Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL302453002M
Compliance #: HL302452905C

Date Concluded: October 18, 2024

Name, Address, and County of Licensee Investigated:

Ingleside
2811 Roland Avenue
Fairmont, MN 56031
Martin County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name: Erin Johnson-Crosby, RN
Special Investigator

Finding: Substantiated, facility responsibility

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

Initial Investigation Allegation(s):
The facility abused the resident when staff restrained the resident with a gait belt in her wheelchair over a two-hour period.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The facility was responsible for the maltreatment. Facility staff unreasonably confined the resident when a transfer belt was used to secure the resident to a wheelchair for over two hours. The incident was not thoroughly investigated by management staff and no action was taken to prevent further occurrence.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record, facility documentation, personnel files, staff schedules, video footage, and related facility

policies and procedures. Also, the investigator observed resident cares at the time of the onsite visit.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia, anxiety, and history of a stroke. The resident's service plan indicated the resident was independent with transfers, required assistance with walking and wheelchair mobility. The resident's assessment indicated the resident was cognitively impaired and was at risk for abuse.

A facility report indicated the resident fell and was restrained to her wheelchair in the dining room. Facility management documented they were not initially aware of the fall or the use of a restraint, but initiated an internal investigation when they became aware of the incident during a review of video surveillance footage.

A facility investigation of the incident identified that the resident fell at 3:47 p.m. and staff assisted the resident off the floor and into her wheelchair. Video footage indicated that at 3:50 p.m., a staff member wrapped a transfer belt around the resident's waist and wheelchair and fastened the belt on the back of the wheelchair. The internal investigation indicated the resident remained restrained in the wheelchair until after 6:30 p.m., when staff assisted her with evening cares. The investigation included no documentation of interviews with staff who worked at the time of the incident.

The resident's medical record included no documentation of the fall or the use of the restraint and no documentation of assessment or monitoring of the resident following the incident.

Video surveillance footage showed the resident sitting in the dining room attempting to remove the transfer belt and unlock the wheelchair brakes; staff present in the area made no attempt to assist the resident or remove the resident from the restraint. The resident was restrained to the wheelchair for over two hours, until staff assisted with evening cares.

During an interview, management staff stated the transfer belt should not have been used to restrain the resident and they were in the process of re-training all staff.

During an interview, the resident's family stated they were not notified of the incident.

The AP did not respond to requests for interview.

Additional staff working at the time of the incident declined to be interviewed.

In conclusion, the Minnesota Department of Health determined abuse 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.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening;
(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult; and
(4) use of any aversive or deprivation procedures for persons with developmental disabilities or related conditions not authorized under section 245.825.
(c) Any sexual contact or penetration as defined in section 609.341, between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.
(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

Vulnerable Adult interviewed: No, due to cognitive impairment.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: No, did not respond to subpoena request.

Action taken by facility:
The AP was no longer employed by the facility.

Action taken by the Minnesota Department of Health:

- <u>If substantiated and facility responsibility, or facility and individual</u>:

  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
Martin County Attorney
Fairmont City Attorney
Fairmont Police Department
Minnesota Board of Executives for Long Term Services and Supports

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30245	A. BUILDING: _____ B. WING _____	C 07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLESIDE	2811 ROLAND AVENUE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL302453020C/#HL302453100M/#HL302452905C/#HL302453002M On July 31, 2024, 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 51 residents receiving services under the Assisted Living with Dementia Care license. The following correction orders are issued for #HL302453020C/#HL302453100M, #HL302452905C/#HL302453002M, tag identification 0250, 0430, 0490, 0510, 0620, 2170 and 2360. The following correction orders are issued for HL302453020C/#HL302453100M, tag identification 620, 2320, and 2360.	0 000		

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0 000	Continued From page 1 The following correction orders are issued for #HL302452905C/#HL302453002M, tag identification 1640 2310 and 2360.	0 000		
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1;	0 250		

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0 250	Continued From page 2 (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required. This had the potential to affect all residents, staff, and visitors of the facility. 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 is issued at a widespread scope (when problems	0 250	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the	

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0 250	Continued From page 3 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 July 31, 2024, at approximately 9:45 a.m., licensed assisted living director (LALD)-A and registered nurse (RN)-B verified they were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659.	0 250	Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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0 250	Continued From page 4 - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing	0 250		

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0 250	Continued From page 5 the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page five was electronically signed by the authorized agent on August 21, 2023. The licensee had an assisted living license issued on November 1, 2023, with an expiration date of October 31, 2024. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - requirements in section 626.557, reporting of maltreatment of vulnerable adults; - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - infection control practices; As a result of this survey, the following orders	0 250		

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0 250	Continued From page 6 were issued 0250, 0430, 0490, 0510, 0620, 1640, 2170, 2310, 2320, and 2360, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on interview and record review, the	0 430		

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0 430	Continued From page 7 licensee failed to provide licensee's accurate Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) to two of two residents (R1, R2) reviewed and affected all residents receiving assisted living services. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: The licensee's UDALSA dated June 1, 2022, indicated licensed staff were in the building, an attached building, or within the campus and available to respond to resident requests 24/7. On July 31, 2024, at 2:30 p.m., registered nurse (RN)-B stated she was the only licensed staff at the facility and was not onsite 24/7. On July 31, 2024, at 5:45 p.m., licensed assisted living director (LALD)-A stated licensed staff were not present 24 hours a day, seven day a week, but were available at all times. LALD-A stated the UDALSA would need to be updated. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 430		
0 490 SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements	0 490		

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0 490	Continued From page 8 (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a daily program of social and recreational activities based on individual and group interests, physical, mental, and psychosocial needs, to create opportunities for active participation in the community. This had the potential to affect all residents who received services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic	0 490		

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0 490	Continued From page 9 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's posted July and August 2024 activity calendar did not include scheduled activities for Saturdays and Sundays. On July 31, 2024, at 10:12 a.m., unlicensed personnel (ULP)-F stated there were activities Monday through Friday but none on the weekends. ULP-F stated there was a 30 minute activity in memory care Monday through Friday. On July 31, 2024, at 10:15 a.m., ULP-C stated there were no structured activities in memory care on Saturday and Sunday and a 30 minute activity on the week days. ULP-C stated there should be more activities in memory care to keep the residents engaged. On July 31, 2024, at 2:30 p.m., registered nurse (RN)-B stated she did not know the rules on activities. On July 31, 2024, at 5:45 p.m., licensed assisted living director (LALD)-A stated unlicensed staff should be doing activities on the weekend but that was not documented on the activity calendar. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 490		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and	0 510		

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0 510	Continued From page 10 maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control related to gloving and hand hygiene for three of three staff, unlicensed personnel (ULP-D), ULP-E, and ULP-I. The licensee also did not implement COVID-19 precautions while in a current outbreak. This had potential to affect all of the residents, staff, and visitors. 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 the residents). The findings include: On July 31, 2024, at 9:15 a.m., an MDH investigator initiated a complaint investigation at	0 510		

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	30245	A. BUILDING: _____ B. WING _____	C 07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 510	Continued From page 11 the facility. Facility staff confirmed there was a resident positive for COVID-19 invession. There was no signage posted indicating positive COVID cases in the facility. Multiple staff were not wearing personal protective equipment (PPE). On July 31, 2024, at 10:11 a.m., the investigator observed an isolation cart outside of a resident's room. ULP-E stated the resident had COVID and some staff were out sick with COVID. On July 31, 2024, at 10:34 a.m., ULP-D and ULP-E put a gait belt on R2, put on gloves, and assisted R2 to the toilet. ULP-D completed perineal cares after toileting and removed gloves. ULP-D and ULP-E did not complete hand hygiene. ULP-D and ULP-E left R2's room and went across the hall to another resident's room. After leaving R2's room, prior to entering the other resident's room, ULP-D and ULP-E did not complete hand hygiene. On July 31, 2024, at 11:52 a.m., ULP-I was observed in the kitchen area with gloves on. ULP-I left the kitchen and brought food down the hall to a resident's room with gloved hands. ULP-I walked out of the resident's rooms with the same gloved hands then entered a code on a key pad to access the kitchen with the same gloves hands. ULP-I then began touching bread to serve to residents. ULP-I touched the kitchen cupboards and the bread with the same gloved hands and served the bread to residents. ULP-I stated another staff member had called in sick so he was helping out in the kitchen and had not had specific food service training. On July 31, 2024, at 12:02 p.m., ULP-E put gloves on to pass out trays to residents, left the dining room, and removed gloves. ULP-E then	0 510		

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0 510	Continued From page 12 put on a new pair of gloves, touched the back of a resident's wheelchair with the same gloved hands, then touched bread for two residents. ULP-E picked up a piece of bread on a resident's tray, crossed her arms, removed gloves, touched her mask and sat back down to assist a resident with eating. ULP-E did not complete hand hygiene prior to assisting the resident with eating. At 12:36 p.m., ULP-E removed her gloves, itched her head and continued to assist the resident with eating. ULP-E did not complete hand hygiene during meal service including assisting residents with eating. On July 31, 2024, at 11:45 a.m., ULP-D stated hand hygiene should be completed after cares are completed with residents and when gloves are removed. ULP-D stated he forget to complete hand hygiene during the observation. On July 31, 2024, at 2:30 p.m., registered nurse (RN)-B stated she was responsible for the infection control program. There was one resident and three staff positive for COVID at that time. RN-B stated they tried to complete contract tracing as much as possible to prevent testing the whole building. RN-B stated hand hygiene should be completed after removing gloves and perineal cares. RN-B stated staff should not touch resident's food with dirty gloved hands. RN-B also stated infection control audits were not documented. RN-B stated surgical masks were recommended for staff but were not required. The licensee's COVID 19 Outbreak Testing policy dated September 6, 2023, did not include what personal protective equipment (PPE) staff should wear during an outbreak. The licensee's Visitation Guidance, dated	0 510		

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0 510	Continued From page 13 December 15, 2021, indicated visitors were to wear proper PPE when entering the building, but did not include guidance for staff. The licensee's Infection Prevention and Control Program, dated December 5, 2023, listed multiple different policies related to infection control but did not include specific policies regarding hand hygiene or PPE. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 620 SS=G	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma (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. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (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 required to report suspected maltreatment of the individual that occurred prior to admission, unless:	0 620		

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0 620	Continued From page 14 (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. This MN Requirement is not met as evidenced by: Based on interview and record review, the	0 620		

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0 620	Continued From page 15 licensee failed to implement their written procedure and comply with statute requirements to ensure cases of suspected maltreatment were reported for one of one resident (R1). Facility staff failed to adhere to the steps outlined in the procedure of immediate action required following a report of suspected maltreatment. The unlicensed personnel (ULP) accused of maltreatment remained working at the facility during the investigation and additional measures were not implemented to reduce the risk of further occurrence. The licensee also failed to complete an immediate and thorough investigation following the reported suspected maltreatment. 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 indicated she admitted to the facility on May 24, 2022 and resided in memory care with a diagnosis of dementia. R1's service plan dated March 16, 2024, indicated R1 required assistance with all activities of daily living including medication administration. R1 would hit staff and use foul language and become angry. Interventions included redirection and to re-approach. R1's assessment dated February 16, 2024,	0 620		

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0 620	Continued From page 16 indicated R1 was vulnerable due to cognition and was not able to give accurate information. R1 was at risk for physical and verbal abuse. Staff were to monitor for signs of agitation, remove the resident or other residents from the area, and report any concerns. Complaint documents dated March 19, 2024, indicated on March 17, 2024 a staff member witnessed unlicensed personnel (ULP)-G slap R1 after R1 spit medications at ULP-G. The report indicated this was not the first time ULP-G had hit a resident. That night R1 was rocking herself back and forth and was saying, "I'm dumb, I'm dumb, I'm so sorry," which was not normal behavior for R1. The report indicated the staff member called the licensed assisted living director (LALD)-A. LALD-A told staff she would "deal with it in the morning." Multiple complaints about ULP-G's conduct were previously reported and ULP-G continued to be employed be the facility. R1's March and April 2024 medication administration records (MAR) indicated ULP-G administered R1's medications on March 17, 2024 at 4:44 p.m. ULP-G also administered R1's medications on March 19, 2024, and April 2, 2024. The licensee's March and April 2024, schedule indicated ULP-G worked in memory care March, 17, March 19, March 20, March 26, April 2, and April 3, 2024. A hand written, unsigned, document dated March 18, 2024, at 2:10 p.m., indicated R1 was in the middle of the entry way from the dining room to the kitchen. R1 stuck out her foot to trip ULP-G and ULP-G stated, "don't do that." ULP-G kept	0 620		

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0 620	Continued From page 17 walking and slapped R1 on the face as ULP-G walked by. The document indicated three people witnessed this. After ULP-G slapped R1, R1 said, Owe, my eye." ULP-G's employee record indicated on March 19, 2024, ULP-G received a written warning for gross misconduct after a report that she slapped a resident. ULP-G was retrained on tools to use when residents are agitated. ULP-G's record indicated she resigned on April 7, 2024. A police report indicated on April 4, 2024, ULP-H told the police investigator she witnessed ULP-G slap the resident on March 17, 2024, around 4:00 to 5:00 p.m., after R1 spit out medications at ULP-G. The police investigator and LALD-A reviewed video footage from 4:00 p.m., to 5:00 p.m for the date of March 17, 2024. The footage showed after ULP-G administered R1's medications, R1 spit the medications at ULP-G. ULP-G wiped off the front of her neck/chest area and appeared to slap R1 across the face. The incident occurred as reported by ULP-H. On April 8, 2024, the police investigator spoke to ULP-G regarding the incident. ULP-G stated she did not slap the resident. The investigator showed her the video footage and ULP-G stated, "it wasn't a slap." On August 15, 2024, at 2:15 p.m., registered nurse (RN)-B stated she received a call from an ULP-H on March 17, 2024, around 5:15 p.m. ULP-H reported ULP-G hit R1. RN-B directed the ULP to call LALD-A. RN-B stated the next day LALD-A completed an internal investigation and filed a MAARC report. RN-B stated the licensee's policy was for the LALD to handle those type of situations and file a report to MAARC if needed.	0 620		

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0 620	Continued From page 18 On August 27, 2024, licensed assisted living director (LALD)-A stated she received a call from an ULP-H on March 17, 2024, in the evening. ULP-H reported to LALD-A she witnessed ULP-G slap a resident and LALD-A told ULP-H she would check into it the next morning. ULP-G continued to worked the rest of the evening shift. LALD-A stated she did not report this incident to MAARC because the police officer said it had already been reported. LALD-A stated the licensee did not suspend ULP-G during the investigation because they didn't have any evidence to substantiate the complaint. LALD-A stated staff always tried to tell on other staff or make things up and she wanted to make sure there was a legit reason to suspend someone. LALD-A stated she did not check R1's medication administration record to check what time ULP-G administered R1's medications. LALD-A stated the licensee's policy indicated staff should report suspected abuse immediately within 24 hours and suspend the staff if there was evidence to substantiate the maltreatment. The licensee's Vulnerable Adult Maltreatment Policy dated December 5, 2023, indicated immediate steps if witnessed incident or allegation of maltreatment was to intervene and stop the maltreatment, get the vulnerable adult to a place of safety, staff will immediately notify the LALD. If a staff person is the alleged perpetrator, the staff person will be directed to leave the building immediately and will be instructed to not come to work until further notice. If the incident appears to be suspected abuse, neglect, or financially exploitation, assisted living director/RN will immediately make a report to the common entry point. No further information provided.	0 620		

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0 620	Continued From page 19 TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
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, observation, and document review, the licensee failed to revise and implement services to prevent multiple falls for one of one resident (R2). In addition, the licensee failed to ensure the service plan was signed by R2's designated representative.	01640		

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01640	Continued From page 20 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). Findings include: R2 diagnoses included vascular dementia with behavioral disturbances, anxiety, and history of a stroke. R2's service plan dated and electronically signed on May 1, 2024, indicated R2 received assistance with dressing, grooming, bathing, eating and bed mobility. An intervention dated May 27, 2021, indicated R2 was independent with transfers and stand by assist for walking. The intervention indicated R2 would have a bed/couch alarm to alert staff throughout the day. An intervention dated February 29, 2024, indicated R2 required full help for wheel chair mobility, one staff for ambulation, and was at risk for for falls. Fall interventions had not been updated on the service plan since September 8, 2022. R2's assessment dated May 29, 2024, indicated R2 has had 10 more falls in the last 6 months and the date of the last fall was December 23, 2023. The assessment identified R2 was independent with transfers and could transfer without help, but also indicated R2 required assistance for transfers with a walker. R2 required occasional supervision/standby assist for walking. An incident report dated April 21, 2024, at 4:45	01640		

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01640	Continued From page 21 a.m., R2 was found sitting on the floor scooting towards the bathroom. The progress notes indicated this was due to R2's physical decline, R2 had become unable to ambulate safely with her walker and staff would continue to attempt to wake her up and toilet her during the night. R2's service plan was not updated to reflect the change identified in the April 21, 2024 incident report. An incident report dated June 5, 2024, at 7:35 p.m., R2 was found on the dining room floor in from of the wheel chair. The intervention indicated staff should administer medications for constipation. R2's service plan was not updated to reflect the change identified in the June 5, 2024 incident report. On July 31, 2024, at 10:34 a.m., the surveyor observed ULP-D and ULP-E assist R2 with transferring. ULP-D put a gait belt around R2 and stated she doesn't stand well. ULP-D and ULP-E had to bear R2's total weight as R2 did not put her feet on the ground. ULP-D stated at times they need to use the EZ stand if not R2 required two assist pivot transfers. R2's service plan was not updated to reflect R2's change in weight-bearing status, increase in assistance needed for transfers, or use of a mechanical lift. On August 15, 2024, at 2:00 p.m., RN-B stated the service plan populates by the assessments. RN-B did not know why interventions for falls had not been documented or added to the service plan since 2022. RN-B stated interventions	01640		

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01640	Continued From page 22 implemented for R2 included urinalysis, altered toileting schedule, using wheelchair more than walking, and manage constipation. RN-B stated R2 transferred independently with supervision. RN-B stated R2 sometimes had bad days but was more of a cognitive issue than a weight bear issue. RN-B confirmed this information was not updated on R2's service plan. On August 7, 2024, at 2:30 p.m., LALD-A stated she changes the service plan when she is notified by the nurse. LALD-A stated if there is a change in the resident's functional ability it should be updated on the resident's service plan. LALD-A stated she signs off on the resident's incident reports but it was the nurses responsibility to implement interventions and will offer suggestions when asked. LALD-A indicated R2's service plan was electronically signed. LALD-A confirmed these changes were not reflect on R2's service plan. On August 28, 2024, at 11:10 a.m., R2's family member (FM)-J stated the facility was good about reporting the resident's falls but was not aware of what interventions were in place to prevent falls. FM-J stated she had never received an email from the licensee to sign R2's service plan. On August 28, 2024, The investigator emailed R2's service plan and service agreement to FM-J to see if she electronically signed these documents. FM-J replied via email stated she did not sign those documents. On August 29, 2024, The investigator emailed LALD-A requesting the email sent to FM-J requesting an electronic signature. LALD-A initially replied R2's service plan was not emailed and that FM-J did not have email and did not	01640		

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01640	Continued From page 23 come to the facility. LALD-A stated she spoke to FM-J and was given verbal permission to electronically sign the documents. LALD-A stated that conversation was not documented. The Contents of Service Plan policy dated November 17, 2023, indicated all assisted living resident should have an up-to-date service plan identifying services to be provided based on the assessment by the RN or other licensed health professional. Service plans and any revisions to service plan will have a signature or other authentication by the facility and by the resident. Other authentication could be email confirmation accepting terms or the service agreement or other method deemed appropriate. Service plans are reviewed and revised as needed upon on-going resident assessment. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) Days	01640		
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions.	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30245	A. BUILDING: _____ B. WING _____	C 07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLESIDE	2811 ROLAND AVENUE FAIRMONT, MN 56031

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02170	Continued From page 24 (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to conduct an evaluation for activities that addressed all provisions and failed to develop an individualized activity plan for two of two residents (R1, R2) 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to	02170		

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02170	Continued From page 25 affect a large portion or all of the residents). The findings include: The facility had an assisted living with dementia care license, effective November 1, 2023. R1 R1's diagnoses included dementia. R1's Individualized Activity Assessment dated May 30, 2022, lacked the following: -past and current interests; -current abilities and skills; -emotional and social needs and patterns; -physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions. In addition, R1's record lacked an individualized activity plan based on the activity evaluation that reflected R1's activity preferences and needs. R2 R2's diagnosis included vascular dementia with behavioral disturbance. R2's Individualized Activity Assessment dated February 28, 2022, lacked the following: --past and current interests; -current abilities and skills; -emotional and social needs and patterns; -physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions.	02170		

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02170	Continued From page 26 In addition, R2's record lacked an individualized activity plan based on the activity evaluation that reflected R2's activity preferences and needs. On July 31, 2024, at 5:45 p.m., licensed assisted living director (LALD)-A stated activities assessments were completed upon admission and was not aware of the current requirements regarding activities assessments and plan. The licensee's Initial and On-Going Nursing Assessment of Residents under the Comprehensive Licensed agency dated November 28, 2023, indicated a comprehensive assessment would included sleep schedule, dietary and social, needs, leisure activities, and out customary routines that are important to the resident's quality of life. The policy did not include what information was required for an activities assessment and plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02170		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide appropriate	02310		

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02310	Continued From page 27 care and services based on the resident's needs and accepted health care standards to ensure dignified and appropriate safety interventions were implemented for one of one resident's (R2) when staff locked R2's wheel chair brakes and used a gait belt to restrain R2 to the wheelchair following a fall. Following the incident the licensee failed to complete an assessment, and no interventions were implemented to prevent the incident from re-occurring. In addition, the licensee failed to allow residents to move freely about the facility by locking the resident's wheelchair brakes and use of pressure alarms for R1, R2, R3, and R5. The licensee also failed to complete assessments related to wheelchair brakes and pressure alarms. This practice resulted in a level three violation (a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Gait belt restraint R2 diagnoses included vascular dementia with behavioral disturbances, anxiety, and history of a stroke. R2's service plan dated May 1, 2024, indicated R2 received assistance with dressing, grooming, bathing, eating and bed mobility. The service plan intervention dated May 27, 2021, indicated R2 was independent with transfers and stand by	02310		

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	30245	A. BUILDING: _____ B. WING _____	C 07/31/2024

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02310	Continued From page 28 assist for walking. An intervention dated February 29, 2024, indicated R2 required full help for wheel chair mobility. R2 was at risk for for falls. Fall interventions had not been updated since September 8, 2022. R2 was at risk to be abused due to difficulty with communication the intervention included to assess for unmet needs, and attempt to meet needs. Complaint documents dated April 5, 2024, indicated on March 17, 2024, facility video footage showed at 3:45 p.m., R2 was sitting in the dining room in her wheelchair. At 3:47 p.m., R2 got out of of her wheelchair in the dining room and began to push another resident's wheelchair and when R2 stopped pushing the resident's wheelchair, R2 fell. Two staff assisted R2 off the floor into the wheel chair. At 3:50 p.m., unlicensed personnel (ULP)-H put a gait belt around the resident's waist and around the back of the wheelchair so R2 would not be able to stand up. Review of facility video footage from March 17, 2024, indicated that at 4:37 p.m., R2 remained in the dining room at the table with the wheel chair brakes locked and a gait belt around R2's waist and clipped behind R2's wheel chair so she would be unable to remove the belt. At 4:45 p.m., R2 attempted to take off the gait belt and unlock the brakes. At 4:55 p.m., R2 was able to get one wheel chair brake unlocked. At 4:57 p.m., R2 continued to be at the dining room table with the gait belt around her waist with the clasp behind the wheelchair. R2's wheel chair brakes continued to also be locked. Staff were moving about the dining room at the time R2 remained in the wheelchair with the gait belt around her and brakes lock and made no attempt to assist R2 or remove the restraint.	02310		

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02310	Continued From page 29 On August 15, 2024, at 2:15 p.m., registered nurse (RN)-B was interviewed and stated she was not notified R2 fell on March 17, 2024, so there was no incident report or documentation of the fall. RN-B was not aware the restraint was place until she was informed by the licensed assisted living director (LALD)-A. RN-B stated she did not complete an assessment or an individual abuse prevention plan after she became aware of the situation. On August 27, 2024, at 2:30 p.m., LALD-A stated ULP-H thought she was keeping R2 safe by putting the gait belt around R2's wheel chair. LALD-A did not know how long R2 was restrained in the wheelchair but the internal investigation indicated R2 was restrained until after 6:30 p.m. when she was assisted with evening cares. LALD-A stated the gait belt should not have been used to restrain R2. LALD-A stated ULP-H had to serve supper as there was no dietary staff that evening. LALD-A stated she was currently in the process of re-training all staff. LALD-A stated an IAPP should have been completed after the incident. On August 28, 2024, at 11:08 a.m., R2's family member stated she was not notified of this incident. Wheel Chair Brakes/Pressure Alarms R1 R1 resided in memory care with diagnoses including dementia and malnutrition. R1's service plan dated March 16, 2024, indicated R1 required staff assistance with transfers, ambulation, and was at risk for falls.	02310		

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02310	Continued From page 30 R1's assessment dated February 16, 2024, indicated R1 transferred with supervision due to unsteadiness with a walker, and had a chair and bed sensor to alert staff of self transferring. R1 required occasional assistance with wheelchair mobility but R1 was able to propel the wheel chair with her feet. R1's medical record did not include an assessment indicating if R1 was able to lock/unlock wheelchair brakes. The record also did not include an assessment regarding why pressure alarms were used for R1. R2 R2 diagnoses included vascular dementia with behavioral disturbances, anxiety, and history of a stroke. R2's service plan dated May 1, 2024, indicated R2 received assistance with dressing, grooming, bathing, eating, and bed mobility. The service plan included interventions dated May 27, 2021, that R2 was independent with transfers and stand by assist for walking. An intervention dated February 29, 2024, indicated R2 required full help for wheel chair mobility but did not specifiy what "full help" was needed. R2's medical record did not include an assessment indicating if R2 was able to lock/unlock wheelchair brakes. The record also did not include an assessment regarding why pressure alarms were used for R2. R3 R3 resided in memory care with diagnoses included dementia, and hypertension. R3's service plan dated May 1, 2024, indicated	02310		

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	30245	A. BUILDING: _____ B. WING _____	C 07/31/2024

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02310	Continued From page 31 R3 required assistance with bed mobility, two staff to pivot transfer or mechanical lift, was unable to walk, staff to ensure alarms are on at all times. chair sensor in place, needs help with wheel chair mobility, R3's 90 day assessment date July 16, 2024, indicated one fall in the last six months. Staff will keep R3's door open or keep her in the common area for supervision. R3's medical record did not include an assessment indicating if R3 was able to lock/unlock wheelchair brakes. The record also did not include an assessment regarding why pressure alarms were used for R3. R5 R5 resided in memory care with current diagnoses including dementia with behavioral disturbance and neurocognitive disorder. R5's service plan dated May 1, 2024, indicated R5 received assistance with dressing, grooming, bathing, eating, transfers, toileting, medication administration. R5's service plan indicated R5 was unable to walk, used a wheelchair for mobility, and required occasional help with wheelchair mobility. R5 was at risk for falls and staff were to ensure bed and chair alarms are on and functioning and respond to alarms in a timely manner. R5's medical record did not include an assessment indicating if R5 was able to lock/unlock wheelchair brakes. The record also did not include an assessment regarding why pressure alarms were used for R5. On July 31, 2024, at 9:45 a.m., the surveyor	02310		

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02310	Continued From page 32 observed R1, R3, and R5, sitting at the dining room tables in the memory care unit with their brakes locked and wheel chair pressure alarms. The television was on in the dining room, but the resident's wheelchairs were not pointed in that direction. On July 31, 2024, at 10:25 a.m., unlicensed personnel (ULP)-C stated every resident in memory care had a pressure alarm on their bed in case they get up at night. ULP-C stated every resident also has a wheel chair pressure alarm so they do not fall. On July 31, 2024, at 10:20 a.m., R2 was placed at the dining room table and brakes were put on by staff. Three other resident's seated at the dining room table also had their wheelchair brakes locked. On July 31, 2024, at 11:45 a.m., ULP-E brought R5 to the table and locked R5's brakes. R5 began trying to move her wheelchair and became agitated. R5 was able to get one brake unlocked and R5 wheeled back and forth in a circle. ULP-E went to R5's table and put on the brakes again. At 12:40 p.m., ULP-E unlocked R5's brakes and brought R5 to her room. On July 31, 2024, at 12:01 p.m., R1 was observed sitting in her wheelchair at the the dining room table in the memory care. R1 had a pressure alarm in her wheelchair and her brakes were locked at the table. On July 31, 2024, at 12:23 p.m., ULP-C stated they lock the resident's wheel chair brakes so they don't slide away from the table. On July 31, 2024, at 2:15 p.m., ULP-D stated it	02310		

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02310	Continued From page 33 was not okay to restrain a resident but it was okay to lock wheelchair brakes if the resident is moving around to keep them in place. On July 31, 2024, at 2:30 p.m., registered nurse (RN)-B stated all residents in memory care have pressure alarms in bed but some are not turned on. RN-B stated all residents have a pressure alarm in their wheelchair and based off of previous fall assessments. RN-B stated staff lock resident wheelchair brakes since some of them like to stand up and we don't want the chair to roll out from under them. RN-B stated most of the residents are able to unlock the brakes but there was not an assessment completed to ensure residents could unlock their brakes or if it was safe for staff to lock the brakes on resident wheelchairs. On July 31, 2024, at 5:45 p.m., licensed assisted living director (LALD)-A stated anything to prevent resident movement would be considered a restraint but stated the licensee's policy stated if staff were not pushing the wheelchair, it should be locked. The licensee's Wheelchair Brakes policy dated November 10, 2023, indicated wheelchair brakes would be locked when a resident is not in motion if escorted by staff. Brakes will be locked for the resident's safety. Resident's that escort themselves will lock and unlock their own brakes. The licensee's Restraints policy dated November 28, 2022, indicated restraints would not be used at the facility and if a staff notice a restraint it should be immediately removed. No further information was provided.	02310		

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02310	Continued From page 34 TIME PERIOD FOR CORRECTION: Seven (7) days	02310		
02320 SS=I	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards were provided by people who were properly trained and competent for one of one resident (R1) when a staff member slapped R1. In addition, the licensee failed to ensure interventions were implemented to protect R1 and other memory care unit residents when no immediate action was taken by facility management after recieving report of the incident. This had the potential to affect all residents who resided in the memory care unit. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	02320		

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02320	Continued From page 35 The findings include: R1's medical record indicated R1 admitted to the facility on May 24, 2022, and resided in memory care with a diagnosis of dementia. R1's service plan dated March 16, 2024, indicated R1 required assistance with all activities of daily living including medication administration. R1 would hit staff and use foul language and become angry. Interventions included redirection and re-approach. R1's assessment dated February 16, 2024, indicated R1 was vulnerable due to cognition and was not able to give accurate information. R1 was at risk for physical and verbal abuse. Staff were to monitor for signs of agitation, remove the resident or other residents from the area, and report any concerns. Complaint documents dated March 19, 2024, indicated a staff member witnessed unlicensed personnel (ULP)-G slap R1 after R1 spit out medications at ULP-G. The report indicated this was not the first time ULP-G had hit a resident. The report indicated the staff member called the licensed assisted living director (LALD)-A and immediately reported the incident. LALD-A told the staff she would deal with it in the morning. That night R1 was rocking herself back and forth and was saying, "I'm dumb, I'm dumb, I'm so sorry," which was not normal for R1. Multiple complaints about ULP-G's conduct have been reported and ULP-G continued to be employed be the facility. R1's medical record did not include documentation of the incident or assessment	02320		

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02320	Continued From page 36 after incident and R1 was not immediately assessed following staff's report of the incident on March 17, 2024. R1's medical record lacked evidence of additional monitoring for emotional distress following the incident concerning the statements made by R1 the night of the incident. The licensee's March and April 2024 staffing schedules indicated ULP-G worked in memory care March, 17, March 19, March 20, March 26, April 2, and April 3, 2024. R1's March and April, 2024 medication administration record (MAR) indicated ULP-G administered R1's medications on March 17, 2024 at 4:44 p.m. ULP-G also administered R1's medications on March 19, 2024 and April 2, 2024. Video footage dated March 17, 2024, at 4:37 p.m., showed ULP-G administer R1's medications with a spoon, then ULP-G stuck out her tongue at R1 and R1 then spit out the medications. ULP-G took her right hand, wiped the front of her shirt and slapped the left side of R1's face with her right hand. Right after that incident, ULP-H walked in to the dining room and looked at R1. A hand written, unsigned, document dated March 18, 2024, at 2:10 p.m., indicated R1 was in the middle of the entry way from the dining room to the kitchen. R1 stuck out her foot to trip ULP-G, and ULP-G stated, "don't do that." ULP-G kept walking and slapped R1 on the face as ULP-G walked by. The document indicated three people witnessed this. After ULP-G slapped R1, R1 said, Owe, my eye." The document did not include the name of the staff member interviewed. The facility internal investigation findings	02320		

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02320	Continued From page 37 indicated on March 19, 2024, at 2:30 p.m., ULP-G reported she completed an evening medication pass prior to supper. ULP-G stated she approached R1 in the dining room to give prescribed medications. When ULP-G administered R1's medications, R1 spit them at ULP-G. ULP-G reported she used her right hand to move R1's face to prevent her from getting spit at again. ULP-G stated she walked away and there were no other incidents that shift. ULP-G was given retraining on interactions with residents when they are agitated and was instructed to walk away. ULP-G was also informed that more formal disciplinary action may be taken, depending on the outcome of the investigation. On March 22, 2024, at 3:00 p.m., LALD-A informed ULP-H the video footage had been reviewed; the stories did not match and there was no footage to substantiate abuse. ULP-H became very excited, raised her voice and stated she was not lying and that the incident did happen. ULP-H began crying and shouting and stated she had no reason to lie about the incident. The record indicated ULP-G was suspended without pay until the complete investigation was done and evaluated by leadership staff. However, ULP-G continued to work her scheduled shifts until ULP-G put in her resignation. A police report indicated on March 28, 2024, around 10:00 a.m., police met with LALD-A. LALD-A stated she was aware of the incident and ULP-G stated R1 spit pills at her and was going to spit again, so ULP-G took R1's face and turned it to the side. LALD-A told police that R1 beats up staff by punching, slapping, and spitting on them. ULP-G told LALD-A she would never slap anyone. Police asked for video footage of the incident. LALD-A told police whe would try and locate the footage.	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30245	A. BUILDING: _____ B. WING _____	C 07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02320	Continued From page 38 The police report on April 4, 2024, indicated ULP-H told the police investigator she witnessed ULP-G slap the resident on March 17, 2024, around 4:00 to 5:00 p.m. after R1 spit out medications at ULP-G. The police investigator and LALD-A reviewed the video footage from 4:00 p.m. to 5:00 p.m. The footage showed after ULP-G administered R1's medications, R1 spit the medications at ULP-G. ULP-G wiped off the front of her neck/chest area and appeared to slap R1 across the face. The incident occurred as reported by ULP-H. On April 8, 2024, the police investigator spoke to ULP-G regarding the incident. ULP-G stated she did not slap the resident. The investigator showed her the video footage and ULP-G stated, "it wasn't a slap." ULP-G's employee record indicated on March 19, 2024, they received a written warning for gross misconduct after a report that she slapped a resident. ULP-G was retrained on tools to use when residents are agitated. ULP-G's record indicated she resigned on April 7, 2024. On August 15, 2024, at 2:15 p.m., registered nurse (RN)-B stated she received a call from an ULP-H on March 17, 2024, around 5:15 p.m., before supper. ULP-H told RN-B that ULP-G hit R1. RN-B directed ULP-H to call LALD-A. RN-B stated the next day, LALD-A was completing an internal investigation and filing a MAARC report. RN-B stated the licensee's policy was for the LALD to handle those situations and report to MAARC if needed. On August 27, 2024, at 9:42 a.m., ULP-G stated she had already been interviewed by police. ULP-G stated "I pushed her face away, when she was going to spit at me and that is all I have	02320		

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02320	Continued From page 39 to say". On August 27, 2024, licensed assisted living director (LALD)-A stated she received a call from ULP-H on March 17, 2024, in the evening reporting that she witnessed ULP-G slap R1. LALD-A told ULP-H she would check into in the next morning. ULP-G continued to worked the rest of the evening shift. LALD-A stated she did not report this incident to MAARC because the police officer (days later) said it had already been reported. LALD-A stated the licensee did not suspend ULP-G during the investigation because they didn't have any evidence to substantiate the complaint. LALD-A stated staff always tried to tell on eachother or make things up and she wanted to make sure there was a legit reason to suspend someone. LALD-A stated she did not check R1's medication administration record to check what time ULP-G administered R1's medications. LALD-A stated the licensee's policy indicated staff should report suspected abuse immediately within 24 hours and suspend the staff if there is evidence to substantiate the maltreatment. LALD-A confirmed the policy was not followed regarding this incident. On August 27, 2024, at 4:14 p.m., R1's family members stated there were not notified of the incident and stated there was no reason for someone to slap R1. R1's family member's stated the staff should have left R1 alone and re-approached after a few minutes when she settled down. The licensee's Vulnerable Adult Maltreatment Policy dated December 5, 2023, indicated immediate steps if witnessed incident or allegation of maltreatment was to intervene and stop the maltreatment, get the vulnerable adult to	02320		

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02320	Continued From page 40 a place of safety, staff will immediately notify the LALD. If a staff person is the alleged perpetrator, the staff person will be directed to leave the building immediately and will be instructed to not come to work until further notice. If the incident appears to be suspected abuse, neglect, or financially exploitation, assisted living director/RN will immediately make a report to the common entry point. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure two of two residents reviewed (R1, R2) were free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred for R1, and the facility and an individual were responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details. The Minnesota Department of Health (MDH) issued a determination maltreatment occurred for	02360	No plan of correction required for tag 2360. Please refer to the public maltreatment report for details.	

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02360	Continued From page 41 R2, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		