Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL296246826M
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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29624	A. BUILDING: _____ B. WING _____	C 06/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ULTIMATE CARE ASSISTED LIVING LOGAN HC	5443 LOGAN AVENUE NORTH BROOKLYN CENTER, MN 55430

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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: #HL296242903C/#HL296246826M On June 13, 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 two residents receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL296242903C/#HL296246826M, tag identification 620, 630, 1390, 1500, 1530, 1620, 1640, 1940, 1960, 2360, 3000.	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.	
0 620 SS=D	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma	0 620		

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0 620	Continued From page 1 (a) The assisted living facility must comply with 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 that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to report suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC) for one of one residents (R1) with records reviewed. R1's foot (podiatrist) doctor ordered daily wound care for R1's right heel wound yet R1's record indicated licensee staff performed only intermittent wound care. R1's wound became infected. R1 was admitted to the hospital with severe right heel pain where hospital staff discovered R1's wound was filled with maggots. R1 spent a few days in the hospital and received intravenous (IV) antibiotics and debridement for her wound. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's medical record was reviewed. R1 admitted to the licensee's facility on January 25, 2022. R1's diagnoses included type 2 diabetes mellitus.	0 620		

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0 620	Continued From page 2 R1's care plan dated January 25, 2022, indicated R1 was to receive assistance with daily bed baths, showers three times per week, diabetic meals, transfers, repositioning every two hours, twice daily range-of-motion exercises, and toileting/peri-care, and medication management. R1 used a standing mechanical lift or total body mechanical lift for transfers and an electric wheelchair for mobility. R1 required foot care two times per month and as needed (prn), in addition to seeing a foot doctor (podiatrist) annually. The area for non-sterile dressing change indicated "not applicable." The service plan was reviewed by registered nurse (RN)-C's on March 25, 2022, May 25, 2022, July 25, 2022, September 25, 2022, and November 25, 2022. R1's assessment dated September 6, 2022, indicated R1 was totally dependent with personal cares, transfers, mobility, and self-preservation. R1's skin assessment dated September 6, 2022, indicated R1 had a right heel wound with acute pain, but it did not indicate her pain level and lacked a description and measurements of her heel wound. R1's podiatry (foot) clinic note dated September 14, 2022, at 1:45 p.m., indicated R1's dressings were changed weekly by licensee staff. R1's podiatrist ordered R1 to receive daily wound care from the licensee's facility. Facility staff were to monitor R1's wound for acute changes or signs of infection. R1's progress note dated September 20, 2022, at 10:29 a.m., R1's dressing was changed. RN-C documented R1 had a special boot on her right foot.	0 620		

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0 620	Continued From page 3 R1's progress notes indicated between September 15, 2022, and October 12, 2022, licensee staff performed one day of wound care for R1's right heel pressure ulcer. R1's progress noted dated October 12, 2022, at 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 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	0 620		

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0 620	Continued From page 4 wound after her discharge from the hospital. RN-C stated the time period to file a MAARC report was within 48 hours. The licensee policy titled Vulnerable Adult, dated February 17, 2022, indicated licensee employees were required to individually assess residents to determine vulnerability to abuse or neglect and develop a specific plan to minimize the risk of abuse to that resident. In addition, all employees who provide assisted living care were mandated to report abuse and/or neglect (including suspected abuse or neglect) of the vulnerable adult according to this policy. Section 1(c) Neglect (2): The absence, likelihood of absence or failure to provide necessary food, clothing, shelter, health care, or supervision for a vulnerable adult. TIME PERIOD TO CORRECT: Seven (7) days	0 620		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the	0 630		

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0 630	Continued From page 5 licensee failed to ensure an individual abuse prevention plan (IAPP) was developed based on assessment of vulnerablities and identify risk to be abused by others with interventions to prevent abuse for one of one resident (R1) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1's medical record was reviewed. R1 admitted to the licensee's facility on January 25, 2022. R1's diagnoses included type 2 diabetes mellitus. R1's service plan dated March 25, 2022, indicated R1 was to receive assistance with daily bed baths, showers three times per week, diabetic meals, foot care, transfers, repositioning every two hours, twice daily range-of-motion exercises, and toileting/peri-care. R1 used a standing mechanical lift or total body mechanical lift for transfers and an electric wheelchair for 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 orientation to person, place, time, ability to give	0 630		

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0 630	Continued From page 6 accurate information, anxiety and depression, interest in environment/activities, range-of-motion, endurance, pain, walking, senses, and behaviors. R1 was not verbally or physically abusive, did not exhibit threatening behaviors, and was not sexually inappropriate. R1's vulnerability assessment lacked documentation an individualized review or assessment was developed that assessed R1's susceptibility to abuse by another individual, including other vulnerable adults, and statement of specific measures to be taken to minimize the risk of abuse to R1 and other vulnerable adults. R1's vulnerability assessment lacked specific interventions for her listed vulnerabilities. On June 28, 2023, at 9:00 a.m., registered nurse (RN)-C stated she developed and revised resident IAPP's. The licensee policy titled Vulnerable Adult, dated February 17, 2022, indicated licensee employees were required to individually assess residents to determine vulnerability to abuse or neglect and develop a specific plan to minimize the risk of abuse to that resident. TIME PERIOD TO CORRECT: Seven (7) days	0 630		
01390 SS=F	144G.62 Subdivision 1 Availability of contact person to staff (a) Assisted living facilities must have a registered nurse available for consultation by staff performing delegated nursing tasks and must have an appropriate licensed health professional available if performing other delegated services such as therapies.	01390		

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01390	Continued From page 7 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a registered nurse (RN) available 24 hours per day seven days per week (24/7) for consultation by staff performing delegated nursing tasks. This had the potential to affect all residents and unlicensed staff. 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), 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). The findings include: During the entrance conference on June 14, 2023, at 9:50 a.m., RN-C stated she worked Monday through Friday, from 9:00 a.m. until 5:00 p.m., as well as after hours and weekends. RN-C stated she was available 24/7 but stated her availability was a "gray area." RN-C stated staff would send her a text message if they needed to reach her during after hours or weekends and she would respond the following business day if it was not urgent. Owner (OW)-D stated RN-C was the only nurse and RN for the licensee's several facilities. On June 28, 23023, at 9:00 a.m., RN-C stated she was surprised when owner (OW)-D stated she was the only nurse and RN for the licensee's several facilities during the entrance conference with Minnesota Department of Health (MDH) investigators on June 13, 2023. RN-C	01390		

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01390	Continued From page 8 contradicted herself when she told investigators she was available by phone 24/7 if staff had issues, but worked 9:00-5:00 p.m. Monday through Friday. RN-C stated hospitals could not discharge residents back to the licensee "after hours" and weekends due to no nurse available and staffing. RN-C stated, if hospitals ask to take a resident back on weekends, she says no. The licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA), undated, page 2, indicated the licensee's licensed staff were either in the building, an attached building, or within the campus and available to respond to resident requests 24/7. Page 16 indicated the licensee had one full-time RN on site. TIME PERIOD TO CORRECT: Seven (7) days.	01390		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal	01500		

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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
01500	Continued From page 9 of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.	01500		

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	29624	A. BUILDING: _____ B. WING _____	C 06/13/2023

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01500	Continued From page 10 This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to ensure a direct care staff member completed at least eight hours of annual training on required topics for each 12 months of employment for one of three employees, registered nurse (RN)-C with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: RN-C was hired by the licensee on February 23, 2021. RN-C's training record lacked eight hours of annual training for each 12 months of employment on the following topics: - training on reporting of maltreatment of vulnerable adults under section 626.557; review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor	01500		

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01500	Continued From page 11 blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; - effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; - review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On July 20, 2023, at 10:07 a.m., the Minnesota Department of Health (MDH) investigator sent an email to owner (OW)-D, requesting RN-C's employee file, including her training record. On July 20, 2023, at 11:32 a.m., a licensee supervisor, unlicensed personnel (ULP)-G stated OW-D was out of the office for one week. ULP-G stated she was in charge while OW-D was gone. ULP-G stated she did not have access to employee files but would try to obtain them. On July 26, 2023, at 10:47 a.m., the MDH investigator received an email from OW-D. The 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. On July 26, 2023, at 4:40 p.m., OW-D stated he was still learning the assisted living statutes since the licensee switched from a comprehensive	01500		

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01500	Continued From page 12 home care license to assisted living licensure in August 1. 2021. Time Period to Correct: Twenty-One (21) Days	01500		
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide evidence that one of	01530		

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01530	Continued From page 13 three employees, registered nurse (RN)-C, completed two hours of dementia care training on required topics for each 12 months of employment with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: RN-C hired by the licensee on February 23, 2021. RN-C's training transcript dated February 25, 2021, indicated RN-C completed the initial 8 hours of dementia care. RN-C's record lacked documentation she completed two hours of training on topics related to dementia for each 12 months of employment. On July 20, 2023, at 10:07 a.m., the Minnesota Department of Health (MDH) investigator sent an email to owner (OW)-D, requesting RN-C's employee file, including her training record. On July 20, 2023, at 11:32 a.m., a licensee supervisor, unlicensed personnel (ULP)-G stated OW-D was out of the office for one week. ULP-G stated she was in charge while OW-D was gone. ULP-G stated she did not have access to employee files but would try to obtain them. On July 26, 2023, at 10:47 a.m., the MDH	01530		

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01530	Continued From page 14 investigator received an email from OW-D. The 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	01530		
01620 SS=G	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (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.	01620		

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01620	Continued From page 15 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure registered nurse (RN)-C performed routine wound care assessments for one of one resident (R1) with record reviewed. R1 was hospitalized with an infected right heel wound and maggots in her wound. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings Include: R1's medical record was reviewed. R1 admitted to the licensee's facility on January 25, 2022. R1's diagnoses included type 2 diabetes mellitus. R1's service plan dated March 25, 2022, indicated R1 was to receive assistance with daily bed baths, showers three times per week, diabetic meals, transfers, repositioning every two hours, twice daily range-of-motion exercises, and toileting/peri-care, and medication management. R1 used an EZ stand or Hoyer lift for transfers and an electric wheelchair for mobility. Facility goals were to ensure R1 was safe, clean, and free from any abuse or neglect while receiving cares from licensee's staff. R1's skin assessment dated September 6, 2022, indicated R1 had a right heel wound with acute pain, but it did not indicate her pain level and	01620		

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01620	Continued From page 16 lacked a description and measurements of her heel wound. R1's progress note dated September 6, 2022, at 11:09 a.m., documented by RN-C, indicated R1's right heel wound was cleaned and redressed. RN-C indicated R1's wound was "healing slowly." R1's progress note dated September 13, 2022, at 7:29 p.m., documented by RN-C, indicated R1's dressing was changed by the ULP. RN-C documented, "assessed, looks good." RN-C failed to measure and clinically described the wound status (signs of infection, type of drainage, type of tissue exposed). R1's podiatry (foot) clinic note dated September 14, 2022, at 1:45 p.m., indicated R1's dressings were changed weekly by licensee staff. R1's podiatrist ordered R1 to receive daily wound care from the licensee's facility. Facility staff were to monitor R1's wound for acute changes or signs of infection. R1's heel wound was documented as an unstageable pressure injury of the right heel. R1's progress note dated September 20, 2022, at 10:29 a.m., R1's dressing was changed. RN-C documented R1 had a special boot on her right foot. RN-C failed to document R1's wound status and measurements. R1's record lacked documentation RN-C assessed R1's wound between September 20, 2022 and October 12, 2022. R1's progress noted dated October 12, 2022, at 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.	01620		

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01620	Continued From page 17 R1's record lacked documentation R1 received daily wound care as ordered by her podiatrist. R1's hospital record dated October 12, 2022, at 5:09 p.m., indicated R1 was admitted to the hospital emergency department (ED) 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 leg the day before she was hospitalized. ED hospital staff found R1's wound was infected with a large number of maggots. Her wound was debrided, and she was administered 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 to have licensee staff perform daily wound care after R1's discharge. On October 14, 2022, at 3:00 p.m., R1 was discharged back to the facility. R1's record lacked documentation RN-C assessed R1's right heel wound after she was discharged back to the licensee's facility. On June 28, 2023, at 9:00 a.m., RN-C stated she assessed R1's wound once a week. RN-C stated she did reassess R1's right heel wound after she was discharged but could not explain why it was not documented. On July 24, 2023, at 1:30 p.m. RN-C stated she ws the only nurse for 12 residents who resided in the licensee's four facilities. The licensee policy titled Comprehensive Nursing	01620		

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01620	Continued From page 18 Assessments, dated February 17, 2022, indicated the licensee's RN assess a resident and from that assessment delegate appropriate tasks to unlicensed personnel (ULP). TIME PERIOD TO CORRECT: Seven (7) days.	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a resident's service plan included all the services to be provided as indicated in their record for one of one resident	01640		

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01640	Continued From page 19 (R1) with record reviewed. In addition, the licensee failed to revise R1's service plan to when R1's foot (podiatrist) doctor ordered daily wound care for a chronic pressure ulcer on her right heel. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1's medical record was reviewed. R1 admitted to the licensee's facility on January 25, 2022. R1's diagnoses included type 2 diabetes mellitus. R1's record indicated she had a right heel wound. R1's care plan/service plan dated January 25, 2022, indicated R1 was to receive assistance with daily bed baths, showers three times per week, diabetic meals, transfers, repositioning every two hours, twice daily range-of-motion exercises, and toileting/peri-care, and medication management. R1 used a standing mechanical lift or total body mechanical lift for transfers and an electric wheelchair for mobility. R1 required foot care two times per month and as needed (prn), in addition to seeing a foot doctor (podiatrist) annually. The area for non-sterile dressing change indicated "not applicable." The service plan was reviewed by registered nurse (RN)-C's on March 25, 2022, May 25, 2022, July 25, 2022, September 25, 2022, and November 25, 2022.	01640		

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01640	Continued From page 20 R1's foot (podiatrist) progress note dated September 14, 2022, indicated R1's podiatrist ordered daily wound care for R1's right heel pressure ulcer. Licensee unlicensed personnel (ULP) were to perform daily dressing changes using betadine, 4 x 4 gauze, absorbable gauze (Kling), and use of an off-loading shoe to relieve pressure off her right heel. R1's pressure ulcer was classified as an unstageable pressure ulcer. R1's service plan lacked documentation it was updated to include daily dressing changes to to her right heel and off-loading shoe. R1's service delivery record dated September 2022, indicated R1 did not receive daily bed baths five times out of the month nor three times per week showers four times out of the month. R1's September service delivery record lacked documentation daily wound care was provided to R1. R1's service delivery record dated October 2022, indicated R1 did not receive daily bed baths seven times out of the month. R1's October 2022 service delivery record lacked documentation staff performed daily wound care for her pressure ulcer. R1's progress note dated October 12, 2022, indicated R1 was hospitalized. On October 14, 2022, indicated R1 was discharged back to the licensee at 5:00 p.m. R1's October 2022 service delivery record indicated ULP falsely documented they performed services for R1 during her 48 hour hospital stay.	01640		

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01640	Continued From page 21 R1's record lacked documentation R1 refused her scheduled services. On June 28, 2023, at 9:00 a.m., RN-C stated she revised resident service plans on a quarterly basis and as needed. RN-C stated she printed out resident service plans and put the plans in resident binders for staff to follow. ULP signed off they read and understood the care plans. RN-C stated she was aware R1 refused showers sometimes for weeks on end, stating that was what contributed to her getting maggots in her right heel wound. RN-C stated she did not implement interventions for R1's refusals or notify R1's podiatrist or provider since it was R1's right to refuse. RN-C stated she did not think to check R1's feet but since her maggots staff are checking her feet and documenting her refusals on a regular basis. On July 14, 2023, at 9:00 a.m., unlicensed personnel (ULP)-E stated R1 was stubborn with her cares and would sometimes refuse. The licensee policy titled Service Plan, dated February 17, 2022, indicated service plans were implemented for all residents. The licensee would provide all services required by the current service plan. Service plans were developed for the resident based on the agreement with the resident/responsible party and on the assessed needs identified in the comprehensive assessment. Service plans must be revised, if needed, based on resident review or reassessment. TIME PERIOD TO CORRECT; Seven (7) days.	01640		

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01940	Continued From page 22	01940		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of one resident (R1)	01940		

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01940	Continued From page 23 with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance on June 13, 2023, at 9:50 a.m., registered nurse (RN)-C stated unlicensed personnel (ULP) performed wound care and dressing changes for R1. R1's medical record was reviewed. R1 admitted to the licensee's facility on January 25, 2022. R1's diagnoses included type 2 diabetes mellitus. R1's skin assessment dated September 6, 2022, indicated R1 had a right heel wound with acute pain, but it did not indicate her pain level and lacked a description and measurements of her heel wound. R1's progress note dated September 13, 2022, at 3:54 p.m., indicated ULP-E, performed wound care for R1's heel pressure wound. R1's foot (podiatrist) progress note dated September 14, 2022, indicated R1's podiatrist ordered daily wound care for R1's right heel pressure ulcer. Licensee staff were to perform daily dressing changes using betadine, 4 x 4 gauze, absorbable gauze (Kling), and use of an off-loading shoe to relieve pressure off her right	01940		

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01940	Continued From page 24 heel. R1's pressure ulcer was classified as an unstageable pressure ulcer. Facility staff were to monitor R1's wound for acute changes or signs of infection. R1's record lacked a treatment management plan to include the following required content: - a statement of the type of service that would be provided - documentation of specific resident instructions relating to the treatments or therapy administration - identification of treatment or therapy tasks that would be delegated to unlicensed personnel - procedures for notifying a registered nurse when a problem arose with treatments or therapy services - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On June 28, 2023, at 9:00 a.m., RN-C stated she used R1's after visit summary to obtain provider's orders and a treatment and therapy management plan. The licensee policy titled Treatment and Therapy Management, dated February 17, 2022, indicated the RN or licensed professional would prepare and individualized treatment or therapy management plan for each resident who received ordered or prescribed treatments or therapy services which addressed: (a) types of services to be provided; (b) procedures for documenting treatments or therapies; (c) procedures for monitoring treatments or therapies to prevent possible complications or adverse reactions; (d)	01940		

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01940	Continued From page 25 identification of treatment or therapy tasks delegated to ULP; (e) procedures for notifying the RN or licensed health professional when a problem arises related to the treatment or therapy service. Each staff member who administered a treatment or therapy was responsible for documenting it in the clinical record. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01960 SS=G	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure foot (podiatrist) orders were implemented for one of one of one resident (R1) with record reviewed. R1's podiatrist ordered daily wound care for R1's right heel pressure ulcer. The licensee failed to implement daily wound care. R1's pressure ulcer became infected and she developed maggots in her pressure ulcer. In addition, the licensee failed to ensure staff documented the reason R1's treatments and therapies were not administered.	01960		

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01960	Continued From page 26 This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's medical record was reviewed. R1 admitted to the licensee's facility on January 25, 2022. R1's diagnoses included type 2 diabetes mellitus. R1's skin assessment dated September 6, 2022, indicated R1 had a right heel wound with acute pain, but it did not indicate her pain level and lacked a description and measurements of her heel wound. R1's foot (podiatrist) progress note dated September 14, 2022, indicated R1's podiatrist ordered daily wound care for R1's right heel pressure ulcer. Licensee staff were to perform daily dressing changes using betadine, 4 x 4 gauze, absorbable gauze (Kling), and use of an off-loading shoe to relieve pressure off her right heel. R1's pressure ulcer was classified as an unstageable pressure ulcer. R1's treatment record dated September 2022, October 2022 and November 2022, indicated there was a task called "bedbath/shower/dressing/changing" for twice weekly. There was no description of what the task was or how to complete it.	01960		

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01960	Continued From page 27 R1's record lacked transcription of R1's daily wound care orders and documenation it was performed. R1's progress notes indicated between September 15, 2022, and October 12, 2022, RN-C completed R1's heel dressing change one-time on September 20, 2022. RN-C documented 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. R1's record failed to include further wound dressing changes during the 22 days before R1 was hospitalized. R1's progress note dated October 12, 2022, at 1:56 p.m., indicated R1 woke up with a left swollen leg and complained of pain. A PRN (as needed) pain medication was given and R1 was provided a bed bath. R1's progress note lacked information regarding R1's wound, nor sending her to the hospital. At 11:15 pm., it was documented R1 was sent to the hospital for 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	01960		

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01960	Continued From page 28 a phone call with a hospital RN, RN-C indicated R1 received wound care every other day, but agreed to comply and have facility staff perform daily wound care once the resident returned to the facility. On June 28, 2023, at 9:00 a.m., RN-C stated she was aware R1 refused showers sometimes for weeks on end, stating that was what contributed to her getting maggots in her right heel wound. RN-C stated she did not implement interventions for R1's refusals or notify R1's podiatrist or provider since it was R1's right to refuse. RN-C stated she did not think to check R1's feet but since her maggots staff are checking her feet and documenting her refusals on a regular basis. On July 14, 2023, at 9:00 a.m., unlicensed personnel (ULP)-E stated she did not provide wound care for R1, stating RN-C performed R1's wound care. ULP-E stated, "RN-C did not give me any directions on anything I should do for the wound." ULP-E stated R1 was stubborn with her cares and would sometimes refuse. The licensee policy titled Treatment and Therapy Management, dated February 17, 2022, indicated the RN or licensed professional would prepare and individualized treatment or therapy management plan for each resident who received ordered or prescribed treatments or therapy services which addressed: (a) types of services to be provided; (b) procedures for documenting treatments or therapies; (c) procedures for monitoring treatments or therapies to prevent possible complications or adverse reactions; (d) identification of treatment or therapy tasks delegated to ULP; (e) procedures for notifying the RN or licensed health professional when a problem arises related to the treatment or therapy	01960		

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01960	Continued From page 29 service. Each staff member who administered a treatment or therapy was responsible for documenting it in the clinical record. TIME PERIOD TO CORRECT: Seven (7) days.	01960		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility and an individual person were 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 is required for this tag.	
03000 SS=D	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not	03000		

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03000	Continued From page 30 required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c.	03000		

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03000	Continued From page 31 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to report suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC) for one of one residents (R1) with records reviewed. R1's foot (podiatrist) doctor ordered daily wound care for R1's right heel wound yet R1's record indicated licensee staff performed only intermittent wound care. R1's wound became infected. R1 was admitted to the hospital with severe right heel pain where hospital staff discovered R1's wound was filled with maggots. R1 spent a few days in the hospital and received intravenous (IV) antibiotics and debridement for her wound. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's medical record was reviewed. R1 admitted to the licensee's facility on January 25, 2022. R1's diagnoses included type 2 diabetes mellitus. R1's care plan dated January 25, 2022, indicated R1 was to receive assistance with daily bed baths, showers three times per week, diabetic meals, transfers, repositioning every two hours, twice daily range-of-motion exercises, and toileting/peri-care, and medication management.	03000		

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03000	Continued From page 32 R1 used a standing mechanical lift or total body mechanical lift for transfers and an electric wheelchair for mobility. R1 required foot care two times per month and as needed (prn), in addition to seeing a foot doctor (podiatrist) annually. The area for non-sterile dressing change indicated "not applicable." The service plan was reviewed by registered nurse (RN)-C's on March 25, 2022, May 25, 2022, July 25, 2022, September 25, 2022, and November 25, 2022. R1's assessment dated September 6, 2022, indicated R1 was totally dependent with personal cares, transfers, mobility, and self-preservation. R1's skin assessment dated September 6, 2022, indicated R1 had a right heel wound with acute pain, but it did not indicate her pain level and lacked a description and measurements of her heel wound. R1's podiatry (foot) clinic note dated September 14, 2022, at 1:45 p.m., indicated R1's dressings were changed weekly by licensee staff. R1's podiatrist ordered R1 to receive daily wound care from the licensee's facility. Facility staff were to monitor R1's wound for acute changes or signs of infection. R1's progress note dated September 20, 2022, at 10:29 a.m., R1's dressing was changed. RN-C documented R1 had a special boot on her right foot. R1's progress notes indicated between September 15, 2022, and October 12, 2022, licensee staff performed one day of wound care for R1's right heel pressure ulcer. R1's progress noted dated October 12, 2022, at	03000		

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03000	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 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 was within 48 hours. The licensee policy titled Vulnerable Adult, dated February 17, 2022, indicated licensee employees	03000		

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03000	Continued From page 34 were required to individually assess residents to determine vulnerability to abuse or neglect and develop a specific plan to minimize the risk of abuse to that resident. In addition, all employees who provide assisted living care were mandated to report abuse and/or neglect (including suspected abuse or neglect) of the vulnerable adult according to this policy. Section 1(c) Neglect (2): The absence, likelihood of absence or failure to provide necessary food, clothing, shelter, health care, or supervision for a vulnerable adult. TIME PERIOD TO CORRECT: Seven (7) days	03000		