted in violation that did not hard safety but had the potent resident's health or safety cause serious injury, implied was issued at an isolated limited number of reside a limited number of staffy situation has occurred on the licensee's facility of diagnoses included type record indicated she had R1's care plan/service planguage to ileting/peri-care, and many standard as to seeing a foot doctor (parea for non-sterile dress "not applicable." The ser	ed. In addition, the R1's service plan to when ctor ordered daily wound ure ulcer on her right a level two violation (a m a resident's health or tial to have harmed a ty, but was not likely to pairment, or death) and d scope (when one or a ents are affected or one or fare involved, or the nly occasionally). Serviewed. R1 admitted on January 25, 2022. R1's a 2 diabetes mellitus. R1's d a right heel wound. Ian dated January 25, to receive assistance with set three times per week, so, repositioning every two end-motion exercises, and medication management. Chanical lift or total body fers and an electric R1 required foot care two needed (prn), in addition podiatrist) annually. The sing change indicated rvice plan was reviewed open of the podiatrist of the podiatric of the podiatrist of the podiatric of the podiatrist of the podiatrist of the podiatrist of the podiatrist of the podiatric of the	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ´	E CONSTRUCTION	(X3) DATE	E SURVEY PLETED	
		29624	B. WING			C 13/2023
	PROVIDER OR SUPPLIER	IVING LOGAN HO 5443 LOG	DRESS, CITY, S AN AVENUE IN CENTER,			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
01640	September 14, 202 ordered daily wound pressure ulcer. Lice (ULP) were to perfousing betadine, 4 x (Kling), and use of pressure off her rig was classified as at R1's service plan laupdated to include her right heel and of R1's service deliver 2022, indicated R1 five times out of the week showers four R1's September se documentation daily R1. R1's service deliver indicated R1 did no seven times out of R1's October 2022 documentation staffor her pressure ulconserved R1 was here 2022, indicated R1 was here 2022, indicated R1 was here 2022, indicated R1 licensee at 5:00 p.m.	c) progress note dated 2, indicated R1's podiatrist d care for R1's right heel ensee unlicensed personnel orm daily dressing changes 4 gauze, absorbable gauze an off-loading shoe to relieve the heel. R1's pressure ulcer n unstageable pressure ulcer n unstageable pressure ulcer. Acked documentation it was daily dressing changes to to off-loading shoe. Try record dated September did not receive daily bed baths a month nor three times per times out of the month. Tryice delivery record lacked by wound care was provided to the month. Tryice delivery record lacked by wound care was provided to the month. Tryice delivery record lacked for performed daily wound care delivery record lacked for performed daily wound care der. The dated October 12, 2022, ospitalized. On October 14, was discharged back to the	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE S	
				С	;
	29624	B. WING		06/1	3/2023
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED L	IVING LOGAN HC 5443 LOG	DRESS, CITY, S AN AVENUE ON CENTER,			
PREFIX (EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01640 Continued From pa	ige 21	01640			
R1's record lacked scheduled services	documentation R1 refused her				
revised resident set basis and as needed out resident services resident binders for they read and understated she was awas sometimes for week what contributed to right heel wound. From the implement intervents R1's podiatrist or part to refuse. RN-C states R1's feet but since	at 9:00 a.m., RN-C stated she rvice plans on a quarterly ed. RN-C stated she printed e plans and put the plans in staff to follow. ULP signed off erstood the care plans. RN-C are R1 refused showers ks on end, stating that was her getting maggots in her eN-C stated she did not tions for R1's refusals or notify rovider since it was R1's right ated she did not think to check her maggots staff are nd documenting her refusals				
personnel (ULP)-E	at 9:00 a.m., unlicensed stated R1 was stubborn with d sometimes refuse.				
February 17, 2022, implemented for all provide all services service plan. Service the resident based resident/responsible needs identified in assessment. Service needed, based on reassessment.					
TIME PERIOD TO	CORRECT; Seven (7) days.				

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
		29624	B. WING		06/1	3/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ULTIMAT	E CARE ASSISTED L	IVING LOGAN HO	AN AVENUE YN CENTER,			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF CORRECTION SHOULD DEFICIENCY)	.D BE	(X5) COMPLETE DATE
01940	Continued From pa	ge 22	01940			
01940 SS=D	144G.72 Subd. 3 In therapy manageme	dividualized treatment or n	01940			
	For each resident reproduced or prescribed services, the assisted and include in the statement of the treatment of the treatment also develop a individualized treatment record contain at least the (1) a statement of the provided; (2) documentation of relating to the treatment administration; (3) identification of the will be delegated to (4) procedures for mappropriate licensed problem arises with services; and (5) any resident-spedocumentation of the treatment or therapy was administration of the treatment or therapy be current and updated to the current	eceiving management of ed treatments or therapy ed living facility must prepare ervice plan a written atment or therapy services I to the resident. The facility and maintain a current nent and therapy d for each resident which must following: ne type of services that will be of specific resident instructions				

Minnesota Department of Health

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING:		` '	(X3) DATE SURVEY COMPLETED		
		29624	B. WING			C 13/2023
	PROVIDER OR SUPPLIER	IVING LOGAN HO 5443 LOG	DDRESS, CITY, STAN AVENUE YN CENTER,	NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
01940	violation that did not safety but had the president's health or cause serious injury was issued at an is limited number of realimited number of realimited number of situation has occurred. The findings included During the entrance a.m., registered numbersonnel (ULP) per dressing changes for R1's medical record to the licensee's fact diagnoses included R1's skin assessment indicated R1 had a pain, but it did not it lacked a description heel wound. R1's progress note 3:54 p.m., indicated care for R1's heel progressing changes in the pressure ulcer. Licentally dressing changauze, absorbable in the pressure ulcer.	ed in a level two violation (a tharm a resident's health or potential to have harmed a safety, but was not likely to y, impairment, or death), and olated scope (when one or a esidents are affected or one or staff are involved or the red only occasionally). e: e on June 13, 2023, at 9:50 rse (RN)-C stated unlicensed erformed wound care and or R1. d was reviewed. R1 admitted cility on January 25, 2022. R1's type 2 diabetes mellitus. ent dated September 6, 2022, right heel wound with acute ndicate her pain level and an and measurements of her dated September 13, 2022, at dulp-E, performed wound				

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	COMP	SURVEY
		29624	B. WING		06/1	3/2023
	PROVIDER OR SUPPLIER	IVING LOGAN HC 5443 LOG	DRESS, CITY, S AN AVENUE 'N CENTER,		•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
01940	unstageable pressumonitor R1's wound infection. R1's record lacked to include the follow - a statement of the provided - documentation of relating to the treatment in identification of the would be delegated - procedures for not a problem arose with services - any resident-specification that all the administered as presente treatment or therapic complications or ad On June 28, 2023, used R1's after visition of the complications or ad On June 28, 2023, used R1's after visition of the complications or ad On June 28, 2023, used R1's after visition of the complications or ad On June 28, 2023, used R1's after visition of the complications or ad On June 28, 2023, used R1's after visition of the complications or ad On June 28, 2023, used R1's after visition of the complications or ad On June 28, 2023, used R1's after visition of the complications or ad On June 28, 2023, used R1's after visition of the complications or ad On June 28, 2023, used R1's after visition of the complex of the RN or licensed and individualized the RN or licensed and individ	ulcer was classified as an are ulcer. Facility staff were to d for acute changes or signs of a treatment management planwing required content: type of service that would be specific resident instructions ments or therapy tasks that to unlicensed personnel tifying a registered nurse when the treatments or therapy ific requirements relating to reatment and therapy received, reatment and therapy was escribed, and monitoring of y to prevent possible				
	services which add be provided; (b) pro treatments or thera monitoring treatmen	ed treatments or therapy ressed: (a) types of services to cedures for documenting pies; (c) procedures for therapies to prevent ons or adverse reactions; (d)				

Minnocata Donartment of Health

	ta Department of He					-
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
VIND LEVIN	OI CONNECTION	IDENTIFICATION NUMBER.	A. BUILDING:			
						;
		29624	B. WING		06/1	3/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
	T OADE ACCIOTED I	5443 LO	GAN AVENUE	NORTH		
ULIIMAI	E CARE ASSISTED L	BROOKL	YN CENTER,	MN 55430		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PRÉFIX	•	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO		COMPLETE DATE
TAG	REGULATORT OR L	SC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	PRIATE	DATE
04040	O a sa Ciana and E a a a a a	OF	04040			
01940	identification of treatment or therapy tasks delegated to ULP; (e) procedures for notifying the RN or licensed health professional when a		01940			
	-	ted to the treatment or therapy member who administered a				
		y was responsible for				
	documenting it in th	•				
	TIME PERIOD FOR	R CORRECTION: Seven (7)				
	days					
01960			01960			
55-G	administration of tre	eatments				
	Fach treatment or t	herapy administered by an				
		ty must be in the resident				
	•	entation must include the				
	signature and title o					
	administered the tre	eatment or therapy and must				
		d time of administration. Wher				
	-	ies are not administered as				
	-	ed, the provider must				
		on why it was not administered				
	to meet the residen	rocedures that were provided				
		t 5 1100d5.				
	This MN Requireme	ent is not met as evidenced				
	by:					
		and record review, the				
		nsure foot (podiatrist) orders				
	•	for one of one of one resident				
	` '	viewed. R1's podiatrist ordered or R1's right heel pressure				
		failed to implement daily				

Minnesota Department of Health

wound care. R1's pressure ulcer became infected

staff documented the reason R1's treatments and

and she developed maggots in her pressure

therapies were not administered.

ulcer. In addition, the licensee failed to ensure

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		29624		B. WING			C 13/2023
	PROVIDER OR SUPPLIER	IVING LOGAN HO	443 LOG	ORESS, CITY, S AN AVENUE 'N CENTER,			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
01960	O Continued From page 26		01960				
	violation that harmed not including serious or a violation that has serious injury, impaissued at an isolate limited number of realimited number of situation has occurred. The findings included R1's medical record to the licensee's factorial diagnoses included.	ed in a level three violated a resident's health or sinjury, impairment, or as the potential to lead irment, or death), and violated one or a staff are involved or thred only occasionally). E: I was reviewed. R1 adresility on January 25, 202 type 2 diabetes mellituent dated September 6.	r safety, r death, to was a r one or le 22. R1's is.				
	indicated R1 had a pain, but it did not in	right heel wound with a ndicate her pain level a nand measurements of	acute nd				
	September 14, 2022 ordered daily wound daily dressing changauze, absorbable off-loading shoe to	progress note dated 2, indicated R1's podiar discare for R1's right here nsee staff were to perfect ges using betadine, 4 x gauze (Kling), and use relieve pressure off here ulcer was classified as the ulcer.	el form k 4 of an r right				
	October 2022 and Note there was a task ca "bedbath/shower/dr	essing/changing" for tw no description of what	ted vice				

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY
		29624	B. WING		06/1	3/ 2023
	PROVIDER OR SUPPLIER	IVING LOGAN HC 5443 LOC	DRESS, CITY, S AN AVENUE YN CENTER,			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
01960	wound care orders performed. R1's progress notes September 15, 202 RN-C completed R one-time on September documented wound assessment of the wound status such drainage, signs or swound measureme R1's record failed to dressing changes of was hospitalized. R1's progress note 1:56 p.m., indicated swollen leg and corneeded) pain medic provided a bed bath information regardinher to the hospital documented R1 was in her heels. R1's hospital record 5:09 p.m., indicated hospital with severe R1 reported her right before with purulen her heel pain intensileg the day before staff found R1's wo with maggots. Her was administered santibiotics and pain	transcription of R1's daily and documenation it was sindicated between 2, and October 12, 2022, 1's heel dressing change of the wound failed to include the as type of tissue present, any symptoms of infection and	01960			

Minnesota Department of Health

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				
			B WING			C
		29624	B. WING		06/	13/2023
	PROVIDER OR SUPPLIER	IVING LOGAN HO	DRESS, CITY, S AN AVENUE YN CENTER,			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
01960	Continued From pa		01960			
	R1 received wound agreed to comply a	hospital RN, RN-C indicated care every other day, but nd have facility staff perform see the resident returned to				
	was aware R1 refusive weeks on end, statisto her getting magg RN-C stated she did for R1's refusals or provider since it was stated she did not the since her maggots.	at 9:00 a.m., RN-C stated she sed showers sometimes for ng that was what contributed ots in her right heel wound. In do not implement interventions notify R1's podiatrist or s R1's right to refuse. RN-C hink to check R1's feet but staff are checking her feet and sfusals on a regular basis.				
	personnel (ULP)-E wound care for R1, wound care. ULP-E me any directions of	stated she did not provide stating RN-C performed R1's stated, "RN-C did not give n anything I should do for the ted R1 was stubborn with her metimes refuse.				
	Management, dated the RN or licensed and individualized to management plan fordered or prescribe services which add be provided; (b) protreatments or there monitoring treatment possible complication identification of treatments delegated to ULP; (RN or licensed hear	titled Treatment and Therapy d February 17, 2022, indicated professional would prepare reatment or therapy for each resident who received ed treatments or therapy ressed: (a) types of services to occdure for documenting pies; (c) procedures for nts or therapies to prevent ons or adverse reactions; (d) atment or therapy tasks (e) procedures for notifying the lith professional when a ted to the treatment or therapy				

Minnesota Department of Health

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	E CONSTRUCTION	(X3) DATE : COMPL	
					С	,
		29624	B. WING	_	06/1	3/2023
	PROVIDER OR SUPPLIER E CARE ASSISTED L	IVING LOGAN HO 5443 LOG	DRESS, CITY, S AN AVENUE 'N CENTER,			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
01960	Continued From pa	ge 29	01960			
		member who administered a y was responsible for e clinical record.				
	TIME PERIOD TO	CORRECT: Seven (7) days.				
02360	144G.91 Subd. 8 Fi	reedom from maltreatment	02360			
	sexual, and emotion exploitation; and all	right to be free from physical, nal abuse; neglect; financial forms of maltreatment /ulnerable Adults Act.				
	by: The facility failed to	ent is not met as evidenced ensure one of one resident(s) free from maltreatment.		No plan of correction is required for tag.	or this	
	Findings include:					
	issued a determinate and the facility and responsible for the with incidents which	partment of Health (MDH) tion maltreatment occurred, an individual person were maltreatment, in connection occurred at the facility. public maltreatment report for				
03000 SS=D	626.557 Subd. 3 Tir	ming of report	03000			
	believe that a vulne been maltreated, or vulnerable adult has which is not reason immediately report common entry point vulnerable adult sol	orter who has reason to rable adult is being or has who has knowledge that a sustained a physical injury ably explained shall the information to the t. If an individual is a ely because the individual is y, a mandated reporter is not				

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE : COMPI	SURVEY LETED
		20624	B. WING		06/4	
		29624	D. WIIVO		06/1	3/2023
	PROVIDER OR SUPPLIER TE CARE ASSISTED L	IVING LOGAN HC 5443 LOG	SAN AVENUE			
	<u></u>	BROOKL	YN CENTER,	MIN 55430		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
03000	Continued From pa	ge 30	03000			
	required to report so individual that occur unless: (1) the individual was another facility and believe the vulneral previous facility; or (2) the reporter know that the individual is in section 626.5572 (a), clause (4). (b) A person not reconscious of this section 626.5572 (a), clause (4). (b) A person not reconscious of this section of the conscious of this section of the conscious of this section of the conscious of the conscious of this section of the conscious of this section of the conscious	uspected maltreatment of the red prior to admission, as admitted to the facility from the reporter has reason to ole adult was maltreated in the ws or has reason to believe a vulnerable adult as defined a vulnerable adult as defined a subdivision 21, paragraph quired to report under the ection may voluntarily report as ection requires a report of a maltreatment, if the reporter on to know that a report has common entry point. Ection shall preclude a eporting to a law enforcement orter who knows or has that an error under section on 17, paragraph (c), clause make a report under this eporter or a facility, at any time estigation by a lead y will determine or should reported error was not neglect teria under section 626.5572, agraph (c), clause (5), the may provide to the common ly to the lead investigative explaining how the event of the common of the lead investigative explaining how the event of the common of the lead investigative explaining how the event of the common of the lead investigative explaining how the event of the common of the lead investigative explaining how the event of the common of the lead investigative explaining how the event of the common of the lead investigative explaining how the event of the common of the lead investigative explaining how the event of the common of the lead investigative explaining how the event of the common of the lead investigative explaining how the event of the common of the lead investigative explaining how the event of the common of the lead investigative explaining how the event of the common				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	` '	(X3) DATE SURVEY COMPLETED		
		29624	B. WING			C 13/2023
	PROVIDER OR SUPPLIER	IVING LOGAN HO	DRESS, CITY, STAN AVENUE	NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
03000	Continued From pa	ge 31	03000			
	by: Based on interview licensee failed to re to the Minnesota Ad (MAARC) for one or records reviewed. For ordered daily wound wound yet R1's records reviewed only interviewed only interviewed became inference to the maggots. R1 spent	ent is not met as evidenced and record review, the eport suspected maltreatment dult Abuse Reporting Center f one residents (R1) with R1's foot (podiatrist) doctor d care for R1's right heel ord indicated licensee staff ermittent wound care. R1's ected. R1 was admitted to the e right heel pain where hospital 's wound was filled with a few days in the hospital and us (IV) antibiotics and r wound.				
	violation that did not safety but had the president's health or cause serious injury was issued at an is limited number of a limited number of	ed in a level two violation (a tharm a resident's health or cotential to have harmed a safety, but was not likely to y, impairment, or death), and clated scope (when one or a esidents are affected or one or staff are involved or the red only occasionally).				
	The findings include	e:				
	to the licensee's fac	d was reviewed. R1 admitted cility on January 25, 2022. R1's type 2 diabetes mellitus.				
	R1 was to receive a baths, showers three meals, transfers, retwice daily range-of	d January 25, 2022, indicated assistance with daily bed ee times per week, diabetic positioning every two hours, f-motion exercises, and and medication management.				

Minnesota Department of Health

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMF	SURVEY
		29624	B. WING			C I 3/2023
	PROVIDER OR SUPPLIER	IVING LOGAN HO	DRESS, CITY, S AN AVENUE YN CENTER,		•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPROPRIES (EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPROPRIES (EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPROPRIES (EACH CORRECTIVE ACTION CORRECTIVE ACTION CORRECTION	ULD BE	(X5) COMPLETE DATE
03000	mechanical lift for the wheelchair for mobitimes per month and to seeing a foot document applicable." The by registered nurse May 25, 2022, July 2022, and Novembor R1's assessment doindicated R1 was to cares, transfers, more ransfers, more ransfe	mechanical lift or total body ransfers and an electric lity. R1 required foot care two d as needed (prn), in addition ctor (podiatrist) annually. The dressing change indicated e service plan was reviewed (RN)-C's on March 25, 2022, 25, 2022, September 25, er 25, 2022. ated September 6, 2022, otally dependent with personal obility, and self-preservation. ent dated September 6, 2022, right heel wound with acute and mand measurements of her clinic note dated September m., indicated R1's dressings kly by licensee staff. R1's left to receive daily wound care facility. Facility staff were to did for acute changes or signs of dated September 20, 2022, at essing was changed. RN-C did a special boot on her right indicated between 2, and October 12, 2022, rmed one day of wound care				

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING LOGAN H SUMMARY STATEMENT OF DEFICIENCISS TAG CONTINUED FOR THE RECOULTORY OR ISC. DENTIFYING INFORMATION) CONTINUED FOR THE RECOULTORY OR ISC. DENTIFYING INFORMATION) COntinued From page 33 1.56 p.m. indicated R1 woke up with her left leg swollen. ULP.E administered as needed (prn) pain medication. Hours later R1 was admitted to the hospital due to pain in her heels. R1's hospital record dated October 12, 2022, at 5:09 p.m., indicated R1 was admitted to the hospital with severe pain in her right heel wound. R1 reported her right heel wound. R1 reported her right heel wound R1 reported her right heel wound was debrided, and she was administered storing intravenous (IV) artibiotics and pain medication. R1 indicated her heel pain intensified and traveled up her right leg who as was administered storing intravenous (IV) artibiotics and pain medication. R1 indicated R1 was admitted to the round note a week. During a phone call with a hospital RN, RN-C indicated R1 received wound care every other day, but agreed agreed to comply and have facility staff perform daily wound care once the resident returned to the facility. On October 14, 2022, at 3:00 p.m., R1 was discharged back to the facility. R1's podiatry clinic note dated October 19, 2022, at 1:55 p.m., R1 indicated ilcensee staff were not performing regular dressing changes on her right heel wound dere once the resident returned to the facility. Cn July 11, 2023, at 2:15 p.m., RN-C stated neither she or the facility filed a MAARC report, stating she was planning on taking care of R1's wound after her discharge from the hospital RN-C stated the time period to file a MAARC report, stating she was planning on taking care of R1's wound after her discharge from the hospital RN-C stated the time period to file a MAARC report, stating she was planning on taking care of R1's wound after her discharge from the hospital report was within 48 hours.		NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	` ,	E SURVEY PLETED
ULTIMATE CARE ASSISTED LIVING LOGAN H CARE CAR			29624	B. WING			
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO HE APPROPRIATE DATE DEFICIENCY) 03000 Continued From page 33 1.56 p.m. indicated R1 woke up with her left leg swollen. ULP-E administered as needed (pm) pain medication. Hours later R1 was admitted to the hospital with severe pain in her right heel wound R1 reported her right heel wound burst open days before with purulent (pus) drainage R1 indicated her heel pain intensified and traveled up her right leg the day before she was hospitalized. Hospital staff found R1's wound was infected and filled with maggots. Her wound was debrided, and she was administered storng intravenous (IV) antibiotics and pain medication. R1 indicated RN-C assessed her wound once a week. During a phone call with a hospital RN, RN-C indicated R1 received wound care every other day, but agreed agreed to comply and have facility staff perform daily wound care once the resident returned to the facility. On October 14, 2022, at 3:00 p.m., R1 was discharged back to the facility. R1's podiatry clinic note dated October 19, 2022, at 1:53 p.m., R1 indicated licensee staff were not performing regular dressing changes on her right heel wound before she was hospitalized. On July 11, 2023, at 2:15 p.m., RN-C stated neither she or the facility liled a MAARC report, stating she was planning on taking care of R1's wound after her discharge from the hospital. RN-C stated the time period to file a MAARC report was within 48 hours.			IVING LOGAN HO 5443 LOG	SAN AVENUE	NORTH		
1:56 p.m. indicated R1 woke up with her left leg swollen. ULP-E administered as needed (pm) pain medication. Hours later R1 was admitted to the hospital due to pain in her heels. R1's hospital record dated October 12, 2022, at 5:09 p.m., indicated R1 was admitted to the hospital with severe pain in her right heel wound. R1 reported her right heel wound burst open days before with purulent (pus) drainage. R1 indicated her heel pain intensified and traveled up her right leg the day before she was hospitalized. Hospital staff found R1's wound was infected and filled with maggots. Her wound was debrided, and she was administered strong intravenous (IV) antibiotics and pain medication. R1 indicated RN-C assessed her wound once a week. During a phone call with a hospital RN, RN-C indicated R1 received wound care every other day, but agreed agreed to comply and have facility staff perform daily wound care once the resident returned to the facility. On October 14, 2022, at 3:00 p.m., R1 was discharged back to the facility. R1's podiatry clinic note dated October 19, 2022, at 1:53 p.m., R1 indicated licensee staff were not performing regular dressing changes on her right heel wound before she was hospitalized. On July 11, 2023, at 2:15 p.m., RN-C stated neither she or the facility filed a MAARC report, stating she was planning on taking care of R1's wound after her discharge from the hospital. RN-C stated the time period to file a MAARC report, stating she was planning on taking care of R1's wound after her discharge from the hospital.	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI	ON SHOULD BE HE APPROPRIATE	COMPLETE
The licensee policy titled Vulnerable Adult, dated February 17, 2022, indicated licensee employees	03000	1:56 p.m. indicated swollen. ULP-E adripain medication. Hother hospital due to R1's hospital record 5:09 p.m., indicated hospital with severe R1 reported her right before with purulenther heel pain intensing the day before staff found R1's wo with maggots. Her was administered stantibiotics and pain RN-C assessed her a phone call with a R1 received wound agreed agreed to coperform daily wound returned to the facil. On October 14, 202 discharged back to R1's podiatry clinic at 1:53 p.m., R1 indicated to the facil. On October 14, 202 discharged back to R1's podiatry clinic at 1:53 p.m., R1 indicated wound before. On July 11, 2023, and neither she or the fact the stating she was play wound after her discharged back to R1's podiatry clinic at 1:53 p.m., R1 indicated wound before. On July 11, 2023, and the she was play wound after her discharged back to R1's podiatry clinic at 1:53 p.m., R1 indicated wound before. On July 11, 2023, and the she was play wound after her discharged back to R1's podiatry clinic at 1:53 p.m., R1 indicated back to R1's podiatry clinic at 1:53 p.m., R1 indicated back to R1's podiatry clinic at 1:53 p.m., R1 indicated back to R1's podiatry clinic at 1:53 p.m., R1 indicated back to R1's podiatry clinic at 1:53 p.m., R1 indicated back to R1's podiatry clinic at 1:53 p.m., R1 indicated back to R1's podiatry clinic at 1:53 p.m., R1 indicated back to R1's podiatry clinic at 1:53 p.m., R1 indicated back to R1's podiatry clinic at 1:53 p.m., R1 indicated back to R1's podiatry clinic at 1:53 p.m., R1 indicated back to R1's podiatry clinic at 1:53 p.m., R1 indicated back to R1's podiatry clinic at 1:53 p.m., R1 indicated back to R1's podiatry clinic at 1:53 p.m., R1 indicated back to R1's podiatry clinic at 1:53 p.m., R1 indicated back to R1's podiatry clinic at 1:53 p.m., R1 indicated back to R1's podiatry clinic at 1:53 p.m., R1 indicated back to R1's podiatry clinic at 1:53 p.m., R1 indicated back to R1's podiatry clinic at 1:53 p.m., R1 indicated back to R1's podiatry clinic at 1:53 p.m., R1 ind	R1 woke up with her left leg ninistered as needed (prn) ours later R1 was admitted to pain in her heels. I dated October 12, 2022, at I R1 was admitted to the e pain in her right heel wound. In theel wound burst open days to (pus) drainage. R1 indicated sified and traveled up her right she was hospitalized. Hospital und was infected and filled wound was debrided, and she trong intravenous (IV) medication. R1 indicated round once a week. During hospital RN, RN-C indicated care every other day, but omply and have facility staffed care once the resident ity. Inote dated October 19, 2022, licated licensee staff were not dressing changes on her right she was hospitalized. It 2:15 p.m., RN-C stated acility filed a MAARC report, nning on taking care of R1's charge from the hospital. The period to file a MAARC shours. It titled Vulnerable Adult, dated titled Vulnerable Adult, dated				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE SUR				
		29624	B. WING		06/1	; 3/2023
	PROVIDER OR SUPPLIER	IVING LOGAN HO 5443 LOG	DRESS, CITY, S AN AVENUE IN CENTER,			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
03000	determine vulnerable develop a specific pabuse to that reside who provide assiste to report abuse and suspected abuse or adult according to the suspected abuse or adult according to the suspected abuse or adult according to the lateral provide necessary health care, or supersupersupersupersupersupersupersuper	ge 34 dividually assess residents to ility to abuse or neglect and plan to minimize the risk of ent. In addition, all employees ed living care were mandated l/or neglect (including reglect) of the vulnerable his policy. Section 1(c) Neglect kelihood of absence or failure ry food, clothing, shelter, ervision for a vulnerable adult. CORRECT: Seven (7) days	03000			