Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL303296444M
Compliance #: HL303292128C

Date Concluded: October 13, 2023

Name, Address, and County of Licensee Investigated:
Charter House Supportive Living
211 2nd St. NW
Rochester, MN 55901
Olmsted County

Facility Type: Assisted Living Facility (ALF)

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

Finding: Substantiated, facility and individual responsibility

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

Initial Investigation Allegation(s):
The alleged perpetrator (AP) abused Resident A when the AP was witnessed holding down Resident A while performing cares causing the resident to scream out in pain. The AP abused Resident B when the AP forcefully and aggressively handled Resident B when assisting with cares.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The facility and the AP were responsible for the maltreatment. The facility was notified of concerns regarding the AP but did not immediately follow up on the concerns, report the incidents, or complete an internal investigation until eight days after the initial concerns were reported. The actions of the AP were witnessed and reported by two unlicensed personnel (ULP).

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of resident and facility

records, including facility policies and procedures. At the time of the onsite visit, the investigator observed resident and staff interactions and provision of cares.

Resident A

Resident A resided in an assisted living facility. The resident's diagnoses included Alzheimer's, depression, and a history of a stroke. The resident's unsigned service plan included assistance with medication administration, toileting, transferring and bed mobility. Resident A's abuse prevention plan did not include susceptibility of abuse by others or interventions to prevent abuse.

Resident B

Resident B resided in an assisted living facility. The resident's diagnoses included dementia and left sided hemiplegia (paralysis of one side of the body). Resident B's service plan included assistance with medication administration, bed mobility, toileting, and transferring. Resident B's assessment indicated the resident was not combative, did not have delusions or hallucinations. The residents individual abuse prevention plan did not include susceptibility of abuse by others or interventions to prevent abuse from occurring.

Facility documentation identified concerns of the AP's behavior and treatment of residents were reported to nurse management staff, however, no immediate action was taken to follow-up on the concerns.

An email sent to the nurse manager from unlicensed personnel (ULP) #1 indicated the AP was not gentle with residents and was witnessed holding residents tightly, holding them down while performing cares, and appeared to hurt the residents. The email did not identify a specific resident or incident when this occurred.

There was no evidence of action taken in response to the email and the AP continued to work as scheduled.

Five days later, a registered nurse (RN) sent an email to the nurse manager informing her that staff had reported the AP was very rough with Resident A when doing cares.

The AP was interviewed by nursing staff the following day and asked the AP about his interactions with Resident A. The AP replied, sometimes were better than others.

The AP continued to work as scheduled the evening following the interview by nursing staff and no additional action taken in response to the email sent to the nurse manager.

Two days later (eight days after the original email was sent to the nurse manager), the facility reported the incident regarding the AP's treatment of Resident A and initiated an internal investigation. The facility report identified the AP was terminated from his position. ULP #1 who

reported the initial concerns and another ULP (ULP #2) who worked with the AP, were interviewed, and provided statements and witness accounts of incidents involving the AP.

Facility internal investigation documents included a statement provided by ULP #1. ULP#1 reported the AP appeared to take his anger out on residents. ULP #1 indicated the AP would hold residents extremely tight. ULP #1 could tell the AP was hurting the residents and the incidents occurred with other male residents. ULP #1's statement included "an incident I don't want to have to experience is a couple weeks ago [AP] was performing a care on [Resident A], and he was holding him excessively tight while [Resident A] was upside down almost falling right off his bed. [Resident A] was obviously in pain, screaming, breathing heavily, and turning purple. I told him to stop, and he [AP] just said, oh he is fine." ULP #1 indicated that more recently, the AP held Resident A down on the toilet and aggressively threw the resident's hands down on the toilet seat handlebars, squeezing Resident A's hands tight.

The internal investigation also included an interview with ULP #2, who indicated the allegations against the AP should be looked in to, and the AP was being rough with residents. ULP #2 described when the AP helped Resident A with toileting, the AP grabbed Resident A's arms and slung them down on the toilet grab bars. The AP gripped the resident's arms so tight ULP #2 thought they would be bruised.

Resident A was assessed by nursing staff and had no evidence of injury or bruising. Resident A could not recall the incident(s).

One week later, Resident B's family member reported to facility staff Resident B told her a caregiver had treated him roughly. Resident B stated the caregiver would come in and throw him around "like a piece of furniture." Resident B stated he would tell the caregiver the behavior was not appropriate, and to stop touching him like that. The facility began an investigation into the family's report. Facility investigation documentation indicated the AP worked during the time frame of the reported incident(s), and the resident's description of the caregiver matched the description of the AP.

Resident B's medical record indicated Resident B began experiencing more behaviors, aggression, and paranoia, around the time of the reported caregiver concerns. Resident B's clinic records indicated the resident was started on an antidepressant due to his change in mood and behavior. Clinic notes recommended nonpharmacologic interventions, including familiar and consistent caregivers, and indicated staff may consider a move off the unit if there were concerns that the physical unit was a trauma reminder.

Review of Resident A and Resident B's facility records and assessments included no evidence of new interventions implemented or updates made to abuse prevention plans following the incidents involving the AP.

During an interview, the RN who emailed the second report of concerns about the AP's behavior stated she did not ask any follow-up questions or interview any other residents or staff regarding the AP's alleged behavior but did pass the report on to the nurse manager.

During an interview, the nurse manager acknowledged the delay in follow up to the initial reports of concerns with the AP's behavior. The nurse manager indicated a report and investigation should have been immediately initiated and the AP should have been suspended upon initiation of the investigation. The nurse manager stated Resident A had no visible injuries but was not able to be interviewed due to his cognition level. The nurse manager stated Resident B had become more aggressive and paranoid during the evening shift which was not present prior to the incident(s) and had to be started on an antidepressant. The nurse manager indicated the incident(s) really took a toll on Resident B and Resident B no longer trusted staff.

During an interview, ULP #1 stated the AP was aggressive with male residents. ULP #1 stated when residents refused cares the AP would make them do it anyway. ULP #1 recalled the incident involving Resident A and stated the AP squeezed Resident A's hands and held his wrists on the toilet. Resident A was screaming and breathing heavily and the ULP told the AP to stop. ULP #1 recalled another incident that occurred when ULP #1 and the AP were assisting Resident B with turning in bed. ULP #1 stated the AP held him tightly and Resident B screamed. ULP #1 could tell the resident was uncomfortable. ULP stated she reported concerns twice to her supervisors regarding the AP's behavior with residents.

During an interview, ULP #2 stated he and the AP assisted Resident A with toileting when the AP grabbed the resident's hands and slammed them down on the arm rests of the toilet riser. The AP held the resident's hand there. ULP #2 stated there was no bruising, but some redness was noted on the residents' wrists after the incident.

The AP was interviewed and denied holding residents down or being aggressive with any residents. The AP felt he was being targeted by staff since he had brought up facility concerns.

Resident A's family was unable to be reached for interview.

During an interview, Resident B's family member stated the resident was mad and more aggressive after the incident, which was not normal for the resident.

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;

Vulnerable Adult interviewed: Unable to be interviewed due to cognitive impairment.
Family/Responsible Party interviewed: Yes; Attempts to contact Resident A's family were not successful
Alleged Perpetrator interviewed: Yes.

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

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

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

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

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

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

cc:

The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Olmstead County Attorney
Rochester City Attorney
Rochester Police Department
Nursing Assistant Registry

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30329	A. BUILDING: _____ B. WING _____	C 08/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARTER HOUSE	211 2ND STREET NW ROCHESTER, MN 55901

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL303292128C/#HL303296444M On August 29, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 255 residents receiving services under the provider's Assisted Living license. The following correction order is issued/orders are issued for #HL303292128C/#HL303296444M, tag identification 0250, 0510, 0620, 0630, 1620, 1640, 1650, 2360, and 3000.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL	

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0 000	Continued From page 1	0 000	ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
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; (9) interferes with or impedes a representative of	0 250		

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0 250	Continued From page 2 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 with records reviewed. This had the potential to affect all 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, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that	0 250	Assisted Living Provider 144G. 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."	

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0 250	Continued From page 3 has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 29, 2023, at 1:00 p.m., clinical nurse supervisor (CNS)-A stated the licensee was 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 five and six 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. - Reporting of Maltreatment of Vulnerable Adults.	0 250	Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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0 250	Continued From page 4 - 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 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	0 250		

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0 250	Continued From page 5 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. honest - 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 authorized agent on May 26, 2021. The licensee had an assisted living license issued on August 1, 2022, with an expiration date of October 31, 2023. The licensee failed to ensure the following policies and procedures were developed and/or implemented: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) handling complaints regarding staff or services provided by staff; (3) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (5) infection control practices;	0 250		

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0 250	Continued From page 6 On September 7, 2023 at 1:30 p.m., CNS-A confirmed the licensee provided assisted living services but needed to continue to work with team members to educate on corresponding policies and procedures, as required. As a result of this survey, the following orders were issued 0250, 0510, 0620, 00630, 1620, 1640, 1650, 2360, and 3000 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		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and 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 and interview, the licensee	0 510		

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0 510	Continued From page 7 failed to establish and maintain an infection control program that complied with accepted health care, medical, and nursing standards for infection control. The deficient practice had the potential to affect residents, employees, 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, 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 potential to affect a large portion or all of the residents). The findings include: The Center's Disease Control, COVID-19 Source Control, Personal Protective Equipment (PPE) and Testing Grid, dated August 21, 2023, identified a resident with a positive COVID-19 test should mask if able. Staff should wear a respirator, eye protection, isolation gown and gloves. The resident should be place in transmission-based precautions and isolated to the room with the door closed. On August 29, 2023, at 12:50 p.m., during the entrance conference clinical nurse supervisor (CNS)-A stated there were three residents positive for COVID-19 residing in supportive living (a separate section of the larger facility). During observation on August 29, 2023, at 1:47 p.m., an isolation cart was located outside of R1'S and R14's room. The signage outside of the rooms indicated droplet precautions and directed staff should wash hands, wear a mask, and eye	0 510		

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0 510	Continued From page 8 protection. During observation on August 29, 2023, at 4:34 p.m., unlicensed personnel (ULP)-G walked into R14's room with a mask on, but no eye protection or gown. During observation on August 29, 2023, 5:01 p.m., ULP-H walked out of R1's room with a mask, and a respirator over her mask, and did not perform hand hygiene. ULP-H then removed the respirator and again did not perform hand hygiene. On August 29, 2023, at 4:47 p.m., ULP-E stated staff were informed yesterday they did not need to wear a gown since the guidance changed to droplet precautions. On August 29, 2023, at 4:53 p.m., registered nurse (RN)-C stated in a COVID positive room staff should perform hand hygiene, wear gloves, goggles, and a gown until the resident tests negative. RN-C stated staff should be wearing gowns in a COVID positive room. On August 29, 2023, at 5:40 p.m., CNS-A stated the facility follows hospital guidance for COVID-19. CNS-A stated staff should perform hand hygiene in and out of any room. The licensee's infection control program and infection preventionist policy dated March 13, 2023, indicated The CDC and Prevention's guidelines were used for prevention of infection with staff and with patient care, cleaning, disinfecting and storage of equipment and supplies, and drug and medication preparation and administration.	0 510		

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	30329	A. BUILDING: _____ B. WING _____	C 08/29/2023

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0 510	Continued From page 9 No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 620 SS=F	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: (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	0 620		

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0 620	Continued From page 10 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 licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment for two of two residents (R1, R2) reviewed for abuse. 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	0 620		

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0 620	Continued From page 11 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: An email sent to registered nurse (RN)-D on April 20, 2023 at 1:34 p.m., indicated ULP-I, "is not gentle with the residents and he has come off very aggressive by holding them way to tight/holding them down while performing cares, almost hurting them it seems, and has made me very uncomfortable." Facility documents did not include follow up related to the email sent on April 20, 2023. There was not documentation of interviews with other staff or residents regarding the allegation. An email sent to RN-D on April 25, 2023, at 10:14 p.m., indicated, ULP-I, "was very rough with [R2] when doing cares." An email sent to RN-D by CNS-A, on April 26, 2023, at 5:25 p.m., indicated CNS-A asked ULP-I how interactions with R2 were going? ULP-I responded sometimes better than others. CNS-A shared that another staff member expressed concerns that ULP-I was rough with R2. CNS-A told ULP-I any rough or threatening behavior could not be tolerated and ULP-I agreed. Facility documents did not include any other information regarding follow up on the email sent on April 25, 2023. There was not documentation of interviews with other staff or residents regarding the allegation. The facility's staffing schedule indicated ULP-I worked as scheduled for the week of April 20-26,	0 620		

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0 620	Continued From page 12 2023. R2 R2 admitted with diagnoses including Alzheimer's, depression and a history of a stroke. R2's unsigned service plan dated May 25, 22, indicated R2 required assistance with medication administration, bathing, dressing, grooming, toileting, transferring and bed mobility. R2's 90 day assessment dated August 24, 2023, indicated R2 anxiousness or mood changes were severe and required staff intervention. The assessment also indicated the resident was occasionally combative and had cognitive impairment. R2's IAPP dated August 11, 2023, indicated R2's vulnerabilities included: orientation to time, place, and person; ability to give accurate information consistently; and ability to report abuse or neglect. The interventions included for staff to provide reorientation as needed, monitor and report any signs or symptoms of abuse to appropriate party. The report also indicated the resident became confused at times and could become physically violent when confused. The assessment did not include susceptibility of abuse by others. The licensee's staffing schedule identified ULP-I worked on the same unit where R1 and R2 resided. ULP-I worked 2:00 p.m., to 10:30 p.m. on April 20, 21, 24, 25, and 26, 2023. The licensee's internal investigation dated April 28, 2023, included an interview with ULP-F. ULP-F stated ULP-I always made her feel	0 620		

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0 620	Continued From page 13 uncomfortable on how ULP-I treated the residents and appeared to take his anger out on the residents. ULP-F stated ULP-I would hold residents extremely tight where you could tell he was hurting the residents. ULP-F also noticed this with another resident too not just R2. ULP-F also stated, "an incident I don't want to have to experience is a couple weeks ago [ULP-I] was performing a care on [R2], and he was holding him excessively tight while [R2] was upside down almost falling right off his bed. [R2] was obviously in pain, screaming, breathing heavily, and turning purple. I told him to stop and he just said, oh he is fine." ULP-I also stated that more recently ULP-I held R2 down on the toilet and aggressively threw his hand down on the toilet seat handlebars, squeezing R2's hand super tight. The internal investigation also included an interview with ULP-E that indicated ULP-E the allegations against ULP-I should be looked into. ULP-E stated he saw ULP-I being rough with a resident. ULP-E described ULP-I was helping R2 with toileting and ULP-I grabbed R2's arms and slung them down on the handlebars. ULP-E stated ULP-I gripped his arms so tight that he thought R2 would have bruising. The licensee reported the incident to MAARC on April 28, 2023, eight days after the original abuse allegation was reported via email to RN-D. There was no documentation during the eight days the licensee conducted interviews with other staff and residents regarding the allegations. R1 R1 admitted with diagnoses including dementia and left sided hemiplegia (paralysis of one side of the body). R1's unsigned service plan dated January 31, 2023, indicated R1 required	0 620		

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0 620	Continued From page 14 assistance with medication administration, dressing, grooming, bathing, bed mobility, toileting, and transferring. R1's 90 day assessment dated July 17, 2023, indicated R1 was not combative, did not have delusions or hallucinations, and did not have exit seeking behavior or refuse care. The assessment also indicated R1 was cognitively impaired. R1's individual abuse prevention plan (IAPP) dated August 11, 2023, identified R1 had vulnerabilities including: orientation to time, place, and person; ability to give accurate information consistently; anxiety and depression; and ability to report abuse or neglect. The interventions included staff provide reorientation as needed, monitor and report any signs or symptoms of abuse to appropriate party. The report also indicated the resident does became confused at time and does become physically violent when confused. The assessment did not include susceptibility of abuse by others or interventions to prevent abuse from occurring. Facility documents dated May 4, 2023, indicated R1's family member indicated R1 stated a caregiver treated him roughly. R1 stated the caregiver would come in and throw him around "like a piece of furniture." R1 stated he would yell at the caregiver telling him that's not appropriate, stop touching me like that. R1 stated the caregiver acted like he was irrelevant and didn't matter. The investigation document indicated ULP-I worked during the time frame R1 described and the description R1 gave, matched the description of ULP-I. R1's clinic records indicated: - On May 18, 2023, indicated R1 had been	0 620		

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0 620	Continued From page 15 mirtazapine (antidepressant) for two weeks and recommended non-pharmalogical interventions and familiar, consistent caregivers. The note indicated if there was not improvement the antidepressant could be increased. - On May 24, 2023, indicated an increase in mirtazapine from 7.5 milligrams (mg) to 15 mg. - On May 30, 2023, indicated a dementia action plan which included if there was not an improvement in agitation in the evening hours could consider stopping mirtazapine and adding another antidepressant. The notes also indicated staff may consider a move off of the unit if concerns the physical unit is a trauma reminder. On August 29, 2023, at 3:14 p.m., RN-C stated an email was sent to her supervisor regarding the concerns about ULP-I's rough care on April 25, 2023. RN-C stated she emailed the concern because her supervisor was not working at the time. RN-C stated she did not ask ULP-F (who reported the concern) any follow up questions or interview any other residents or staff because it was confidential. RN-C stated the next day she went to follow up with her supervisor. RN-C stated there was no training regarding vulnerable adults following this incident. On September 6, 2023, at 10:00 a.m., RN-D stated as soon as there is a suspicion of maltreatment it should be reported immediately and a report to the state agency should be completed within 24 hours. RN-D stated the internal investigation should have begun immediately and the alleged perpetrator should not have been allowed to work until the investigation was conducted and completed. RN-D stated she did not interview any other staff	0 620		

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0 620	Continued From page 16 or residents regarding the AP's conduct, RN-D did not know why the suspected maltreatment was not reported within 24 hours. RN-D stated the charge nurse who took the initial concern should have started the internal investigation immediately. RN-D also stated since that incident R1 had become more aggressive and paranoid during the evening shift which was not present prior to this incident. RN-D stated R1 also had to be started on an antidepressant following this incident. RN-D stated this incident really took a toll on R1 and now R1 did not trust caregivers. On September 7, 2023, at 1:30 p.m., CNS-A did not recall if she was aware of the email sent on April 20, 2023, but stated if there was suspected maltreatment of a resident the staff person should be removed from resident care until an investigation is completed. CNS-A stated an internal investigation should have began immediately including interviewing all other residents and staff on that unit. CNS-A stated the suspected maltreatment should have been reported to the state agency within 24 hours. CNS-A stated an email would not be an acceptable form of communication regarding reporting maltreatment to a supervisor. The licensee's Vulnerable Adult Reporting and Investigation policy dated March 28, 2023, indicated any staff person who witnesses or suspects any form of resident maltreatment including self-neglect or resident to resident abuse must report the incident immediately to the RN in charge and the Director or Health Services, or designee. An employee who has been accused of resident abuse is placed on leave with no resident until the investigation is complete. The nurse in charge or Director of Heath Services, or designee must report to the	0 620		

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0 620	Continued From page 17 Minnesota Adult Abuse Reporting Center (MAARC). The report must be completed immediately within 24 hours of the incident's discovery. The policy also indicated an internal investigation will be completed and steps take to keep the victim of maltreatment and other resident safe from additional threats the perpetrator may pose. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
0 630 SS=I	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 an individual abuse prevention plan (IAPP) with the required content including the person's susceptibility to abuse by another individual, the person's risk of abusing others, statements of the specific measure to be taken to minimize the risk	0 630		

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0 630	Continued From page 18 of abuse and include self-abuse for two of two residents (R1, R2) with records reviewed. In addition, the licensee failed to ensure the assessment were completed by a registered nurse (RN). This had the potential to affect all 255 residents as the licensee's IAPP did not include required components. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: An email sent to registered nurse (RN)-D on April 20, 2023 at 1:34 p.m., from an unlicensed staff indicated ULP-I, "is not gentle with the residents and he has come off very aggressive by holding them way to tight/holding them down while performing cares, almost hurting them it seems, and has made me very uncomfortable." Facility documents did not include follow up related to the email sent on April 20, 2023. There was not documentation of interviews with other staff or residents regarding the allegation. An email sent to RN-D on April 25, 2023, at 10:14 p.m., indicated, ULP-I, "was very rough with [R2] when doing cares." An email sent to RN-D by CNS-A on April 26, 2023, at 5:25 p.m., indicated CNS-A asked ULP-I how interactions with R2 was going? ULP-I	0 630		

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0 630	Continued From page 19 responded sometimes better than others. CNS-A shared that another staff member expressed concerns that ULP-I was rough with R2. CNS-A told ULP-I any rough or threatening behavior could not be tolerated and ULP-I agreed. Facility documents did not include any other information including follow up on the email sent on April 25, 2023. There was not documentation of interviews with other staff or residents regarding the allegation. The licensee's staffing schedule identified ULP-I on the same unit where R1 and R2 resided. ULP-I worked 2:00 p.m., to 10:30 p.m. on April 20, 21, 24, 25, and 26. The licensee's internal investigation dated April 28, 2023, included an interview with ULP-F. ULP-F stated ULP-I always made her feel uncomfortable on how ULP-I treated the residents and appeared to take his anger out on the residents. ULP-F stated ULP-I would hold residents extremely tight where you could tell he was hurting the residents. ULP-F also noticed this with another resident too not just R2. ULP-F also stated, "an incident I don't want to have to experience is a couple weeks ago [ULP-I] was performing a care on [R2], and he was holding him excessively tight while [R2] was upside down almost falling right off his bed. [R2] was obviously in pain, screaming, breathing heavily, and turning purple. I told him to stop and he just said, oh he is fine." ULP-I also stated that more recently ULP-I held R2 down on the toilet and aggressively threw his hand down on the toilet seat handlebars, squeezing R2's hand super tight. The internal investigation also included an interview with ULP-E that indicated ULP-E the	0 630		

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0 630	Continued From page 20 allegations against ULP-I should be looked into. ULP-E stated he saw ULP-I being rough with a resident. ULP-E described ULP-I was helping R2 with toileting and ULP-I grabbed R2's arms and slung them down on the handlebars. ULP-E stated ULP-I gripped his arms so tight that he thought R2 would have bruising. The licensee reported the incident to MAARC on April 28, 2023, eight days after the original abuse allegation. There was no documentation during the eight days the licensee conducted interviews with other staff and residents regarding the allegations. R2 R2 admitted with diagnoses including Alzheimer's, depression and a history of a stroke. R2's unsigned service plan dated May 25, 22, indicated R2 required assistance with medication administration, bathing, dressing, grooming, toileting, transferring and bed mobility. R2's 90 day assessment dated August 24, 2023, indicated resident anxiousness or mood changes are severe and require staff intervention. The assessment also indicated the resident was occasionally combative and had cognitive impairment. R2's IAPPs dated May 21, 2023, and July 3, 2023, were completed by a licensed practical nurse (LPN) and did not include susceptibility of abuse by others or interventions to prevent the vulnerability. The assessments did not include information regarding the recent allegations or attempts to prevent further abuse.	0 630		

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0 630	Continued From page 21 R2's IAPP dated August 11, 2023, indicated R2's vulnerabilities included: orientation to time, place, and person; ability to give accurate information consistently; and ability to report abuse or neglect. The interventions included staff provide reorientation as needed, monitor and report any signs or symptoms of abuse to appropriate party. The report also indicated the resident does became confused at time and does become physically violent when confused. The assessment did not include susceptibility of abuse by others or interventions to prevent vulnerability. R1 R1 admitted with diagnoses including dementia and left sided hemiplegia (paralysis of one side of the body). R1's unsigned service plan dated January 31, 2023, indicated R1 required assistance with medication administration, dressing, grooming, bathing, bed mobility, toileting, and transferring. Facility internal investigation documents dated May 4, 2023, indicated R1's family member interview indicated a caregiver treated R1 roughly. R1 stated the caregiver would come in and throw him around "like a piece of furniture." R1 stated he would yell at the caregiver telling him that's not appropriate, stop touching me like that. R1 stated the caregiver acted like he was irrelevant and didn't matter. The investigation document indicated ULP-I worked during the time frame R1 described and the description R1 gave matched the description of ULP-I. R1's clinic records indicated: - On May 18, 2023, indicated R1 had been mirtazapine (antidepressant) for two weeks and	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30329	A. BUILDING: _____ B. WING _____	C 08/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARTER HOUSE	211 2ND STREET NW ROCHESTER, MN 55901

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0 630	Continued From page 22 recommended non-pharmacological interventions and familiar, consistent caregivers. The note indicated if there was not improvement the antidepressant could be increased. - On May 24, 2023, indicated an increase in mirtazapine from 7.5 milligrams (mg) to 15 mg. - On May 30, 2023, indicated a dementia action plan which included if there was not an improvement in agitation in the evening hours could consider stopping mirtazapine and adding another antidepressant. The notes also indicated staff may consider a move off of the unit if concerns the physical unit is a trauma reminder. R1's 90 day assessment dated July 17, 2023, indicated R1 was not combative, did not have delusions or hallucinations, and did not have exit seeking behavior or refuse care. The assessment also indicated R1 was cognitively impaired. R1's IAPP dated July 17, 2023, completed by a LPN did not include susceptibility of abuse by others or interventions to prevent the vulnerability. The assessments did not include information regarding the recent allegations or attempts to prevent further abuse. R1's IAPP dated August 11, 2023, identified R1 had vulnerabilities including: orientation to time, place, and person; ability to give accurate information consistently; anxiety and depression; and ability to report abuse or neglect. The interventions included staff provide reorientation as needed, monitor and report any signs or symptoms of abuse to appropriate party. The report also indicated the resident does became confused at time and does become physically violent when confused. The assessment did not	0 630		

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0 630	Continued From page 23 include susceptibility of abuse by others or interventions to prevent abuse from occurring. On September 6, 2023, at 10:00 a.m., RN-D stated R1 ahad to be started on an antidepressant following the incident with ULP-I. RN-D stated this incident really took a toll on R1 and now R1 did not trust caregivers. RN-D stated an IAPP should have been completed after the incident for R1 and R2. RN-D stated she was not aware of the required components for the IAPP. On September 7, 2023, at 1:30 p.m., Clinical Nurse Supervisor (CNS)-A indicated all statutes should be followed regarding the IAPP. CNS-A also stated interventions should be included for all areas of vulnerability. The licensee's Vulnerable Adult Reporting and Investigation policy dated March 28, 2023, did not include information related to the IAPP. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision	01620		

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01620	Continued From page 24 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment after a change of condition for one of one resident (R1). 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: R1 R1 admitted with diagnoses including dementia and left sided hemiplegia (paralysis of one side of the body).	01620		

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01620	Continued From page 25 R1's unsigned service plan dated January 31, 2023, indicated R1 required assistance with medication administration, dressing, grooming, bathing, bed mobility, toileting, and transferring. Facility internal investigation documents dated May 4, 2023, indicated R1's family member indicated R1 stated a caregiver treated him roughly. R1 stated the caregiver would come in and throw him around "like a piece of furniture." R1 stated he would yell at the caregiver telling him that's not appropriate, stop touching me like that. R1 stated the caregiver acted like he was irrelevant and didn't matter. The investigation document indicated ULP-I worked during the time frame R1 described and the description R1 gave matched the description of ULP-I. R1's clinic records indicated: - On May 18, 2023, indicated R1 had been mirtazapine (antidepressant) for two weeks and recommended non-pharmalogical interventions and familiar, consistent caregivers. The note indicated if there was not improvement the antidepressant could be increased. - On May 24, 2023, indicated an increase in mirtazapine from 7.5 milligrams (mg) to 15 mg. - On May 30, 2023, indicated a dementia action plan which included if there was not an improvement in agitation in the evening hours could consider stopping mirtazapine and adding another antidepressant. The notes also indicated staff may consider a move off of the unit if concerns the physical unit is a trauma reminder. R1's 90 day assessment dated July 17, 2023, indicated R1 was not combative, did not have delusions or hallucinations, and did not have exit	01620		

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01620	Continued From page 26 seeking behavior or refuse care. The assessment also indicated R1 was cognitively impaired. R1's individual abuse prevention plan (IAPP) dated August 11, 2023, identified R1 had vulnerabilities including: orientation to time, place, and person; ability to give accurate information consistently; anxiety and depression; and ability to report abuse or neglect. The interventions included staff provide reorientation as needed, monitor and report any signs or symptoms of abuse to appropriate party. The report also indicated the resident does became confused at time and does become physically violent when confused. The assessment did not include susceptibility of abuse by others or interventions to prevent abuse from occurring. On August 29, 2023, at 3:14 p.m., RN-C stated an email was sent to her supervisor regarding the concerns about rough care on April 25, 2023. RN-C stated she emailed the concern because her supervisor was not working at the time. RN-C stated she did not ask ULP-F any follow up questions or interview any other residents or staff because it was confidential. RN-C stated the next day she went to follow up with her supervisor. RN-C stated there was no training regarding vulnerable adults following this incident. On September 6, 2023, at 10:00 a.m., RN-D stated since that incident R1 had become more aggressive and paranoid during the evening shift which was not present prior to this incident. RN-D stated R1 also had to be started on an antidepressant following this incident. RN-D stated this incident really took a toll on R1 and now R1 did not trust caregivers. RN-D stated an change of condition should have been completed	01620		

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01620	Continued From page 27 at this time. On September 7, 2023, at 1:30 p.m., Clinical Nurse Supervisor (CNS)-A stated an assessment should be completed if there is a change in condition. The licensee's Admission Process for Assisted Living policy dated July 14, 2021, indicated the RN completed a functional assessment of the resident's physical and cognitive needs to determine care and services recommended. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
01640 SS=F	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,	01640		

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01640	Continued From page 28 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 observation, interview, and record review, the licensee failed to ensure the service plan included a signature or other authentication by the resident or resident representative and the facility, to document agreement on the services to be provided for two of two residents (R1, R2). 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: R1 R1 admitted with diagnoses including dementia and left sided hemiplegia (paralysis of one side of the body). R1's unsigned service plan dated January 31, 2023, indicated R1 required assistance with medication administration, dressing, grooming, bathing, bed mobility, toileting, and transferring. R1's service plan did not include the frequency of each services, identification of staff or categories of staff who will provide the services; the schedule and methods of monitoring assessments of the resident; and the schedule	01640		

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01640	Continued From page 29 and methods of monitoring staff providing services. R2 R2 admitted with diagnoses including Alzheimer's, depression and a history of a stroke. R2's unsigned service plan dated May 25, 22, indicated R2 required assistance with medication administration, bathing, dressing, grooming, toileting, transferring and bed mobility. R2's service plan did not include the frequency of each services, identification of staff or categories of staff who will provide the services; the schedule and methods of monitoring assessments of the resident; and the schedule and methods of monitoring staff providing services. On September 6, 2023, at 10:00 a.m., registered nurse (RN)-D stated she was not aware of all of the required components of a service plan and was not aware all services required documentation. RN-D stated the service plan for both residents should have been signed. RN-D was not aware if the service plan required a signature with revisions. RN-D stated another RN completed the admission paperwork and pieces were missing upon admission. RN-D could not verify all residents service plans were signed upon admission and revisions. On September 7, 2023, at 1:30 p.m., clinical nurse supervisor (CNS)-A stated the service plan should meet all required components and be signed upon admission and with revisions. CNS-A also stated documentation was required for all services provided.	01640		

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01640	Continued From page 30 The licensee's Assisted living contents of service plan policy dated March 10, 2023, indicated the service plan contained all required information and is signed by the RN and by the resident and/or representative. The service plan established after completion of full individualized initial assessment and each subsequent reassessment includes: a description of the assisted living services, including nursing and medication management services; treatments and or therapy service; to be provided by our agency; the frequency of each service; according to the resident's current assessment and preferences; the fees for assisted living services; identifications of the expected source of payment is included in the service agreement; the identification of the staff or categories of staff that will provide services; the schedule and methods of monitoring reviews or re-assessments of the resident; the frequency of supervision of staff providing services and the identification of the supervisors who will be providing the supervision; and a contingency plan. No further information was provided. TIME PERIOD TO CORRECT- Twenty-one (21) days.	01640		
01650 SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services;	01650		

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01650	Continued From page 31 (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included all required content for two of two residents (R1, R2). 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:	01650		

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01650	Continued From page 32 R1 R1 admitted with diagnoses including dementia and left sided hemiplegia (paralysis of one side of the body). R1's unsigned service plan dated January 31, 2023, indicated R1 required assistance with medication administration, dressing, grooming, bathing, bed mobility, toileting, and transferring. R1's service plan did not include the frequency of each services, identification of staff or categories of staff who will provide the services; the schedule and methods of monitoring assessments of the resident; and the schedule and methods of monitoring staff providing services. R2 R2 admitted with diagnoses including Alzheimer's, depression and a history of a stroke. R2's unsigned service plan dated May 25, 22, indicated R2 required assistance with medication administration, bathing, dressing, grooming, toileting, transferring and bed mobility. R2's service plan did not include the frequency of each services, identification of staff or categories of staff who will provide the services; the schedule and methods of monitoring assessments of the resident; and the schedule and methods of monitoring staff providing services. On September 6, 2023, at 10:00 a.m., registered nurse (RN)-D stated she was not aware of all of the required components of a service plan and was not aware all services provided needed to be	01650		

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01650	Continued From page 33 documented. RN-D stated the service plan for both residents should have been signed. RN-D was not aware if the service plan required a signature with revisions. RN-D stated another RN completed the admission paperwork and pieces were missing upon admission. On September 7, 2023, at 1:30 p.m., clinical nurse supervisor (CNS)-A stated the service plan should meet all required components and be signed upon admission and with revisions. CNS-A also stated documentation was required for all services provided. The licensee's Assisted living contents of service plan policy dated March 10, 2023, indicated the service plan contained all required information and is signed by the RN and by the resident and/or representative. The service plan established after completion of full individualized initial assessment and each subsequent reassessment includes: a description of the assisted living services, including nursing and medication management services; treatments and or therapy service; to be provided by our agency; the frequency of each service; according to the resident's current assessment and preferences; the fees for assisted living services; identifications of the expected source of payment is included in the service agreement; the identification of the staff or categories of staff that will provide services; the schedule and methods of monitoring reviews or re-assessments of the resident; the frequency of supervision of staff providing services and the identification of the supervisors who will be providing the supervision; and a contingency plan. No further information was provided.	01650		

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01650	Continued From page 34 TIME PERIOD TO CORRECT- Twenty-one (21) days.	01650		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one residents reviewed (R1) and R2 were free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No plan of correction is required for this tag.	