STATE LICENSING COMPLIANCE REPORT

Report #: HL302844685C

Date Concluded: December 21, 2022

Name, Address, and County of Facility Investigated:
Champlin Shores
119 Hayden Lake Road East
Champlin MN, 55316
Hennepin County

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

Evaluator's Name: Kris Detsch, RN
Special Investigator

The Minnesota Department of Health conducted a complaint investigation to determine compliance with state laws and rules governing the provision of care under Minnesota Statutes, Chapter 144G. The purpose of this complaint investigation was to review if facility policies and practices comply with applicable laws and rules. No maltreatment under Minnesota Statutes, Chapter 626 was alleged.

To view a copy of the correction orders, if any, please visit: https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html, or call 651-201-4201 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached state form.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30284	A. BUILDING: _____ B. WING _____	C 12/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAMPLIN SHORES	119 EAST HAYDEN LAKE ROAD CHAMPLIN, MN 55316

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0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING 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: #HL302845955C/# HL302843603M and HL302844685C On December 21, 2022, 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 eighty-two residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL302845955C/# HL302843603M, tag identification 330, 630, 2320, 2360. The following correction order is issued for #HL302844685C, tag identification 1070.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. 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 surveyors' 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 subd. 1, 2, and 3.	
0 330 SS=F	144G.30 Subd. 4 Information provided by facility (a) The assisted living facility shall provide accurate and truthful information to the	0 330		

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0 330	Continued From page 1 department during a survey, investigation, or other licensing activities. (b) Upon request of a surveyor, assisted living facilities shall within a reasonable period of time provide a list of current and past residents and their legal representatives and designated representatives that includes addresses and telephone numbers and any other information requested about the services to residents. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide the surveyor with documentation that was requested for one of one resident (R1) reviewed in a timely manner. The surveyor made multiple requests for documentation. This practice had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: On December 21, 2022, at 8:00 a.m., surveyor entered licensee's building. Executive director, (ED)-A was not present, and staff were unable to provide documentation. ED-A arrived at approximately 10:20 a.m., and surveyor requested licensee's policies, and R1's medical records. ED-A said information would be gathered and sent to surveyor by the end of the day because she was busy with Christmas activities	0 330		

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0 330	Continued From page 2 for the residents. Surveyor provided ED-A a list of documents required for investigation. On December 22, 2022, at 9:55 a.m., surveyor sent ED-A an email requesting documentation. On December 22, 2022, at 11:34 a.m., surveyor received an email from ED-A stating, "We will be sending documents shortly". On December 22, 2022, at 11:58 a.m., surveyor received an email from ED-A with some of the policies that surveyor requested upon enter on December 21, 2022. No other documentation was provided. On December 22, 2022, at 12:41 p.m., surveyor received an email from ED-A with the rest of the policies that surveyor requested upon enter on December 21, 2022. No other documentation was provided. On December 22, 2022, at 3:25 p.m., surveyor sent an email to ED-A informing her the licensee's policies were received, however R1's records were not sent to surveyor. On December 23, 2022, at 9:37 a.m., surveyor called licensee and talked with registered nurse, (RN)-C and requested she send surveyor requested information. RN-C said she was busy yesterday (December 22, 2022), with admissions and would try to gather information. On December 23, 2022, at 11:40 a.m., surveyor received R1's medical record, however medication administration, treatment records, and incident reports were not present. During on December 23, 2022, at 1:30 p.m., with	0 330		

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0 330	Continued From page 3 RN-C, the surveyor requested medication administration and treatment record (MAR/TAR), and incident reports from R1's falls. RN-C said licensee was having difficulty obtaining documents because they were changing systems. RN-C said she was unable to print incident reports. On December 23, 2022, at 2:33 p.m., surveyor received an email from RN-C that contained R1's (MAR/TAR). No incident reports were provided. TIME PERIOD TO CORRECT: Seven (7) Days	0 330		
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 licensee failed to develop and implement and individual abuse prevention plan that included an individualized review or assessment of the person's susceptibility of abuse by another individual, including other vulnerable adults, and statements of the specific measures to be taken	0 630		

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0 630	Continued From page 4 to minimize the risk of abuse for one of one resident (R1) 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: R1 admitted to license on December 20, 2021, with diagnoses including Alzheimer disease, Parkinson's disease, and tremors. R1's service plan dated December 20, 2021, indicated R1 had occasional disruptive, aggressive, or socially inappropriate behavior and had moderate cognitive decline. The service plan indicated R1 was at risk for falls. During an interview with executive director (ED)-A at 10:20 a.m., surveyor request R1's medical record, including assessments. On December 23, 2022, at 11:40 a.m., registered nurse (RN)-C sent R1's medical records and assessments to surveyor. The records lacked R1's individual abuse prevention plan (IAPP). During an interview with RN-C on December 23, 2022, at 1:24 p.m., surveyor request R1's IAPP. RN-C said the licensee did not complete IAPP assessments. RN-C said the licensee received a "tag" from the state and the licensee is now starting to complete IAPP assessment. RN-C	0 630		

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0 630	Continued From page 5 said the assessments are, "not going live until January" (2023). RN-C acknowledged that IAPP assessments should have been completed. The licensee policy, 2.44 Vulnerable Adult Maltreatment- Prevention and Reporting dated October 31, 2022, indicated licensee would develop individualized vulnerable adult abuse prevention plans to identify vulnerability risk and develop measures to minimize maltreatment. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
01070 SS=D	144G.52 Subd. 10 Right to return If a resident is absent from a facility for any reason, including an emergency relocation, the facility shall not refuse to allow a resident to return if a termination of housing has not been effectuated. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee refused to allow the return of one of one resident (R2) with record reviewed. R2 was not allowed to return to the licensee after transfer to the emergency room for wound observation. The licensee had not issued a notice of termination of services, but requested the hospital send R2 to a skilled nursing facility. The licensee failed to offer any option for R2 to return with necessary 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	01070		

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01070	Continued From page 6 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: R2 was admitted to licensee on August 8, 2022, for diagnoses including complete traumatic amputation at level between knee and ankle and deep vein thrombosis. R2's admission assessment dated August 16, 2022, indicated R1 was orientated to person, place, time, and situation. The assessment indicated R2 was independent with mobility and used an electric wheelchair. The assessment indicated R2 required a sit to stand lift (E-Z stand) for transfers and help from two staff. The assessment indicated R1 had a lower limb prosthesis and would receive physical therapy, occupational therapy, home health aide, and nursing services. R2's progress notes dated August 18, 2022, at 2:47 p.m., indicated R2 went to nursing staff because his right leg was weeping. R2's progress notes indicated nursing removed his dressings and noticed open wounds with maggots present. R2's progress notes dated August 18, 2022, at 7:09 p.m., indicated R2's physician requested R2 go to the emergency room to check for infection because maggots were present in his wounds. The progress notes indicated registered nurse (RN)-C called the emergency room and requested R2 transfer to a skilled nursing facility because R2 had an inappropriate sling for his E-Z	01070		

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01070	Continued From page 7 stand machine. During an interview with RN-C on December 27, 2022, at approximately 1:00 p.m., RN-C said R2 had an inappropriate sling for his E-Z stand machine. RN-C said she did not know how staff transferred R2 during the time frame prior to emergency room placement. RN-C said there were no notices of discharge sent to the resident. RN-C said there was no communication with the Ombudsman. RN-C said there were no attempts to assist R2 to find alternative placement. During an interview with executive director (ED)-A on December 21, 2022, at 11:18 a.m., ED- A acknowledged the licensee should have provided R2 a notice of termination of services and followed the required process for contract termination. The licensee's Uniform Disclosure of Assisted Living Services and Amenities, (UDALSA) dated October 28, 2022, indicated licensee was able to provide service for sit to stand lifts and mechanical lifts. The document indicated the licensee was able to provide basic wound care. The licensee's, 1.15 Contract Termination, policy dated October 31, 2022, indicated an expedited termination notice would be given 15 days before the effective date of termination. The policy indicated the licensee would assist in coordinating the move to another provider. The policy indicated the office of ombudsman would be notified in advance. TIME PERIOD FOR CORRECTION: Seven (7) days	01070		

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02320	Continued From page 8	02320		
02320 SS=G	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 have a fall management system that ensured staff provided a resident with supervision and implement interventions after falls for one of one resident (R1) reviewed. R1 received multiple fractures to her ribs, a fracture of her right elbow, and fracture of her right hip after a fall. 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 admitted to licensee on December 20, 2021, with diagnoses including Alzheimer disease, Parkinson's disease, and tremors. R1's assessment titled, health and service evaluation (v2021) results and service plan, dated	02320		

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02320	Continued From page 9 December 20, 2021, indicated R1 had occasional disruptive, aggressive, or socially inappropriate behavior and had moderate cognitive decline. The assessment indicated the resident required medication administration, meals, dressing, grooming, bathing, and escort services. The assessment indicated R1 was at risk for falls and the interventions included R1's room to be free from clutter, glasses were on when she was awake, and frequent checks were to be provided at night. R1's progress note dated October 3, 2022, at 6:30 p.m., indicated staff found R1 sitting on her buttocks. The note indicated R1 sustained a skin tear to her left upper extremity and staff informed hospice of the fall. On October 4, 2022, hospice ordered an X-ray. On October 5, 2022, R1 had fractures of her ribs. R1's record lacked evidence nursing added further fall interventions after the fall on October 3, 2022. R1's progress note dated October 14, 2022, indicated R1 fell and R1 was, "crying of right-side pain". On October 19, 2022, hospice ordered X-ray of R1's right hip and arm. On October 20, 2022, x-ray results showed R1's right hip and right elbow was fractured. R1's records indicated October 16, 2022, at 6:00 p.m., the licensee received an order from hospice requesting staff turn and reposition R1 every two hours to keep R1 off her sacral wounds. The order indicated staff were to provide Desitin to sacral wounds after incontinence cares. R1's nursing assessment dated October 18, 2022, indicated R1 had fallen 1-2 times in the last	02320		

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02320	Continued From page 10 90 days, however the assessment failed to identify any changes to the plan of care. The assessment failed to identify any individualized interventions to reduce fall and injury risk, although R1 had significant injury of fractures. R1's MAR/TAR dated October 1, 2022, through October 31, 2022, failed to identify safety checks, repositioning, or toileting. The MAR/TAR indicated staff failed to apply Desitin to R1. The licensee failed to implement and communicate interventions to unlicensed personnel (ULP). R1's progress notes dated October 22, 2022, at 12:12 p.m., indicated R1 died at 3:40 p.m. Surveyor toured the memory care unit on December 21, 2022, at 8:20 a.m., and observed there were no staffing assignments for the caregivers. Surveyor confirmed there were thirteen residents in the memory care unit. During an interview with unlicensed personnel (ULP)-G on December 21, 2022, at 8:30 a.m., ULP-G said nursing did not assign caregivers a group of residents to be responsible for. ULP-G said there were two caregivers on the unit, and they were supposed to work together to provide care for all the residents. ULP-G said there were no scheduled safety checks in memory care. During an interview with registered nurse (RN)-C on December 23, 2022, at 1:24 p.m., RN-C said there was always two caregivers in memory care. RN-C confirmed caregivers do not have residents assigned to them. RN-C said the caregivers work together to provide all cares to the residents. RN-C said there were no specific times for safety checks on the residents. RN-C said safety checks and toileting schedules would be documented on	02320		

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02320	Continued From page 11 MAR/TAR. During an interview with hospice nurse (RN)-F on December 28, 2022, at 11:06 a.m., RN-F said he told RN-C on October 3, 2022, to make sure staff are providing safety checks and scheduled toileting. The licensee's policy, 6.15 Staffing Requirements- licensed nurse and ULP, dated October 27, 2022, indicated staff would provide services consistent with current practice standards appropriate to the resident's needs. 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: Based on observations, interviews, and document review, the facility failed to ensure one of one residents reviewed (R1) was free from maltreatment. R1 was neglected. Findings include: The Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility was responsible for the maltreatment, in connection with incidents which	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	

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02360	Continued From page 12 occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	02360		