Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306015963M
Compliance #: HL306014768C

Date Concluded: June 5, 2023

Name, Address, and County of Licensee Investigated:
Summit Ridge Place
1325 Summit Ave N
Sauk Rapids, MN 56379
Benton County

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

Evaluator's Name: Barbara Axness, 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 neglected the resident when multiple resident-to-resident and resident-to-staff altercations occurred and the facility failed assess and identify new vulnerabilities, susceptibilities to abuse, and/or new risks of harming others. No new interventions were implemented, and existing interventions were not evaluated.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to provide supervision to protect the resident's health and safety following multiple resident-to-resident and resident-to-staff altercations. The facility was aware the resident exhibited aggressive behaviors and failed to assess, identify, and implement interventions to mitigate future incidents. The facility failed to ensure staff received dementia training and failed to educate staff on managing the resident's behaviors.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted law enforcement. The investigation included review of facility records and hospital records. At the time of the onsite visit, the investigator observed direct care and medication administration at the facility.

The resident resided in an assisted living with dementia care facility. The resident's diagnoses included vascular dementia with behavior disturbance (a type of dementia caused by brain damage from impaired blood flow to the brain that causes difficulty with reasoning, planning, judgment, memory, and other thought processes) and depression. The resident did not have a current service plan. The resident did not have an Individual Abuse Prevention Plan and no assessments had been completed.

The resident's record contained 12 incident reports over a period of seven weeks. The incident reports detailed resident-to-resident and resident-to-staff altercations where the resident exhibited behaviors including hitting another resident in the face, pushing another resident causing the other resident to fall on the floor, yelling and swearing at residents and staff, grabbing, hitting, punching, and scratching staff, and pinching a staff member so hard it drew blood. In addition, the incident reports detailed several episodes of sexual behaviors including rubbing another resident's hand on her chest, "rubbing on another male resident and inappropriately touching him", crawling into bed with another resident and "rolling on top of her", and entering other resident rooms after being asked repeatedly to leave. The incident reports did not identify new interventions or attempts to mitigate further occurrences. No assessments were completed after any of the 12 incidents, and no measures were taken to ensure the safety of the resident or other residents living in the facility. An Individual Abuse Prevention Plan was never developed for the resident and staff were not provided further direction, education, or training on how to manage the resident's behavior.

One incident report indicated police were called after the resident became physically violent towards a staff member during a shower. The resident was sent to the hospital after the altercation.

Hospital records indicated the resident was evaluated by psychiatry and medication changes were made. Inpatient psychiatry did not feel the resident was appropriate for admission and recommended the resident return to the facility.

The resident's record contained a partially completed change of condition reassessment, completed remotely by a nurse, after the resident returned from the hospital. The partially completed assessment indicated the resident did not have psychological issues, behaviors, or cognitive issues. The resident's behaviors were not identified on the assessment and the only behavioral symptom noted was "wandering." No new interventions were implemented to ensure the safety of the resident or other residents.

During investigative interviews, multiple unlicensed personnel (ULP) stated the resident had frequent, almost daily, resident-to-resident and resident-to-staff altercations which included physical violence, verbal aggression, and sexual behaviors. Several ULP stated other residents and some staff members were scared of the resident. ULP reported they were directed to call 911 as an intervention and had called 911 on two occasions, including when the resident had COVID-19 and wouldn't stay in her room. One ULP stated police told the staff "there was nothing they could do" because the staff worked on a memory care unit. Another intervention ULP were directed to use was to redirect the resident or call family to come in and sit with the resident. ULP said redirection upset the resident, she would strike out at staff and it wasn't usually successful. Several ULP reported the resident was observed providing oral sex to another resident but "family was notified, and everyone was ok with it" so no new interventions were implemented. However, ULP indicated the sexual behaviors directed towards other residents was not wanted and residents would yell for her to stop. All ULP interviewed stated they were not provided education or training on how to manage the resident's behaviors and did not recall receiving dementia training.

During an interview, a former registered nurse (RN) stated she quit after a few weeks as she was only provided minimal orientation.

During an interview, the current RN stated she did not know why interventions were not implemented or why assessments were not completed for the resident.

During an interview, the regional director of operations (RDO) stated their on-call nurse completed the change of condition assessment and the on-call nurse was not always close to the facility, so it had to be done remotely. The RDO identified challenging behaviors the facility could manage were behaviors that included altercations with staff "to a degree" of hitting, spitting, and verbal behaviors, and felt the facility did a good job of training staff to handle those behaviors. The RDO stated they provided staff with a printed packet with slides about dementia care to take home and review on their own. The RDO wasn't sure how many hours of training were included or how long it took staff to review the printed information. The RDO stated the facility did not receive any resident records with the change of ownership that occurred a few months prior but was not sure why assessments or service plans were not completed after the ownership change. The RDO stated she was not involved with nursing, so she was not aware records were missing so much content.

During an interview, the resident's family member stated the resident's behaviors seemed to accelerate after being confined to her room. The family member said, "9 times out of 10, they were restricting her to her room, and she had enough and struck out." The family member stated the facility didn't offer much for activities and staff did not seem to know how to deal with dementia and behaviors. The family member stated staff didn't know how to provide redirection, so she tried to help them learn different tactics. The family member indicated if the facility staff contacted them, they frequently came over to help with the resident and they were usually able to calm her down by walking around with her. The family member said she was

updated on the resident's sexual behaviors, which were out of character for the resident. The family member indicated they had heard those types of behaviors were common in the type of dementia the resident had but didn't know what other interventions the facility used besides redirection.

The licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) indicated the facility was prepared to manage challenging behaviors and was able to provide one-to-one staffing for special circumstances.

The facility did not have employee files on several employees. Available employee files reviewed, indicated required hours of dementia training were not completed.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means:
(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.
(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Vulnerable Adult interviewed: No, unable
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
No action taken.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

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

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Benton County Attorney
Sauk Rapids City Attorney
Sauk Rapids Police Department
Minnesota Board of Executives for Long Term Services and Supports
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30601	A. BUILDING: _____ B. WING _____	C 03/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT RIDGE PLACE	1325 SUMMIT AVENUE NORTH SAUK RAPIDS, MN 56379

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0 000	Initial Comments ******ATTENTION****** 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: #HL306015963M/#HL306014768C and #HL306015964M/#HL306015070C On March 21, 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 13 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL306015963M/#HL306014768C and #HL306015964M/#HL306015070C, tag identification 0430, 0620, 0630, 1060, 1070, 1540, 2110, 2320, 2360, and 3000.	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.	
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to	0 430		

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0 430	Continued From page 1 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 licensee failed to ensure the uniform checklist disclosure of services (UDALSA) accurately reflected services provided by the licensee. This had the potential to affect all residents. 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 the potential to affect a large portion or all the residents). The findings include: The licensee's Uniform Disclosure of Assisted	0 430		

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0 430	Continued From page 2 Living Services and Amenities (UDALSA), last updated March 24, 2022, indicated on page 3 under Dementia Care Services Available it was indicated that the facility was prepared to manage challenging behaviors. On page 15, Section 9: Staffing indicated the facility was able to provide one-to-one staffing for special circumstances. No comments were listed to indicate what the special circumstances would be. In addition, page 16 of the UDALSA indicated there was a registered nurse (RN) on-site full time. On March 21, 2023, at 9:20 a.m., unlicensed personnel (ULP)-J stated the facility RN was only onsite one or two days per week, but if they needed anything or had questions, they could call her and she would answer. On March 21, 2023, at 9:30 a.m., licensed assisted living director in residence (LALDIR)-B confirmed the facility RN was on site Monday and Fridays and on call otherwise. LALDIR-B stated the RN works at a sister facility (approximately 65 miles away) on the days she is not at the facility. LALDIR-B stated the RN is always on call and works full time for the company but is not full time at the facility. On March 21, 2023, at 11:15 a.m., regional director of operations (RDO)-A stated she was not sure why the UDALSA indicated they provided one-to-one staffing for special circumstances. RDO-A stated, "That's a head stumper, we were told we are not able to do one-to-one staffing," and confirmed that was not accurate on the UDALSA. RDO-A stated the challenging behaviors the facility was able to manage would be evaluated as incidents arise but they would not be able to manage behaviors	0 430		

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0 430	Continued From page 3 where there's physical harm to others. RDO-A stated they would be able to manage behaviors that included altercations with staff "to a degree," hitting, spitting, and verbal behaviors and the facility had done a good job of training staff to handle those behaviors. RDO-A confirmed there is not a full time RN on site. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430		
0 620 SS=F	144G.42 Subd. 6 (a) 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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to submit a report timely to the Minnesota Adult Abuse Reporting Center (MAARC) for two of two residents (R1, R2) reviewed forresident to resident altercations. 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).	0 620		

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0 620	Continued From page 4 The findings include: R1 R1's diagnoses included Wernicke's encephalopathy (a brain disorder that can cause confusion, disorientation, and lack of muscle coordination), alcohol induced dementia, and depression. The resident admitted to the facility on December 1, 2020, and began receiving services under the current licensee after a change of ownership occurred on June 1, 2022. The resident's record lacked evidence of a current service plan. The resident's record lacked evidence of any recent assessments. A progress note entered on August 11, 2022, indicated a 90 day assessment had been completed with no concerns noted. The resident was noted to be jovial and cooperative. The resident's record lacked evidence of a current Individual Abuse Prevention Plan (IAPP). Progress notes from August 1, 2022, through the resident's September 22, 2022, discharge were requested. Progress notes provided began on September 7, 2022 and included the following notes: -September 7, 2022, at 8:01 a.m., a behavior note entered by registered nurse (RN)-C noted "Resident to staff altercation with aggressive behavior. Per RA [resident assistant] staff, resident asked for ice, RAs saw cup she had was very dirty with brown water, so staff offered to get her a clean cup to fill and resident attempted to	0 620		

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0 620	Continued From page 5 bite staff. Resident got in RA's face, began name calling, hitting, and pushing. Per RA staff, resident was using very vulgar language such as "shove a banana up your cunt." "Go fuck yourself." "I hope you get raped and like it." Staff choose (sic) to walk away in another direction until resident stopped following them. Blue stone physicians updated." -September 8, 2022, at 4:01 p.m., a behavior note entered by on call RN-I noted "Resident was attempting to force feed another resident a banana at the table. Staff asked her to not feed other residents. [R1] became agitated and started to take items off the med cart and push things over, she threw the banana peel at the staff hitting her in the face and chest. The staff bent over to pick up the banana peel. As soon as she stood up the resident ran up behind the staff and struck her in the back of the head. Staff walked away from the resident and the resident angrily went to her apartment, slammed the door and locked it. The staff reported the incident to the PCP [primary care physician] and verbal orders received to call EMS [emergency medical services]. Resident was transported to ER [emergency room] for psychiatric evaluation of her behaviors...Families (sic) current wishes are that the resident doesn't return to the community as she is a danger to other vulnerable adults. This was relayed to PCP who is working with ER LSW [licensed social worker] to find more appropriate placement. No new interventions were implemented and a MAARC report was not submitted. -September 13, 2022, at 3:00 a.m., a behavior noted entered by RN-C noted, "Resident discharged from the [hospital] with diagnosis of aggressive behaviors...Guardian is requesting	0 620		

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0 620	Continued From page 6 that resident should remain in her room for meals and supervised when out in the community with other residents as guardian is concerned for the well-being of staff and residents within the community." No new interventions were implemented and a MAARC report was not submitted. -September 22, 2022, at 9:05 a.m., a progress note entered by RN-C indicated the resident discharged and transferred to a different senior living community. R1s record contained a partially completed change of condition assessment from September 13, 2022, the day she returned from the hospital. The assessment was completed remotely and indicated R1 had a mood disorder and will hit, swear, bite, and name call. The resident was noted to have behaviors with a history of harming others, verbally and physically abusive to staff, and demonstrates anxious/paranoid or suspicious behavior. The resident was noted to be alert and responsive, oriented to person, place, time, and situation and had no apparent memory loss and could recall or retain information like recent events and was able to make safe judgments and function appropriately in social situations. The assessment further indicated the resident had behavioral symptoms including verbal and physical aggression and redirection was effective. The resident's record contained a care plan initiated on September 13, 2022. The section listing interventions for the resident's behaviors was blank, with no interventions listed. The care plan indicated the resident did not have memory loss and could recall and retain information.	0 620		

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0 620	Continued From page 7 On March 20, 2023, at 8:50 a.m., unlicensed personnel (ULP)-G stated she worked frequently with R1 and the resident had behaviors just about daily and was very physically abusive towards other residents and staff. ULP-G stated the only interventions she was aware of was redirecting the resident or calling her family to come in and sit with her. ULP-G stated she had personally witnessed R1 push other residents on at least two occasions. ULP-G stated staff would often have to put themselves between R1 and other residents because she would try to push, punch, or throw things at them. ULP-G confirmed other residents were afraid of R1 and her behaviors had been going on for several months. ULP-G stated she had reported the resident to resident altercations to management but did not file a MAARC report herself. On March 21, 2023, at 9:20 a.m., ULP-J stated she would leave work on a nightly basis with bruises from R1 and that R1 would hit other residents too. ULP-J stated they would try to calm the resident down and keep other residents away from her if they weren't able to redirect her but that wasn't always effective. ULP-J stated R1 had targeted one resident and would focus a lot of her behaviors towards the other resident. ULP-J stated R1 had been having behaviors since at least November 2021. ULP-J stated she was aware of a time when another staff member called police after the resident bit her breast. ULP-J stated the police were called to help deal with her aggression and the resident had told police she'd bit the staff member again, so she was taken to the ER. ULP-J stated she was aware the resident had dementia and cognition issues. ULP-J stated she had done video training on dementia but did not get any training on managing difficult or challenging behaviors.	0 620		

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0 620	Continued From page 8 On March 21, 2023, at 10:40 a.m., licensed assisted living director in residence (LALDIR)-B stated she had worked as a ULP from February 2022 to October 2022. LALDIR-B stated R1 would manipulate other residents and was more high functioning so she knew who to target. LALDIR-B stated R1 would be aggressive towards staff and residents and would pinch and hit and yell. LALDIR-B stated they'd try to redirect R1 or get her to calm down and figure out what triggered her. LALDIR-B stated R1 was sent to the ER after trying to feed another resident and when they told her she couldn't do that, it set her off. R1 threw a remote at a staff members head and said she was going to kill herself so they called the police. LALDIR-B stated she knew they changed a medication in the ER but it didn't do much and she wasn't sure what other interventions should be used. On March 21, 2023, at 11:15 a.m., regional director of operations (RDO)-A stated she was not sure if R1 or R2 had service plans, individual abuse prevention plans, behavioral assessments, or other assessments. RDO-A stated with the change of ownership on June 1, 2022, they did not get a lot of the records from the prior owner and was not sure what had been completed by facility staff. RDO-A stated she did not realize the resident record was missing those documents until they were requested by the investigator. RDO-A confirmed the September 13, 2022, assessment was not an accurate reflection of R1 and R2's current condition as both the change in condition assessments were completed remotely by an on call nurse who was not close to the facility. RDO-A stated that using the police as an intervention for behaviors was not ideal but every situation was different and it depended on the	0 620		

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0 620	Continued From page 9 staff member's comfort level with the behavior and if there was a safety issue. RDO-A confirmed an intervention used for R1 after her return from the hospital was keeping her in her room as that's what her family had requested. RDO-A confirmed the facility had not assessed if this was a restraint or if other interventions would have been more effective and they had only implemented it because family requested they do so. RDO-A stated she was aware of incident reports for both R1 and R2 and there was a history of resident to resident altercations for both residents. RDO-A stated she was not sure if they had been reported to MAARC but the facility had done in house investigations. Copies of the investigations were requested however RDO-A stated they did not document their investigations and did not have any records to show what their investigations entailed. RDO-A confirmed many of the incident reports were only partially filled out. RDO-A confirmed several of the incidents would be reportable but that direction would come from nursing, not the regional director as the regional director is not responsible for nursing. RDO-A confirmed she was a mandated reporter. RDO-A stated there were concerns about readmitting R1 and R2 due to safety concerns for the other residents and they were not sure they could keep the other residents safe from R1 and R2. RDO-A confirmed a MAARC report on behalf of the other residents and their safety concerns were not completed after R1 and R2 readmitted to the facility. R2 R2's diagnoses included vascular dementia with behavior disturbance (a type of dementia caused by brain damage from impaired blood flow to the brain that causes difficulty with reasoning, planning, judgment, memory, and other thought	0 620		

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0 620	Continued From page 10 processes) and depression. The resident admitted to the facility around April 28, 2022, and began receiving services under the current licensee after a change of ownership occurred on June 1, 2022. The resident's record lacked evidence of a current service plan. The resident's record lacked evidence of any recent assessments. The resident's record lacked evidence of a current Individual Abuse Prevention Plan (IAPP). Progress notes from August 1, 2022, through the resident's September 20, 2022, discharge were requested. Progress notes provided began on September 4, 2022 and included the following notes: -September 4, 2022, at 10:27 a.m., a progress note entered by RN-C indicated there was a "resident to staff altercation-aggressive behavior. Resident pinched staff on arm, hard enough to draw blood. Resident hit, punched, spit, kicked, and threw hard toys and urine bucket at staff. Resident flashing her chest. Resident wishing death on staff as well as saying she was going to kill us. Incident witnessed by all staff and residents. Intervention, resident assisted to her room. No further behavioral concerns noted at this time..." -September 7, 2022, at 8:19 a.m., a behavior note entered by RN-C noted, "resident was coming out of another resident's room, staff offered that she was very mad. RA [resident assistant] attempted to redirect resident to her	0 620		

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0 620	Continued From page 11 room, resident was upset and punched RA in the chest. There were not other witnesses at the time of incident..." R2's record contained several incident reports detailing resident to resident and resident to staff altercations: -July 20, 2022, at 3:30 p.m., a resident to resident altercation was reported by ULP after R2 hit another resident twice in the face, leaving little red marks. No new interventions were noted and the incident was not reported to MAARC. -July 20, 2022,at 7:40 p.m., a resident to resident altercation was reported by ULP after R2 was observed rubbing another resident's hand on her chest. The other resident was noted to be pulling away and told R2 to stop. R2 hit the resident in the back. No new interventions were noted and the incident was not reported to MAARC. -July 21, 2022, at 6:00 p.m., a resident to resident and resident to staff altercation were reported by ULP after R2 was observed rubbing on another male resident and inappropriately touching him. The male resident was pushing R2 away and told her to go away. When staff intervened, R2 became very angry and began punching staff. No new interventions were noted and the incident was not reported to MAARC. -July 25, 2022, throughout the day, a resident to staff altercation was reported by ULP after R2 was observed walking up and down the hallways "being rude, yelling, calling names, in other resident's rooms, ripped [staff member's] nail off, choked, and pushed [staff member] down the hallway."	0 620		

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0 620	Continued From page 12 -August 12, 2022, at 2:17 p.m., the resident was reported to have had a fall. -August 15, 2022, at 8:00 p.m., a resident to resident altercation was reported by ULP after R2 was observed to be crawling in to bed with another resident and "roll on top of her." When ULP attempted to redirect R2, she punched staff with a closed fist to the face. A note was entered by the RN on August 16, 2022, indicating "no additional interventions needed." No new interventions were noted and the incident was not reported to MAARC. -August 16, 2022, at 9:15 p.m., a resident to resident altercation was reported by ULP after R2 went in another resident's room and pushed her, causing the resident to fall back on the floor. The other resident was noted to have a small scratch on her forearm after the altercation. No new interventions were noted and the incident was not reported to MAARC. -August 17, 2022, from 3:00 p.m. to 6:00 p.m., ULP completed an incident report after R2 would not stay out of other residents rooms, even after being asked to leave. R2 was noted to keep hitting staff. No new interventions were noted and the incident was not reported to MAARC. -August 17, 2022, at 5:30 p.m., a resident to resident altercation was reported by ULP after R2 went up to a resident who was eating dinner and wouldn't leave her alone. The other resident threw coffee at R2 and R2 hit the resident. Staff documented "We got [resident] to walk away and R2 keeped (sic) going at her." No new interventions were noted and the incident was not reported to MAARC.	0 620		

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0 620	Continued From page 13 -August 27, 2022, at 7:45 p.m., a resident to resident and resident to staff altercation was reported by ULP after R2 entered another resident's room and broke her TV. Staff reported attempting to redirect R2 but she kept yelling and swearing and grabbed the staff member's wrist and would not let go. No new interventions were noted and the incident was not reported to MAARC. -September 4, 2022, a resident to staff altercation was reported by ULP after R2 pinched a staff member on the arm and drew blood. -September 5, 2022, a resident to staff altercation was reported by ULP after R2 came out of another resident's room and was very mad. ULP attempted redirection but R2 punched her in the chest. An incident report completed by ULP-G on September 8, 2022, indicated on September 7, 2022, she "took [R2] into the bathroom for a shower...when I went to help her with her pants, she only allowed me to pulled (sic) them halfway down before stepping into the shower. She then took them off in the shower. She wouldn't let me wash her up so we finished while she was scream and pinching me. She wouldn't let me dress her or dry her off. Was walking around the bathroom naked, wet, throwing things and trying to rip things off the wall. When I wouldn't let her out off (sic) the bathroom naked she started hitting and scratching me. Sister's (sic) were both called and both said they couldn't come or they didn't know what we want her to do about it. Cops were called. [R2] spit on one cop and hit both. [R2] walked out of the bathroom with only a shirt and wet socks on, so we had to shut all other residents in the living room." For immediate	0 620		

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0 620	Continued From page 14 interventions, ULP-G noted she tried talking calmly, moving quickly, moving slowly, letting her get herself dress (sic), singing our song, covering with a towel so we could leave the bathroom. I put everything she could break, throw, or pull on away out of her reach. I gave her space. Then called sisters (both). Then police were called." No new interventions were noted and the incident was not reported to MAARC. The resident was sent to the emergency room. The resident returned from the hospital on September 13, 2022. The resident's record contained a partially completed change of condition assessment dated September 13, 2022. The assessment was completed remotely and had nothing noted for psychological issues, behaviors, or cognitive issues. Wandering was the only issue checked for behavioral symptoms. The resident was not noted to have any other behaviors. No new interventions were put in place to ensure the safety of other residents or R2. On March 20, 2023, at 9:00 a.m., ULP-G stated R2 could be in a really great mood then with the flip of a switch, she'd be in a rage. ULP-G stated, "I can 100% say yes, the other residents were scared of her. We got to the point we had to put locks on the doors so she couldn't get into the other resident's rooms." ULP-G stated there were a few times R2 was caught going in to another male resident's room and providing oral sex to that resident but "family was notified and everyone was ok with it" so it was not reported to MAARC and no other interventions were put in place. ULP-G stated R2 would try sticking her hands up another male resident's shorts and "he'd slap her away" and staff would try to intervene and redirect when they saw it	0 620		

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0 620	Continued From page 15 happening. ULP-G stated R2 would try to climb in bed with a different male resident, hold his hand, or kiss him and that the resident's family was notified but the resident was his own person so no other interventions were done. ULP-G stated she did not feel safe working with R2 and felt like she couldn't keep other residents safe either. ULP-G stated RDO-A was notified of all those incidents and she was not sure if any MAARC reports were made regarding R2's behaviors. ULP-G stated the only interventions they used included redirection or calling the resident's family to come in and sit with her, if the resident's behaviors were too violent, they would call the police. On March 20, 2023, at 9:20 a.m., ULP-F stated both R1 and R2 would have physical altercations with both residents and staff. ULP-F stated interventions used included sending her to her room to relax, redirecting, and calling family to come in and sit with her. ULP-F stated the police had to be called after R2 wouldn't stay in her room after being diagnosed with COVID-19. ULP-F stated police didn't come as they stated, "there was nothing they could do because I worked in a memory care unit." ULP-F stated she didn't get any other guidance or direction from the nurse on how to handle either resident's challenging behaviors and could not recall getting any training on MAARC reporting. ULP-F stated she didn't feel like she could care for R2 towards the end because it was too dangerous and she still had scars on her arms from being scratched and hit by R2. On March 21, 2023, at 9:30 a.m., ULP-J stated R2's behaviors depended on the day, sometimes she'd be great other times everything was wrong. ULP-J stated R2 would hit and pinch staff and	0 620		

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0 620	Continued From page 16 would go after other residents at times. ULP-J stated R2 had some other episodes of inappropriate behavior towards other residents and that they had caught her giving oral sex to another resident once. ULP-J stated R2 would try to touch several other male residents and they would tell her no and to stop but she wouldn't and they were in wheelchairs so not able to get away. ULP-J was not sure if any of the incidents had been reported to MAARC but thought since R2's guardian was ok with it, it was fine. ULP-J stated the police had to be called on R2 after she hit and spit on staff and she did the same to the responding officers. ULP-J stated when both R1 and R2 returned from the ER, they did not get any new interventions or new direction on how to manage either resident's behaviors. ULP-J stated she knew R2 had dementia but didn't know anything else on what she had. On March 21, 2023, at 10:45 a.m., LALDIR-B stated R2 would go from 0 to 60, she'd be laughing then smack you in the face. LALDIR-B stated if R2 had bad behaviors, they'd try to redirect or try activities like coloring or music but it wasn't always effective. LALDIR-B stated she was not sure if any MAARC reports had been submitted for any of the resident to resident altercations. LALDIR-B stated she was not aware of any new interventions or changes to either residents plan of care after they returned from the hospital. The licensee's 2.49 Vulnerable Adult Maltreatment - Prevention & Reporting policy, dated August 1, 2021, indicated that "in accordance with state and federal vulnerable adult laws, our agency's employees will report any suspected maltreatment (abuse, neglect or financial exploitation of our home care clients	0 620		

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0 620	Continued From page 17 [assisted living residents]." In addition, "if the incident appears to be suspected abuse, neglect or financial exploitation, the Director of Health Services or Community Director shall immediately make an oral report to the CEP [common entry point]." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
0 630 SS=H	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 ensure an individual abuse prevention plan (IAPP) was developed to address resident vulnerability with specific interventions for behaviors for two of two residents (R1, R2) , who had a history of resident to resident altercations and resident to staff altercations. In addition, the licensee failed to ensure the IAPP addressed resident vulnerability with specific interventions for sexual behaviors	0 630		

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0 630	Continued From page 18 for one of one residents (R2) who had a history of inappropriately touching and interacting with other residents in the assisted living with dementia care facility. 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 and R2 both had a documented history of behaviors, including verbal and physical aggression towards staff and other residents. The RN failed to assess the behaviors, cause for behaviors, and failed to identify interventions to de-escalate the residents' displayed behaviors. Both residents continued to display verbal and physical behaviors that resulted in other residents being hit, pushed, and yelled at. In addition, the RN failed to assess sexual behaviors displayed by R2, resulting in other male residents being inappropriately touched against their will. The RN also failed to ensure change of condition assessments were completed on both R1 and R2 after a return from the hospital, to accurately reflected their current behavioral symptoms and current health condition and failed to develop an individualized abuse prevention plan (IAPP) for either resident. R1 R1's diagnoses included Wernicke's	0 630		

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0 630	Continued From page 19 encephalopathy (a brain disorder that can cause confusion, disorientation, and lack of muscle coordination), alcohol induced dementia, and depression. The resident admitted to the facility on December 1, 2020, and began receiving services under the current licensee after a change of ownership occurred on June 1, 2022. The resident's record lacked evidence of a current service plan. The resident's record lacked evidence of any recent assessments. A progress note entered on August 11, 2022, indicated a 90 day assessment had been completed with no concerns noted. The resident was noted to be jovial and cooperative. The resident's record lacked evidence of a current Individual Abuse Prevention Plan (IAPP). Progress notes from August 1, 2022, through the resident's September 22, 2022, discharge were requested. Progress notes provided began on September 7, 2022 and included the following notes: -September 7, 2022, at 8:01 a.m., a behavior note entered by registered nurse (RN)-C noted "Resident to staff altercation with aggressive behavior. Per RA [resident assistant] staff, resident asked for ice, RAs saw cup she had was very dirty with brown water, so staff offered to get her a clean cup to fill and resident attempted to bite staff. Resident got in RA's face, began name calling, hitting, and pushing. Per RA staff, resident was using very vulgar language such as "shove a banana up your cunt." "Go fuck yourself." "I hope you get raped and like it." Staff choose (sic) to walk away in another direction	0 630		

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0 630	Continued From page 20 until resident stopped following them. Blue stone physicians updated." -September 8, 2022, at 4:01 p.m., a behavior note entered by on call RN-I noted "Resident was attempting to force feed another resident a banana at the table. Staff asked her to not feed other residents. [R1] became agitated and started to take items off the med cart and push things over, she threw the banana peel at the staff hitting her in the face and chest. The staff bent over to pick up the banana peel. As soon as she stood up the resident ran up behind the staff and struck her in the back of the head. Staff walked away from the resident and the resident angrily went to her apartment, slammed the door and locked it. The staff reported the incident to the PCP [primary care physician] and verbal orders received to call EMS [emergency medical services]. Resident was transported to ER [emergency room] for psychiatric evaluation of her behaviors...Families (sic) current wishes are that the resident doesn't return to the community as she is a danger to other vulnerable adults. This was relayed to PCP who is working with ER LSW [licensed social worker] to find more appropriate placement. No new interventions were implemented and a MAARC report was not submitted. -September 13, 2022, at 3:00 a.m., a behavior noted entered by RN-C noted, "Resident discharged from the [hospital] with diagnosis of aggressive behaviors...Guardian is requesting that resident should remain in her room for meals and supervised when out in the community with other residents as guardian is concerned for the well-being of staff and residents within the community." No new interventions were implemented and a MAARC report was not submitted. -September 22, 2022, at 9:05 a.m., a progress	0 630		

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0 630	Continued From page 21 note entered by RN-C indicated the resident discharged and transferred to a different senior living community. The facility failed to develop an IAPP after any of the above documented incidents ocurred. The resident's record contained a partially completed change of condition assessment from September 13, 2022, the day she returned from the hospital. The assessment was completed remotely and indicated R1 had a mood disorder and will hit, swear, bite, and name call. The resident was noted to have behaviors with a history of harming others, verbally and physically abusive to staff, and demonstrates anxious/paranoid or suspicious behavior. The resident was noted to be alert and responsive, oriented to person, place, time, and situation and had no apparent memory loss and could recall or retain information like recent events and was able to make safe judgments and function appropriately in social situations. The assessment further indicated the resident had behavioral symptoms including verbal and physical aggression and redirection was effective. The facility failed to develop an IAPP after the resident returned to the facility. The resident's record contained a care plan initiated on September 13, 2022. The section listing interventions for the resident's behaviors was blank with no interventions listed. The care plan indicated the resident did not have memory loss and could recall and retain information. The resident's September 2022 medication administration record (MAR) indicated the resident had an order for QUEtiapine Fumarate (an antipsychotic medication to treat mood	0 630		

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0 630	Continued From page 22 conditions) 0.5 tablets by mouth every 12 hours as needed for agitation. The medication was not used at any point in September. A MAR for August 2022 was requested, but not provided. On March 20, 2023, at 8:50 a.m., unlicensed personnel (ULP)-G stated she worked frequently with R1 and the resident had behaviors just about daily and was very physically abusive towards other residents and staff. ULP-G stated the only interventions she was aware of was redirecting the resident or calling her family to come in and sit with her. ULP-G stated she had personally witnessed R1 push other residents on at least two occasions. ULP-G stated staff would often have to put themselves between R1 and other residents because she would try to push, punch, or throw things at them. ULP-G confirmed other residents were afraid of R1 and her behaviors had been going on for several months. ULP-G stated she had reported the resident to resident altercations to management but did not do a MAARC report herself. On March 21, 2023, at 9:20 a.m., ULP-J stated she would leave work on a nightly basis with bruises from R1 and that R1 would hit other residents as well too. ULP-J stated they would try to calm the resident down and keep other residents away from her if they weren't able to redirect her but that wasn't always effective. ULP-J stated R1 had targeted one resident and would focus a lot of her behaviors towards the other resident. ULP-J stated R1 had been having behaviors since at least November 2021. ULP-J stated she was aware of a time when another staff member called police after the resident bit her breast. ULP-J stated the police were called to help deal with her aggression and the resident had told police she'd bit the staff member again	0 630		

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	30601	A. BUILDING: _____ B. WING _____	C 03/21/2023

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0 630	Continued From page 23 so she was taken to the ER. ULP-J stated she was aware the resident had dementia and cognition issues. ULP-J stated she had done video training on dementia but did not get any training on managing difficult or challenging behaviors. On March 21, 2023, at 10:40 a.m., licensed assisted living director in residence (LALDIR)-B stated she had worked as a ULP from February to October 2022. LALDIR-B stated R1 would manipulate other residents and was more high functioning so she knew who to target. LALDIR-B stated R1 would be aggressive towards staff and residents and would pinch and hit and yell. LALDIR-B stated they'd try to redirect R1 or get her to calm down and figure out what triggered her. LALDIR-B stated R1 was sent to the ER after trying to feed another resident and when they told her she couldn't do that, it set her off. R1 threw a remote at a staff members head and said she was going to kill herself so they called the police. LALDIR-B stated she knew they changed a medication in the ER but it didn't do much and she wasn't sure what other interventions should be used. R2 R2's diagnoses included vascular dementia with behavior disturbance (a type of dementia caused by brain damage from impaired blood flow to the brain that causes difficulty with reasoning, planning, judgment, memory, and other thought processes) and depression. The resident admitted to the facility around April 28, 2022, and began receiving services under the current licensee after a change of ownership occurred on June 1, 2022.	0 630		

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0 630	Continued From page 24 The resident's record lacked evidence of a current service plan. The resident's record lacked evidence of any recent assessments. The resident's record lacked evidence of a current Individual Abuse Prevention Plan (IAPP). Progress notes from August 1, 2022, through the resident's September 20, 2022, discharge were requested. Progress notes provided began on September 4, 2022 and included the following notes: -September 4, 2022, at 10:27 a.m., a progress note entered by RN-C indicated there was a "resident to staff altercation-aggressive behavior. Resident pinched staff on arm, hard enough to draw blood. Resident hit, punched, spit, kicked, and threw hard toys and urine bucket at staff. Resident flashing her chest. Resident wishing death on staff as well as saying she was going to kill us. Incident witnessed by all staff and residents. Intervention, resident assisted to her room. No further behavioral concerns noted at this time..." -September 7, 2022, at 8:19 a.m., a behavior note entered by RN-C noted, "resident was coming out of another resident's room, staff offered that she was very mad. RA [resident assistant] attempted to redirect resident to her room, resident was upset and punched RA in the chest. There were not other witnesses at the time of incident..." R2's record contained several incident reports detailing resident to resident and resident to staff altercations. -July 20, 2022, at 3:30 p.m., a resident to resident altercation was reported by ULP after R2	0 630		

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0 630	Continued From page 25 hit another resident twice in the face, leaving little red marks. No new interventions were noted and the incident was not reported to MAARC. -July 20, 2022,at 7:40 p.m., a resident to resident altercation was reported by ULP after R2 was observed rubbing another resident's hand on her chest. The other resident was noted to be pulling away and told R2 to stop. R2 hit the resident in the back. No new interventions were noted and the incident was not reported to MAARC. -July 21, 2022, at 6:00 p.m., a resident to resident and resident to staff altercation were reported by ULP after R2 was observed rubbing on another male resident and inappropriately touching him. The male resident was pushing R2 away and told her to go away. When staff intervened, R2 became very angry and began punching staff. No new interventions were noted and the incident was not reported to MAARC. -July 25, 2022, throughout the day, a resident to staff altercation was reported by ULP after R2 was observed walking up and down the hallways "being rude, yelling, calling names, in other resident's rooms, ripped [staff member's] nail off, choked, and pushed [staff member] down the hallway." -August 12, 2022, at 2:17 p.m., the resident was reported to have had a fall. -August 15, 2022, at 8:00 p.m., a resident to resident altercation was reported by ULP after R2 was observed to be crawling in to bed with another resident and "roll on top of her." When ULP attempted to redirect R2, she punched staff with a closed fist to the face. A note was entered by the RN on August 16, 2022, indicating "no additional interventions needed." No new interventions were noted and the incident was not reported to MAARC. -August 16, 2022, at 9:15 p.m., a resident to resident altercation was reported by ULP after R2	0 630		

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0 630	Continued From page 26 went in another resident's room and pushed her, causing the resident to fall back on the floor. The other resident was noted to have a small scratch on her forearm after the altercation. No new interventions were noted and the incident was not reported to MAARC. -August 17, 2022, from 3:00 p.m. to 6:00 p.m., ULP completed an incident report after R2 would not stay out of other residents rooms, even after being asked to leave. R2 was noted to keep hitting staff. No new interventions were noted and the incident was not reported to MAARC. -August 17, 2022, at 5:30 p.m., a resident to resident altercation was reported by ULP after R2 went up to a resident who was eating dinner and wouldn't leave her alone. The other resident threw coffee at R2 and R2 hit the resident. Staff documented "We got [resident] to walk away and R2 keeped (sic) going at her." No new interventions were noted and the incident was not reported to MAARC. -August 27, 2022, at 7:45 p.m., a resident to resident and resident to staff altercation was reported by ULP after R2 entered another resident's room and broke her TV. Staff reported attempting to redirect R2 but she kept yelling and swearing and grabbed the staff member's wrist and would not let go. No new interventions were noted and the incident was not reported to MAARC. -September 4, 2022, a resident to staff altercation was reported by ULP after R2 pinched a staff member on the arm and drew blood. -September 5, 2022, a resident to staff altercation was reported by ULP after R2 came out of another resident's room and was very mad. ULP attempted redirection but R2 punched her in the chest. The facility failed to develop an IAPP after any of	0 630		

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0 630	Continued From page 27	0 630		

the documented incidents ocurred.

An incident report completed by ULP-G on September 8, 2022, indicated on September 7, 2022, she "took [R2] into the bathroom for a shower...when I went to help her with her pants, she only allowed me to pulled (sic) them halfway down before stepping into the shower. She then took them off in the shower. She wouldn't let me wash her up so we finished while she was scream and pinching me. She wouldn't let me dress her or dry her off. Was walking around the bathroom naked, wet, throwing things and trying to rip things off the wall. When I wouldn't let her out off (sic) the bathroom naked she started hitting and scratching me. Sister's (sic) were both called and both said they couldn't come or they didn't know what we want her to do about it. Cops were called. [R2] spit on one cop and hit both. [R2] walked out of the bathroom with only a shirt and wet socks on, so we had to shut all other residents in the living room." For immediate interventions, ULP-G noted she tried talking calmly, moving quickly, moving slowly, letting her get herself dress (sic), singing our song, covering with a towel so we could leave the bathroom. I put everything she could break, throw, or pull on away out of her reach. I gave her space. Then called sisters (both). Then police were called." No new interventions were noted and the incident was not reported to MAARC. The resident was sent to the emergency room.

The resident returned from the hospital on September 13, 2022. The resident's record contained a partially completed change of condition assessment dated September 13, 2022. The assessment was completed remotely and had nothing noted for psychological issues, behaviors, or cognitive issues. Wandering was

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0 630	Continued From page 28 the only issue checked for behavioral symptoms. The resident was not noted to have any other behaviors. No new interventions were put in place to ensure the safety of other residents or R2. The facility failed to develop an IAPP after the resident returned to the facility. On March 20, 2023, at 9:00 a.m., ULP-G stated R2 could be in a really great mood then with the flip of a switch, she'd be in a rage. ULP-G stated, "I can 100% say yes, the other residents were scared of her. We got to the point we had to put locks on the doors so she couldn't get into the other resident's rooms." ULP-G stated there were a few times R2 was caught going in to another male resident's room and providing oral sex to that resident but "family was notified and everyone was ok with it" so it was not reported to MAARC and no other interventions were put in place. ULP-G stated R2 would try sticking her hands up another male resident's shorts and "he'd slap her away" and staff would try to intervene and redirect when they saw it happening. ULP-G stated R2 would try to climb in bed with a different male resident, hold his hand, or kiss him and that the resident's family was notified but the resident was his own person so no other interventions were done. ULP-G stated she did not feel safe working with R2 and felt like she couldn't keep other residents safe either. ULP-G stated RDO-A was notified of all those incidents and she was not sure if any MAARC reports were made regarding R2's behaviors. ULP-G stated the only interventions they used included redirection or calling the resident's family to come in and sit with her, if the resident's behaviors were too violent, they would call the police. On March 20, 2023, at 9:20 a.m., ULP-F stated	0 630		

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0 630	Continued From page 29 both R1 and R2 would have physical altercations with both residents and staff. ULP-F stated interventions used included sending her to her room to relax, redirecting, and calling family to come in and sit with her. ULP-F stated the police had to be called after R2 wouldn't stay in her room after being diagnosed with COVID-19. ULP-F stated police didn't come as they stated, "there was nothing they could do because I worked in a memory care unit." ULP-F stated she didn't get any other guidance or direction from the nurse on how to handle either resident's challenging behaviors and could not recall getting any training on MAARC reporting. ULP-F stated she didn't feel like she could care for R2 towards the end because it was too dangerous and she still had scars on her arms from being scratched and hit by R2. On March 21, 2023, at 9:30 a.m., ULP-J stated R2's behaviors depended on the day, sometimes she'd be great other times everything was wrong. ULP-J stated R2 would hit and pinch staff and would go after other residents at times. ULP-J stated R2 had some other episodes of inappropriate behavior towards other residents and that they had caught her giving oral sex to another resident once. ULP-J stated R2 would try to touch several other male residents and they would tell her no and to stop but she wouldn't and they were in wheelchairs so not able to get away. ULP-J was not sure if any of the incidents had been reported to MAARC but thought since R2's guardian was ok with it, it was fine. ULP-J stated the police had to be called on R2 after she hit and spit on staff and she did the same to the responding officers. ULP-J stated when both R1 and R2 returned from the ER, they did not get any new interventions or new direction on how to manage either resident's behaviors. ULP-J stated	0 630		

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0 630	Continued From page 30 she knew R2 had dementia but didn't know anything else on what she had. On March 21, 2023, at 10:45 a.m., LALDIR-B stated R2 would go from 0 to 60, she'd be laughing then smack you in the face. LALDIR-B stated if R2 had bad behaviors, they'd try to redirect or try activities like coloring or music but it wasn't always effective. LALDIR-B stated she was not sure if any MAARC reports had been submitted for any of the resident to resident altercations. LALDIR-B stated she was not aware of any new interventions or changes to either residents plan of care after they returned from the hospital. On March 21, 2023, at 11:15 a.m., regional director of operations (RDO)-A stated she was not sure if R1 or R2 had service plans, individual abuse prevention plans, behavioral assessments, or other assessments. RDO-A stated with the change of ownership on June 1, 2022, they did not get a lot of the records from the prior owner and was not sure what had been completed by facility staff. RDO-A stated she did not realize the resident record was missing those documents until they were requested by the investigator. RDO-A confirmed the September 13, 2022, assessment was not an accurate reflection of R1 and R2's current condition as both the change in condition assessments were completed remotely by an on call nurse who was not close to the facility. RDO-A stated using the police as an intervention for behaviors was not idea but every situation was different and it depended on the staff member's comfort level with the behavior and if there was a safety issue. RDO-A confirmed an intervention used for R1 after her return from the hospital was keeping her in her room as that's what her family had requested. RDO-A	0 630		

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0 630	Continued From page 31 confirmed the facility had not assessed if this was a restraint or if other interventions would have been more effective and they had only implemented it because family requested they do so. RDO-A stated she was aware of incident reports for both R1 and R2 and there was a history of resident to resident altercations for both residents. RDO-A stated she was not sure if they had been reported to MAARC but the facility had done in house investigations. Copies of the investigations were requested however RDO-A stated they did not document their investigations and did not have any records to show what their investigations entailed. RDO-A confirmed many of the incident reports were only partially filled out. RDO-A confirmed several of the incidents would be reportable but that direction would come from nursing, not the regional director as the regional director is not responsible for nursing. RDO-A confirmed she was a mandated reporter. RDO-A stated there were concerns about readmitting R1 and R2 due to safety concerns for the other residents and they were not sure they could keep the other residents safe from R1 and R2. RDO-A confirmed a MAARC report on behalf of the other residents and their safety concerns were not completed after R1 and R2 readmitted to the facility. The licensee's 6.05 Individual Abuse Prevention Plan policy, dated August 1, 2021, indicated the facility would develop and implement an individual abuse prevention plan for each vulnerable adult. All residents in an assisted living are categorically considered vulnerable adults. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7)	0 630		

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0 630	Continued From page 32 days.	0 630		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care	01060		

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01060	Continued From page 33 if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content to the resident, legal representative, and designated representative; and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) when the resident did not return from the emergency relocation within four days 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 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: R1 R1's progress notes indicated the resident was sent to the emergency room (ER) for a psychiatric evaluation of behaviors on September 8, 2022, after attempting to force feed another resident a banana. The resident returned to the facility five days later on September 13, 2022. R1 discharged from the facility on September 22, 2022.	01060		

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01060	Continued From page 34 R1's record lacked a written notice that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the OOLTC; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, R1's record lacked notification to the OOLTC that the resident had been relocated and had not returned to the facility within four days. R2 R2's progress notes lacked documentation of the resident being sent to the ER on September 7, 2022. An incident report completed on September 8, 2022, indicated the police had been called after the resident started hitting and scratching a staff member. R2's progress notes indicated the resident returned to the facility six days later on September 13, 2022. The resident discharged from the facility on September 20, 2022. The resident's hospital progress notes indicated the resident was sent to the emergency room on September 7, 2022, and discharged on September 13, 2022. R2's record lacked a written notice that contained, at a minimum:	01060		

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	30601	A. BUILDING: _____ B. WING _____	C 03/21/2023

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01060	Continued From page 35 - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the OOLTC; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, R2's record lacked notification to the OOLTC that the resident had been relocated and had not returned to the facility within four days. On March 21, 2023, at 11:30 a.m., regional director of operations (RDO)-A confirmed notices were not completed for R1 and R2 and the OOLTC had not been notified. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
01070 SS=E	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:	01070		

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01070	Continued From page 36 Based on interview and record review, the licensee failed to allow the return of two of two residents (R1, R2) after they were sent to the emergency room, although the licensee had not issued a notice of termination of services or housing. Hospital records indicated the licensee would not accept R1 and R2 back after being medically cleared to return as a nurse was not available and there were concerns for staff and resident safety. R1 and R2 spent five days in the emergency room waiting for the facility to allow them to return. However, the licensee's UDALSA indicated the licensee could provide the additional services R1 and R2 required including one to one staffing for special circumstances and the ability to manage challenging behaviors. The licensee failed to offer any option for R1 or R2 to return as a housing-only resident with the necessary services provided by another agency. 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). Findings include: The licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA), last updated March 24, 2022, indicated on page 3 under Dementia Care Services Available the facility was prepared to manage challenging behaviors. On page 15, Section 9: Staffing the facility was able to provide one-to-one staffing for	01070		

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01070	Continued From page 37 special circumstances. No comments were listed to indicate what the special circumstances would be. R1 R1's diagnoses included Wernicke's encephalopathy (a brain disorder that can cause confusion, disorientation, and lack of muscle coordination), alcohol induced dementia, and depression. The resident admitted to the facility on December 1, 2020, and began receiving services under the current licensee after a change of ownership occurred on June 1, 2022. The resident's record lacked evidence of a current service plan. The resident's record lacked evidence of any recent assessments. A progress note entered on August 11, 2022, indicated a 90 day assessment had been completed with no concerns noted. The resident was noted to be jovial and cooperative. Progress notes indicated the resident had episodes of resident to staff and resident and resident to resident altercations with aggressive behavior including hitting staff and trying to feed other residents. A a progress note indicated on Thursday, September 8, 2022, the resident was sent to the emergency room for a "psychiatric evaluation of behaviors" and returned to the facility on Tuesday, September 13, 2022, five days after she was cleared for discharge back to the facility. R1's emergency room history and physical indicated a medical work-up was completed and	01070		

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01070	Continued From page 38 the resident's ammonia levels were high and that could be the cause of the increased behaviors. The resident was started on a medication to decrease ammonia levels. Psychiatry evaluated the resident at the request of the facility. Psychiatry recommended the resident be discharged back to the facility the evening of September 8, 2022. On September 9, 2022, at 1:11 a.m., the emergency room physician documented they had tried to discharge R1 back to the facility that evening [September 8, 2022], but "unfortunately we are unable to accomplish that this evening. We will try discharge tomororw [September 9, 2022]. Over the course of the next five days, the resident remained in the emergency room waiting for the facility to allow her to return. Psychiatry notes from September 8, 2022, indicated "inpatient geri-psych is not recommended as patient is completely aware of her behaviors, they are intentional when staff are not meeting her needs. I do question if patients aggressive behavior is more related to her personality structure than from dementia as behaviors are intentional." Hospital records included a social worker's progress note from September 8, 2022, which noted, "Called patient's care facility shortly after 1900 (7:00 p.m.) on 9/8. Spoke with [registered nurse (RN)-C]. Writer discussed with [RN-C] that it was passed on in report that they were not going to take this patient back to their facility. [RN-C] states that "I didn't specifically say that." Writer then explained that patient was found to have elevated ammonia, and that could be contributing to the increased behaviors.[RN-C] then stated that "unfortunately this isn't her first time acting up." Writer explained that we would	01070		

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01070	Continued From page 39 be administering Lactulose to correct the elevated ammonia. [RN-C] stated that they would not be taking this patient back tonight. When asked why, [RN-C] said "because of the behaviors she has had towards staff and other residents." [RN-C] further expressed that the provider at the facility had stated that the patient needs a geri-psych evaluation. Writer asked if they had the ability to perform this assessment at their facility. [RN-C] advised that the patient had been seen by behavioral health at the facility, but not specifically geri-psych. Psych here evaluated patient and determined that acute care inpatient treatment is unnecessary. Patient appropriate to return to facility and follow up with [physician]. Writer called and talked to staff at facility and was told that management staff would return call. Writer called by [regional director of operations (RDO)-A]. [RDO-A] stated that the facility "SPECIFICALLY said that anyone calling about returning patients need to talk to [director of clinical services (DCS)-D]" and that they "SPECIFICALLY said they won't be taking this patient back tonight." Writer asked for [DCS-D] phone number and it was provided. Charge nurse notified and she contacted [DCS-D]." Hospital records included a social worker's progress note on September 9, 2022, noted, "called [RDO-A] at Summit Ridge and provided update that [daughter] would like pt [R1] to return there while alternative placement could be worked on...Writer reminded [RDO-A] that pt [R1] has the right to return and they need to make accomodations and that the Ombudsman would be updated." Hospital records included a social worker's progress note from September 12, 2022, which noted, "Called Summit Ridge ALF (assisted living	01070		

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01070	Continued From page 40 facility) to coordinate patient's return to facility. SW (social worker) was advised nursing staff were not in yet and to call back after 0900. SW called again and spoke with [RDO-A]. [RDO-A] informed SW that their nurse was unable to come in today and that she was working with corporate HR (human resources) to finalize plans. [RDO-A] stated she would contact SW with update. Received phone call from [DCS-D] with Summit Ridge Corporate stating patient is unable to return to their facility due to safety concerns. Reviewed conversations from Friday (9/9) and agreement that patient would return today (September 12, 2022). SW advised [DCS-D] that SW would follow up with Ombudsman. Left voice message for [ombudsman] with update of situation. Received call back from [ombudsman] stating she has been in contact with [RDO-A] at Summit Ridge confirming patient can return today. [Ombudsman] was aware of nursing situation and stated [RDO-A] was working to resolve this. Left message with [unlicensed personnel] at Summit Ridge requesting [RDO-A] call SW back. Received return call from [DCS-D] stating they were unable to secure nursing staff today and requested patient return tomorrow (9/13). SW agreed to this. Unit SW updated patient's daughter that patient will remain in hospital tonight with plans to return to Summit Ridge ALF tomorrow (9/13). Unit SW explained psychiatry has evaluated patient and is not recommending inpatient MH (mental health) treatment or geri-psych." R2 R2's diagnoses included vascular dementia with behavior disturbance (a type of dementia caused by brain damage from impaired blood flow to the brain that causes difficulty with reasoning, planning, judgment, memory, and other thought	01070		

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01070	Continued From page 41 processes) and depression. The resident admitted to the facility around April 28, 2022, and began receiving services under the current licensee after a change of ownership occurred on June 1, 2022. The resident's record lacked evidence of a current service plan. The resident's record lacked evidence of any recent assessments. Progress notes indicated the resident had episodes of "resident to staff altercations with aggressive behavior" including pinching staff hard enough to draw blood, hitting, punching, spitting, kicking, and throwing things at staff and residents. R2's record contained several incident reports detailing nine separate resident to resident and resident to staff altercations where the resident was reported to have hit, bit, pushed, punched, or scratched other residents and staff. An incident report from September 8, 2022, indicated on September 7, 2022, the police were called after R2 became combative during a shower. The resident was taken to the emergency room to be evaluated for behaviors. The resident returned from the hospital on September 13, 2022, five days after she was cleared for discharge back to the facility. R2's emergency room history and physical assessment from September 7, 2022, indicated an inpatient psych consult was placed and R2 was evaluated. A geriatric psych provider was also consulted and medication changes were	01070		

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01070	Continued From page 42 recommended. On September 8, 2022 at 1:14 a.m., the emergency room physician documented, "at this time, inpatient psych is recommending discharge. However, we have been unable to get ahold of the patient's memory care facility to determine if they will accept return hom and except (sic) this medical plan." Over the course of the next five days, the resident remained in the emergency room waiting for the facility to allow her to return. Hospital progress notes included a progress note from Friday, September 9, 2022, which noted, "Received update after Psychiatric Provider who spoke with AL (assisted living) Provider. RN informed writer she received a call from AL indicating they are willing to take patient back but not until Monday 9/12 as it is too late in the day. Writer called [hospital employee] who indicated she did see notes from AL on other clients she follows that indicated they must return onsite by noon and that it is too late now for today." Hospital progress notes included a progress note from Monday, September 12, 2022, which noted, "Received return call from [DSC-D] stating they were unable to secure nursing staff today and requested patient return tomorrow (9/13). SW (social worker) agreed to this. [DCS-D] also requested names of alternative placement options to discuss with patient's family. SW provided information for [other communities.] ...Called Summit Ridge ALF (assisted living facility) to coordinate patient's return to facility. SW was advised nursing staff were not in yet and to call back after 0900. SW called again and spoke with [RDO-A]. [RDO-A] informed SW that their nurse was unable to come in today and that she was working with corporate HR (human resources) to finalize plans."	01070		

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01070	Continued From page 43 On March 16, 2023, at 1:30 p.m., former registered nurse (RN)-C stated she had only worked at the facility for less than six weeks. RN-C confirmed both R1 and R2 had a history of behaviors and being aggressive towards other residents and staff at times. RN-C stated she was not involved much with the decision to readmit R1 and R2 and it was handled by corporate. RN-C stated she did not complete the return change in condition assessments for either residents and that an on call nurse had completed them. RN-C stated she was so new at the time this occured she didn't know the rules are regulations they had to adhere to. On March 16, 2023, at 1:45 p.m., director of clinical services (DCS)-D stated there were two residents who were combative and putting other residents and staff in danger so they had to call the police. One of the residents tried to swing at the police so the police took her to the ER for a psych eval. DCS-D confirmed the facility is a memory care community that serves residents with dementia and behaviors. DCS-D stated the ER had called after hours saying they didn't see anything wrong with the residents so were sending them back and she had said they weren't able to until the nurse could do an assessment to ensure they were appropriate since the residents had been harming other residents. DCS-D stated she got involved after the hospital said they weren't able to keep the residents in the ER over the weekend. DCS-D stated she wanted the residents to have a psych eval before returning and wanted to make sure the facility nurse assessed them. DCS-D stated the return assessment would be a full universal assessment that included an individual abuse prevention plan to make sure the residents were not abusing others or at risk of being abused and that would	01070		

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01070	Continued From page 44 need to be done before returning. DCS-D stated they watned to make sure a medication assessment was also completed and that all facility assessments would be done in person. DCS-D confirmed she had not reviewed the two assessments for R1 and R2 and was not aware they were done remotely and not completed. On March 21, 2023, at 11:15 a.m., regional director of operations (RDO)-A stated from what she undersood, the hospital had wanted to send the residents back after hours toward the middle of the night and it came down to they didn't feel the other residents would be safe if they returned. RDO-A stated she did not recall telling the hospital they couldn't return because a nurse was not available. However, RDO-A stated the on call nurse had completed the readmission assessments remotely as the on call nurse is not always close to the facility. RDO-A stated the corporate office and onsite staff had managed most of the readmission process. The licensee's 1.05 Readmission from other Health Care Facility, dated July 22, 2022, indicated "the facility will ensure that residents that are readmitted to the facility after an extended period at another health care facility will be re-assessed prior to re-admission to ensure the facility is still capable of meeting the needs of the resident. Based on the assessment the facility may not be able to take the resident back or may have to adjust the care plan to meet the new needs of the resident after a change in condition." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01070		

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01540 SS=F	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure five of five employees (registered nurse (RN)-C, unlicensed personnel (ULP)-F, ULP-K, ULP-L, and former licensed assisted living director (LALD)-M) received the required amount of dementia care training in the required time frame. 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	01540		

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01540	Continued From page 46 a large portion or all of the residents). The findings include: The licensee was granted an assisted living with dementia care license after a change of ownership occurred on June 1, 2022. RN-C RN-C was hired July 26, 2022, to provide supervision to ULP and provide direct care and services to the licensee's residents. RN-C's employee record lacked evidence the required amount of dementia care training in the required time frame. ULP-F ULP-F was hired April 29, 2022, to provide direct care and services to the licensee's residents. ULP-F's employee record lacked evidence the required amount of dementia care training in the required time frame. ULP-K ULP-K was hired July 5, 2022, to provide direct care and services to the licensee's residents. ULP-K's employee record lacked evidence the required amount of dementia care training in the required time frame. ULP-L ULP-L was hired May 10, 2022, to provide direct care and services to the licensee's residents. ULP-L's employee record lacked evidence the required amount of dementia care training in the required time frame. LALD-M LALD-M was hired April 29, 2022, to provide oversight of the licensee's operations.	01540		

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01540	Continued From page 47 LALD-M's employee record lacked evidence the required amount of dementia care training in the required time frame. On March 24, 2023, at 9:15 a.m., regional director of operations (RDO)-A stated she thought dementia training was completed on all employees within the required time frame but did not have any documentation to show it had been completed. RDO-A stated dementia training is verbally gone over and discussed upon hire and that it's something they talk about with employees. RDO-A stated the dementia training consisted of printing a packet of paperwork from Relias (online education system) and employees would take it home and review it on their own. RDO-A stated she thought it was about eight hours of training but was not sure how long it took staff to read through the printed out slides. RDO-A stated they did not have any documentation from employees hired prior to the June 1, 2022, change of ownership to show they had completed required dementia training and could not confirm if the prior owner had provided the required training. The licensee's 5.07 Staffing policy, dated February 1, 2022, indicated all Cornerstone staff regardless of working in a facility licensed as an Assisted Living Program with Dementia will undergo 8 hours of dementia-specific education within 30 days of employment. An additional policy provided titled 5.03 Dementia Training, dated August 1, 2021, indicated direct care employees at assisted living with dementia care licensed facilities would complete eight hours of initial training within 80 hours of the employment start date. Supervisors of direct care	01540		

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01540	Continued From page 48 staff were to complete eight hours of initial training within 120 hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01540		
02110 SS=C	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only;	02110		

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02110	Continued From page 49 (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement all required policies and procedures related to dementia care. In addition, the licensee failed to ensure the required dementia care policies and procedures were provided to each resident and/or the resident's legal and designated representatives. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the client/resident and does not affect health or safety) and is 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: The facility currently held an Assisted Living with Dementia Care license. On March 21, 2023, at 10:45 a.m., the investigator asked for the licensee's assisted living with dementia care policies and procedures. The policies and procedures provided did not include the following: - evaluation of behavioral symptoms and design of supports for intervention plans, including	02110		

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02110	Continued From page 50 nonpharmacological practices that are person-centered and evidence-informed; - wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; - medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; - limiting the use of public address and intercom systems for emergencies and evacuation drills only; - transportation coordination and assistance to and from outside medical appointments; and - safekeeping of residents' possessions. On March 21, 2023, at 11:20 a.m., regional director of operations (RDO)-A stated she was not sure if they had the above mentioned required dementia policies and she would have to check. On March 23, 2023, at 9:42 a.m., the investigator again requested the above mentioned dementia care policies. Regional nurse manager (RNM)-E emailed the investigator several policies related to dementia training but no policies that covered the above mentioned topics. On March 24, 2023, at 9:15 a.m., RDO-A stated she was not sure if they had the required policies and would have to check with the corporate office to see if that's something they had as she was not familiar with those policies. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02110		

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02320	Continued From page 51	02320		
02320 SS=H	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 ensure care and services were provided in accordance with an up-to-date service plan and by people who were properly trained and competent to perform their duties for 2 of 2 residents (R1, R2) with records reviewed. The licensee failed to act on their knowledge of safety concerns including verbal and physically abusive behaviors of R1 and R2 towards other residents and staff, failed to assess and implement interventions to mitigate further incidents, and failed to train and educate staff on how to manage behaviors. 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include:	02320		

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02320	Continued From page 52 The licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA), last updated March 24, 2022, indicated on page 3 under Dementia Care Services Available it was indicated that the facility was prepared to manage challenging behaviors. On page 15, Section 9: Staffing indicated the facility was able to provide one-to-one staffing for special circumstances. No comments were listed to indicate what the special circumstances would be. In addition, page 16 of the UDALSA indicated there was a registered nurse (RN) on-site full time. On March 21, 2023, at 9:30 a.m., the licensed assisted living director in residence (LALDIR)-B confirmed the facility RN was on site Monday and Fridays and on call otherwise. LALDIR-B stated the RN works at a sister facility (approximately 65 miles away) on the days she is not at the facility. LALDIR-B stated the RN is always on call and works full time for the company but is not onsite full time at the facility. R1 R1's diagnoses included Wernicke's encephalopathy (a brain disorder that can cause confusion, disorientation, and lack of muscle coordination), alcohol induced dementia, and depression. The resident admitted to the facility on December 1, 2020 and began receiving services under the current licensee after a change of ownership occurred on June 1, 2022. The resident's record lacked evidence of a current service plan. The resident's record lacked evidence of any	02320		

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02320	Continued From page 53 recent assessments. A progress note entered on August 11, 2022, indicated a 90-day assessment had been completed with no concerns noted. The resident was noted to be jovial and cooperative. The resident's record lacked evidence of a current Individual Abuse Prevention Plan (IAPP). Progress notes from August 1, 2022, through the resident's September 22, 2022, discharge were requested. Progress notes provided began on September 7, 2022, and included the following notes: -September 7, 2022, at 8:01 a.m., a behavior note entered by registered nurse (RN)-C noted "Resident to staff altercation with aggressive behavior. Per RA [resident assistant] staff, resident asked for ice, RAs saw cup she had was very dirty with brown water, so staff offered to get her a clean cup to fill and resident attempted to bite staff. Resident got in RA's face, began name calling, hitting, and pushing. Per RA staff, resident was using very vulgar language such as "shove a banana up your cunt." "Go fuck yourself." "I hope you get raped and like it." Staff choose (sic) to walk away in another direction until resident stopped following them. Blue stone physicians updated." -September 8, 2022, at 4:01 p.m., a behavior note entered by on call RN-I noted "Resident was attempting to force feed another resident a banana at the table. Staff asked her to not feed other residents. [R1] became agitated and started to take items off the med cart and push things over, she threw the banana peel at the staff hitting her in the face and chest. The staff bent over to pick up the banana peel. As soon as she stood up the resident ran up behind the staff	02320		

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02320	Continued From page 54 and struck her in the back of the head. Staff walked away from the resident and the resident angrily went to her apartment, slammed the door and locked it. The staff reported the incident to the PCP [primary care physician] and verbal orders received to call EMS [emergency medical services]. Resident was transported to ER [emergency room] for psychiatric evaluation of her behaviors...Families (sic) current wishes are that the resident doesn't return to the community as she is a danger to other vulnerable adults. This was relayed to PCP who is working with ER LSW [licensed social worker] to find more appropriate placement. No new interventions were implemented and a MAARC report was not submitted. -September 13, 2022, at 3:00 a.m., a behavior noted entered by RN-C noted, "Resident discharged from the [hospital] with diagnosis of aggressive behaviors...Guardian is requesting that resident should remain in her room for meals and supervised when out in the community with other residents as guardian is concerned for the well-being of staff and residents within the community." No new interventions were implemented and a MAARC report was not submitted. -September 22, 2022, at 9:05 a.m., a progress note entered by RN-C indicated the resident discharged and transferred to a different senior living community. R1s record contained a partially completed change of condition assessment from September 13, 2022, the day she returned from the hospital. The assessment was completed remotely and indicated R1 had a mood disorder and will hit, swear, bite, and name call. The resident was	02320		

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02320	Continued From page 55 noted to have behaviors with a history of harming others, verbally and physically abusive to staff, and demonstrates anxious/paranoid or suspicious behavior. The resident was noted to be alert and responsive, oriented to person, place, time, and situation and had no apparent memory loss and could recall or retain information like recent events and was able to make safe judgments and function appropriately in social situations. The assessment further indicated the resident had behavioral symptoms including verbal and physical aggression and redirection was effective. The resident's record contained a care plan initiated on September 13, 2022. The section listing interventions for the resident's behaviors was blank, with no interventions listed. The care plan indicated the resident did not have memory loss and could recall and retain information. On March 20, 2023, at 8:50 a.m., unlicensed personnel (ULP)-G stated she worked frequently with R1 and the resident had behaviors just about daily and was very physically abusive towards other residents and staff. ULP-G stated the only interventions she was aware of was redirecting the resident or calling her family to come in and sit with her. ULP-G stated she had personally witnessed R1 push other residents on at least two occasions. ULP-G stated staff would often have to put themselves between R1 and other residents because she would try to push, punch, or throw things at them. ULP-G confirmed other residents were afraid of R1 and her behaviors had been going on for several months. ULP-G stated she had reported the resident to resident altercations to management but did not file a MAARC report herself.	02320		

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02320	Continued From page 56 On March 21, 2023, at 9:20 a.m., ULP-J stated she would leave work on a nightly basis with bruises from R1 and that R1 would hit other residents too. ULP-J stated they would try to calm the resident down and keep other residents away from her if they weren't able to redirect her but that wasn't always effective. ULP-J stated R1 had targeted one resident and would focus a lot of her behaviors towards the other resident. ULP-J stated R1 had been having behaviors since at least November 2021. ULP-J stated she was aware of a time when another staff member called police after the resident bit her breast. ULP-J stated the police were called to help deal with her aggression and the resident had told police she'd bit the staff member again, so she was taken to the ER. ULP-J stated she was aware the resident had dementia and cognition issues. ULP-J stated she had done video training on dementia but did not get any training on managing difficult or challenging behaviors. On March 21, 2023, at 10:40 a.m., LALDIR-B stated she had worked as ULP from February 2022 to October 2022. LALDIR-B stated R1 would manipulate other residents and was more high functioning, so she knew who to target. LALDIR-B stated R1 would be aggressive towards staff and residents and would pinch and hit and yell. LALDIR-B stated they'd try to redirect R1 or get her to calm down and figure out what triggered her. LALDIR-B stated R1 was sent to the ER after trying to feed another resident and when they told her she couldn't do that, it set her off. R1 threw a remote at a staff members head and said she was going to kill herself, so they called the police. LALDIR-B stated she knew they changed a medication in the ER but it didn't do much and she wasn't sure what other interventions should be used.	02320		

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02320	Continued From page 57 R2 R2's diagnoses included vascular dementia with behavior disturbance (a type of dementia caused by brain damage from impaired blood flow to the brain that causes difficulty with reasoning, planning, judgment, memory, and other thought processes) and depression. The resident admitted to the facility around April 28, 2022 and began receiving services under the current licensee after a change of ownership occurred on June 1, 2022. The resident's record lacked evidence of a current service plan. The resident's record lacked evidence of any recent assessments. The resident's record lacked evidence of a current Individual Abuse Prevention Plan (IAPP). Progress notes from August 1, 2022, through the resident's September 20, 2022, discharge were requested. Progress notes provided began on September 4, 2022 and included the following notes: -September 4, 2022, at 10:27 a.m., a progress note entered by RN-C indicated there was a "resident to staff altercation-aggressive behavior. Resident pinched staff on arm, hard enough to draw blood. Resident hit, punched, spit, kicked, and threw hard toys and urine bucket at staff. Resident flashing her chest. Resident wishing death on staff as well as saying she was going to kill us. Incident witnessed by all staff and residents. Intervention, resident assisted to her room. No further behavioral concerns noted at	02320		

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02320	Continued From page 58 this time..." -September 7, 2022, at 8:19 a.m., a behavior note entered by RN-C noted, "resident was coming out of another resident's room, staff offered that she was very mad. RA [resident assistant] attempted to redirect resident to her room, resident was upset and punched RA in the chest. There were not other witnesses at the time of incident..." R2's record contained several incident reports detailing resident to resident and resident to staff altercations: -July 20, 2022, at 3:30 p.m., a resident to resident altercation was reported by ULP after R2 hit another resident twice in the face, leaving little red marks. No new interventions were noted and the incident was not reported to MAARC. -July 20, 2022,at 7:40 p.m., a resident to resident altercation was reported by ULP after R2 was observed rubbing another resident's hand on her chest. The other resident was noted to be pulling away and told R2 to stop. R2 hit the resident in the back. No new interventions were noted and the incident was not reported to MAARC. -July 21, 2022, at 6:00 p.m., a resident to resident and resident to staff altercation were reported by ULP after R2 was observed rubbing on another male resident and inappropriately touching him. The male resident was pushing R2 away and told her to go away. When staff intervened, R2 became very angry and began punching staff. No new interventions were noted and the incident was not reported to MAARC. -July 25, 2022, throughout the day, a resident to	02320		

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02320	Continued From page 59 staff altercation was reported by ULP after R2 was observed walking up and down the hallways "being rude, yelling, calling names, in other resident's rooms, ripped [staff member's] nail off, choked, and pushed [staff member] down the hallway." -August 12, 2022, at 2:17 p.m., the resident was reported to have had a fall. -August 15, 2022, at 8:00 p.m., a resident to resident altercation was reported by ULP after R2 was observed to be crawling in to bed with another resident and "roll on top of her." When ULP attempted to redirect R2, she punched staff with a closed fist to the face. A note was entered by the RN on August 16, 2022, indicating "no additional interventions needed." No new interventions were noted and the incident was not reported to MAARC. -August 16, 2022, at 9:15 p.m., a resident to resident altercation was reported by ULP after R2 went in another resident's room and pushed her, causing the resident to fall back on the floor. The other resident was noted to have a small scratch on her forearm after the altercation. No new interventions were noted and the incident was not reported to MAARC. -August 17, 2022, from 3:00 p.m. to 6:00 p.m., ULP completed an incident report after R2 would not stay out of other residents rooms, even after being asked to leave. R2 was noted to keep hitting staff. No new interventions were noted and the incident was not reported to MAARC. -August 17, 2022, at 5:30 p.m., a resident to resident altercation was reported by ULP after R2 went up to a resident who was eating dinner and	02320		

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02320	Continued From page 60 wouldn't leave her alone. The other resident threw coffee at R2 and R2 hit the resident. Staff documented "We got [resident] to walk away and R2 keeped (sic) going at her." No new interventions were noted and the incident was not reported to MAARC. -August 27, 2022, at 7:45 p.m., a resident to resident and resident to staff altercation was reported by ULP after R2 entered another resident's room and broke her TV. Staff reported attempting to redirect R2 but she kept yelling and swearing and grabbed the staff member's wrist and would not let go. No new interventions were noted and the incident was not reported to MAARC. -September 4, 2022, a resident to staff altercation was reported by ULP after R2 pinched a staff member on the arm and drew blood. -September 5, 2022, a resident to staff altercation was reported by ULP after R2 came out of another resident's room and was very mad. ULP attempted redirection but R2 punched her in the chest. An incident report completed by ULP-G on September 8, 2022, indicated on September 7, 2022, she "took [R2] into the bathroom for a shower...when I went to help her with her pants, she only allowed me to pulled (sic) them halfway down before stepping into the shower. She then took them off in the shower. She wouldn't let me wash her up so we finished while she was scream and pinching me. She wouldn't let me dress her or dry her off. Was walking around the bathroom naked, wet, throwing things and trying to rip things off the wall. When I wouldn't let her out off (sic) the bathroom naked she started	02320		

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02320	Continued From page 61 hitting and scratching me. Sister's (sic) were both called and both said they couldn't come or they didn't know what we want her to do about it. Cops were called. [R2] spit on one cop and hit both. [R2] walked out of the bathroom with only a shirt and wet socks on, so we had to shut all other residents in the living room." For immediate interventions, ULP-G noted she tried talking calmly, moving quickly, moving slowly, letting her get herself dress (sic), singing our song, covering with a towel so we could leave the bathroom. I put everything she could break, throw, or pull on away out of her reach. I gave her space. Then called sisters (both). Then police were called." No new interventions were noted and the incident was not reported to MAARC. The resident was sent to the emergency room. The resident returned from the hospital on September 13, 2022. The resident's record contained a partially completed change of condition assessment dated September 13, 2022. The assessment was completed remotely and had nothing noted for psychological issues, behaviors, or cognitive issues. Wandering was the only issue checked for behavioral symptoms. The resident was not noted to have any other behaviors. No new interventions were put in place to ensure the safety of other residents or R2. On March 20, 2023, at 9:00 a.m., ULP-G stated R2 could be in a really great mood then with the flip of a switch, she'd be in a rage. ULP-G stated, "I can 100% say yes, the other residents were scared of her. We got to the point we had to put locks on the doors so she couldn't get into the other resident's rooms." ULP-G stated there were a few times R2 was caught going in to another male resident's room and providing oral sex to	02320		

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02320	Continued From page 62 that resident but "family was notified and everyone was ok with it" so it was not reported to MAARC and no other interventions were put in place. ULP-G stated R2 would try sticking her hands up another male resident's shorts and "he'd slap her away" and staff would try to intervene and redirect when they saw it happening. ULP-G stated R2 would try to climb in bed with a different male resident, hold his hand, or kiss him and that the resident's family was notified but the resident was his own person so no other interventions were done. ULP-G stated she did not feel safe working with R2 and felt like she couldn't keep other residents safe either. ULP-G stated RDO-A was notified of all those incidents and she was not sure if any MAARC reports were made regarding R2's behaviors. ULP-G stated the only interventions they used included redirection or calling the resident's family to come in and sit with her, if the resident's behaviors were too violent, they would call the police. On March 20, 2023, at 9:20 a.m., ULP-F stated both R1 and R2 would have physical altercations with both residents and staff. ULP-F stated interventions used included sending her to her room to relax, redirecting, and calling family to come in and sit with her. ULP-F stated the police had to be called after R2 wouldn't stay in her room after being diagnosed with COVID-19. ULP-F stated police didn't come as they stated, "there was nothing they could do because I worked in a memory care unit." ULP-F stated she didn't get any other guidance or direction from the nurse on how to handle either resident's challenging behaviors and could not recall getting any training on MAARC reporting. ULP-F stated she didn't feel like she could care for R2 towards the end because it was too dangerous and she	02320		

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02320	Continued From page 63 still had scars on her arms from being scratched and hit by R2. On March 21, 2023, at 9:30 a.m., ULP-J stated R2's behaviors depended on the day, sometimes she'd be great other times everything was wrong. ULP-J stated R2 would hit and pinch staff and would go after other residents at times. ULP-J stated R2 had some other episodes of inappropriate behavior towards other residents and that they had caught her giving oral sex to another resident once. ULP-J stated R2 would try to touch several other male residents and they would tell her no and to stop but she wouldn't and they were in wheelchairs so not able to get away. ULP-J was not sure if any of the incidents had been reported to MAARC but thought since R2's guardian was ok with it, it was fine. ULP-J stated the police had to be called on R2 after she hit and spit on staff and she did the same to the responding officers. ULP-J stated when both R1 and R2 returned from the ER, they did not get any new interventions or new direction on how to manage either resident's behaviors. ULP-J stated she knew R2 had dementia but didn't know anything else on what she had. On March 21, 2023, at 10:45 a.m., LALDIR-B stated R2 would go from 0 to 60, she'd be laughing then smack you in the face. LALDIR-B stated if R2 had bad behaviors, they'd try to redirect or try activities like coloring or music but it wasn't always effective. LALDIR-B stated she was not sure if any MAARC reports had been submitted for any of the resident to resident altercations. LALDIR-B stated she was not aware of any new interventions or changes to either resident's plan of care after they returned from the hospital.	02320		

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02320	Continued From page 64 On March 21, 2023, at 11:15 a.m., the Regional Director of Operations (RDO)-A was questioned about the licensee's UDULSA. RDO-A stated she was not sure why the UDALSA indicated the facility provided one-to-one staffing for special circumstances. RDO-A stated, "That's a head stumper, we were told we are not able to do one-to-one staffing," and confirmed that was not accurate on the UDALSA. RDO-A stated the challenging behaviors the facility was able to manage would be evaluated as incidents arise but they would not be able to manage behaviors where there was physical harm to others. RDO-A stated they would be able to manage behaviors that included altercations with staff "to a degree," of hitting, spitting, and verbal behaviors and the facility had done a good job of training staff to handle those behaviors. RDO-A confirmed there is not a full time RN on site. RDO then stated she was not sure if R1 or R2 had service plans, individual abuse prevention plans, behavioral assessments, or other assessments to demonstrate behavioral symptoms were identified and/or addressed. RDO-A stated with the change of ownership on June 1, 2022, they did not get a lot of the records from the prior owner and was not sure what had been completed by facility staff. RDO-A stated she did not realize the resident record was missing those documents until they were requested by the investigator. RDO-A confirmed the September 13, 2022, assessment was not an accurate reflection of R1 and R2's current condition as both the change in condition assessments were completed remotely by an on call nurse who was not close to the facility. RDO-A stated that using the police as an intervention for behaviors was not ideal but every situation was different and it depended on the staff member's comfort level with the behavior and if there was a safety issue.	02320		

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02320	Continued From page 65 RDO-A confirmed an intervention used for R1 after her return from the hospital was keeping her in her room as that's what her family had requested. RDO-A confirmed the facility had not assessed if this was a restraint or if other interventions would have been more effective and they had only implemented it because family requested they do so. RDO-A stated she was aware of incident reports for both R1 and R2 and there was a history of resident to resident altercations for both residents. RDO-A stated she was not sure if they had been reported to MAARC but the facility had done in house investigations. Copies of the investigations were requested however RDO-A stated they did not document their investigations and did not have any records to show what their investigations entailed. RDO-A confirmed many of the incident reports were only partially filled out. RDO-A confirmed several of the incidents would be reportable but that direction would come from nursing, not the regional director as the regional director is not responsible for nursing. RDO-A confirmed she was a mandated reporter. RDO-A stated there were concerns about readmitting R1 and R2 due to safety concerns for the other residents and they were not sure they could keep the other residents safe from R1 and R2. RDO-A confirmed a MAARC report on behalf of the other residents and their safety concerns were not completed after R1 and R2 readmitted to the facility. The licensee's 6.05 Individual Abuse Prevention Plan policy, dated August 1, 2021, indicated the facility would develop and implement an individual abuse prevention plan for each vulnerable adult. All residents in an assisted living are categorically considered vulnerable adults.	02320		

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02320	Continued From page 66 The licensee's 1.03 Resident Record policy, dated February 1, 2022, indicated Cornerstone Management Services will retain a resident record containing all of the required and pertinent health and residency information needed for resident in onsite for each resident admitted into the facility. The licensee's 1.05 Readmission from other Health Care Facility, dated July 22, 2022, indicated "the facility will ensure that residents that are readmitted to the facility after an extended period at another health care facility will be re-assessed prior to re-admission to ensure the facility is still capable of meeting the needs of the resident. Based on the assessment the facility may not be able to take the resident back or may have to adjust the care plan to meet the new needs of the resident after a change in condition." No further information was 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 resident reviewed (R1, R2) were free from maltreatment. Findings include:	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 67 The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment of R1 and R2, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details. No plan of correction is required for this tag.	02360		
03000 SS=F	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a	03000		

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03000	Continued From page 68 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 resident to resident altercations. 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).	03000		

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03000	Continued From page 69	03000		

The findings include:

R1
R1's diagnoses included Wernicke's encephalopathy (a brain disorder that can cause confusion, disorientation, and lack of muscle coordination), alcohol induced dementia, and depression.

The resident admitted to the facility on December 1, 2020, and began receiving services under the current licensee after a change of ownership occurred on June 1, 2022.

The resident's record lacked evidence of a current service plan.

The resident's record lacked evidence of any recent assessments. A progress note entered on August 11, 2022, indicated a 90 day assessment had been completed with no concerns noted. The resident was noted to be jovial and cooperative.

The resident's record lacked evidence of a current Individual Abuse Prevention Plan (IAPP).

Progress notes from August 1, 2022, through the resident's September 22, 2022, discharge were requested. Progress notes provided began on September 7, 2022 and included the following notes:
-September 7, 2022, at 8:01 a.m., a behavior note entered by registered nurse (RN)-C noted "Resident to staff altercation with aggressive behavior. Per RA [resident assistant] staff, resident asked for ice, RAs saw cup she had was very dirty with brown water, so staff offered to get her a clean cup to fill and resident attempted to bite staff. Resident got in RA's face, began name calling, hitting, and pushing. Per RA staff,

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03000	Continued From page 70 resident was using very vulgar language such as "shove a banana up your cunt." "Go fuck yourself." "I hope you get raped and like it." Staff choose (sic) to walk away in another direction until resident stopped following them. Blue stone physicians updated." -September 8, 2022, at 4:01 p.m., a behavior note entered by on call RN-I noted "Resident was attempting to force feed another resident a banana at the table. Staff asked her to not feed other residents. [R1] became agitated and started to take items off the med cart and push things over, she threw the banana peel at the staff hitting her in the face and chest. The staff bent over to pick up the banana peel. As soon as she stood up the resident ran up behind the staff and struck her in the back of the head. Staff walked away from the resident and the resident angrily went to her apartment, slammed the door and locked it. The staff reported the incident to the PCP [primary care physician] and verbal orders received to call EMS [emergency medical services]. Resident was transported to ER [emergency room] for psychiatric evaluation of her behaviors...Families (sic) current wishes are that the resident doesn't return to the community as she is a danger to other vulnerable adults. This was relayed to PCP who is working with ER LSW [licensed social worker] to find more appropriate placement. No new interventions were implemented and a MAARC report was not submitted. -September 13, 2022, at 3:00 a.m., a behavior noted entered by RN-C noted, "Resident discharged from the [hospital] with diagnosis of aggressive behaviors...Guardian is requesting that resident should remain in her room for meals and supervised when out in the community with other residents as guardian is concerned for the well-being of staff and residents within the	03000		

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03000	Continued From page 71 community." No new interventions were implemented and a MAARC report was not submitted. -September 22, 2022, at 9:05 a.m., a progress note entered by RN-C indicated the resident discharged and transferred to a different senior living community. The resident's record contained a partially completed change of condition assessment from September 13, 2022, the day she returned from the hospital. The assessment was completed remotely and indicated R1 had a mood disorder and will hit, swear, bite, and name call. The resident was noted to have behaviors with a history of harming others, verbally and physically abusive to staff, and demonstrates anxious/paranoid or suspicious behavior. The resident was noted to be alert and responsive, oriented to person, place, time, and situation and had no apparent memory loss and could recall or retain information like recent events and was able to make safe judgments and function appropriately in social situations. The assessment further indicated the resident had behavioral symptoms including verbal and physical aggression and redirection was effective. The resident's record contained a care plan initiated on September 13, 2022. The section listing interventions for the resident's behaviors was blank with no interventions listed. The care plan indicated the resident did not have memory loss and could recall and retain information. On March 20, 2023, at 8:50 a.m., unlicensed personnel (ULP)-G stated she worked frequently with R1 and the resident had behaviors just about daily and was very physically abusive	03000		

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03000	Continued From page 72 towards other residents and staff. ULP-G stated the only interventions she was aware of was redirecting the resident or calling her family to come in and sit with her. ULP-G stated she had personally witnessed R1 push other residents on at least two occasions. ULP-G stated staff would often have to put themselves between R1 and other residents because she would try to push, punch, or throw things at them. ULP-G confirmed other residents were afraid of R1 and her behaviors had been going on for several months. ULP-G stated she had reported the resident to resident altercations to management but did not do a MAARC report herself. On March 21, 2023, at 9:20 a.m., ULP-J stated she would leave work on a nightly basis with bruises from R1 and that R1 would hit other residents as well too. ULP-J stated they would try to calm the resident down and keep other residents away from her if they weren't able to redirect her but that wasn't always effective. ULP-J stated R1 had targeted one resident and would focus a lot of her behaviors towards the other resident. ULP-J stated R1 had been having behaviors since at least November 2021. ULP-J stated she was aware of a time when another staff member called police after the resident bit her breast. ULP-J stated the police were called to help deal with her aggression and the resident had told police she'd bit the staff member again so she was taken to the ER. ULP-J stated she was aware the resident had dementia and cognition issues. ULP-J stated she had done video training on dementia but did not get any training on managing difficult or challenging behaviors. On March 21, 2023, at 10:40 a.m., licensed assisted living director in residence (LALDIR)-B	03000		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
03000	Continued From page 73 stated she had worked as a ULP from February to October 2022. LALDIR-B stated R1 would manipulate other residents and was more high functioning so she knew who to target. LALDIR-B stated R1 would be aggressive towards staff and residents and would pinch and hit and yell. LALDIR-B stated they'd try to redirect R1 or get her to calm down and figure out what triggered her. LALDIR-B stated R1 was sent to the ER after trying to feed another resident and when they told her she couldn't do that, it set her off. R1 threw a remote at a staff members head and said she was going to kill herself so they called the police. LALDIR-B stated she knew they changed a medication in the ER but it didn't do much and she wasn't sure what other interventions should be used. R2 R2's diagnoses included vascular dementia with behavior disturbance (a type of dementia caused by brain damage from impaired blood flow to the brain that causes difficulty with reasoning, planning, judgment, memory, and other thought processes) and depression. The resident admitted to the facility around April 28, 2022, and began receiving services under the current licensee after a change of ownership occurred on June 1, 2022. The resident's record lacked evidence of a current service plan. The resident's record lacked evidence of any recent assessments. The resident's record lacked evidence of a current Individual Abuse Prevention Plan (IAPP).	03000		

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	30601	A. BUILDING: _____ B. WING _____	C 03/21/2023

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03000	Continued From page 74 Progress notes from August 1, 2022, through the resident's September 20, 2022, discharge were requested. Progress notes provided began on September 4, 2022 and included the following notes: -September 4, 2022, at 10:27 a.m., a progress note entered by RN-C indicated there was a "resident to staff altercation-aggressive behavior. Resident pinched staff on arm, hard enough to draw blood. Resident hit, punched, spit, kicked, and threw hard toys and urine bucket at staff. Resident flashing her chest. Resident wishing death on staff as well as saying she was going to kill us. Incident witnessed by all staff and residents. Intervention, resident assisted to her room. No further behavioral concerns noted at this time..." -September 7, 2022, at 8:19 a.m., a behavior note entered by RN-C noted, "resident was coming out of another resident's room, staff offered that she was very mad. RA [resident assistant] attempted to redirect resident to her room, resident was upset and punched RA in the chest. There were not other witnesses at the time of incident..." R2's record contained several incident reports detailing resident to resident and resident to staff altercations. -July 20, 2022, at 3:30 p.m., a resident to resident altercation was reported by ULP after R2 hit another resident twice in the face, leaving little red marks. No new interventions were noted and the incident was not reported to MAARC. -July 20, 2022,at 7:40 p.m., a resident to resident altercation was reported by ULP after R2 was observed rubbing another resident's hand on her chest. The other resident was noted to be pulling away and told R2 to stop. R2 hit the resident in	03000		

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03000	Continued From page 75 the back. No new interventions were noted and the incident was not reported to MAARC. -July 21, 2022, at 6:00 p.m., a resident to resident and resident to staff altercation were reported by ULP after R2 was observed rubbing on another male resident and inappropriately touching him. The male resident was pushing R2 away and told her to go away. When staff intervened, R2 became very angry and began punching staff. No new interventions were noted and the incident was not reported to MAARC. -July 25, 2022, throughout the day, a resident to staff altercation was reported by ULP after R2 was observed walking up and down the hallways "being rude, yelling, calling names, in other resident's rooms, ripped [staff member's] nail off, choked, and pushed [staff member] down the hallway." -August 12, 2022, at 2:17 p.m., the resident was reported to have had a fall. -August 15, 2022, at 8:00 p.m., a resident to resident altercation was reported by ULP after R2 was observed to be crawling in to bed with another resident and "roll on top of her." When ULP attempted to redirect R2, she punched staff with a closed fist to the face. A note was entered by the RN on August 16, 2022, indicating "no additional interventions needed." No new interventions were noted and the incident was not reported to MAARC. -August 16, 2022, at 9:15 p.m., a resident to resident altercation was reported by ULP after R2 went in another resident's room and pushed her, causing the resident to fall back on the floor. The other resident was noted to have a small scratch on her forearm after the altercation. No new interventions were noted and the incident was not reported to MAARC. -August 17, 2022, from 3:00 p.m. to 6:00 p.m., ULP completed an incident report after R2 would	03000		

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03000	Continued From page 76 not stay out of other residents rooms, even after being asked to leave. R2 was noted to keep hitting staff. No new interventions were noted and the incident was not reported to MAARC. -August 17, 2022, at 5:30 p.m., a resident to resident altercation was reported by ULP after R2 went up to a resident who was eating dinner and wouldn't leave her alone. The other resident threw coffee at R2 and R2 hit the resident. Staff documented "We got [resident] to walk away and R2 keeped (sic) going at her." No new interventions were noted and the incident was not reported to MAARC. -August 27, 2022, at 7:45 p.m., a resident to resident and resident to staff altercation was reported by ULP after R2 entered another resident's room and broke her TV. Staff reported attempting to redirect R2 but she kept yelling and swearing and grabbed the staff member's wrist and would not let go. No new interventions were noted and the incident was not reported to MAARC. -September 4, 2022, a resident to staff altercation was reported by ULP after R2 pinched a staff member on the arm and drew blood. -September 5, 2022, a resident to staff altercation was reported by ULP after R2 came out of another resident's room and was very mad. ULP attempted redirection but R2 punched her in the chest. An incident report completed by ULP-G on September 8, 2022, indicated on September 7, 2022, she "took [R2] into the bathroom for a shower...when I went to help her with her pants, she only allowed me to pulled (sic) them halfway down before stepping into the shower. She then took them off in the shower. She wouldn't let me wash her up so we finished while she was scream and pinching me. She wouldn't let me	03000		

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03000	Continued From page 77 dress her or dry her off. Was walking around the bathroom naked, wet, throwing things and trying to rip things off the wall. When I wouldn't let her out off (sic) the bathroom naked she started hitting and scratching me. Sister's (sic) were both called and both said they couldn't come or they didn't know what we want her to do about it. Cops were called. [R2] spit on one cop and hit both. [R2] walked out of the bathroom with only a shirt and wet socks on, so we had to shut all other residents in the living room." For immediate interventions, ULP-G noted she tried talking calmly, moving quickly, moving slowly, letting her get herself dress (sic), singing our song, covering with a towel so we could leave the bathroom. I put everything she could break, throw, or pull on away out of her reach. I gave her space. Then called sisters (both). Then police were called." No new interventions were noted and the incident was not reported to MAARC. The resident was sent to the emergency room. The resident returned from the hospital on September 13, 2022. The resident's record contained a partially completed change of condition assessment dated September 13, 2022. The assessment was completed remotely and had nothing noted for psychological issues, behaviors, or cognitive issues. Wandering was the only issue checked for behavioral symptoms. The resident was not noted to have any other behaviors. No new interventions were put in place to ensure the safety of other residents or R2. On March 20, 2023, at 9:00 a.m., ULP-G stated R2 could be in a really great mood then with the flip of a switch, she'd be in a rage. ULP-G stated, "I can 100% say yes, the other residents were scared of her. We got to the point we had to put	03000		

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03000	Continued From page 78 locks on the doors so she couldn't get into the other resident's rooms." ULP-G stated there were a few times R2 was caught going in to another male resident's room and providing oral sex to that resident but "family was notified and everyone was ok with it" so it was not reported to MAARC and no other interventions were put in place. ULP-G stated R2 would try sticking her hands up another male resident's shorts and "he'd slap her away" and staff would try to intervene and redirect when they saw it happening. ULP-G stated R2 would try to climb in bed with a different male resident, hold his hand, or kiss him and that the resident's family was notified but the resident was his own person so no other interventions were done. ULP-G stated she did not feel safe working with R2 and felt like she couldn't keep other residents safe either. ULP-G stated RDO-A was notified of all those incidents and she was not sure if any MAARC reports were made regarding R2's behaviors. ULP-G stated the only interventions they used included redirection or calling the resident's family to come in and sit with her, if the resident's behaviors were too violent, they would call the police. On March 20, 2023, at 9:20 a.m., ULP-F stated both R1 and R2 would have physical altercations with both residents and staff. ULP-F stated interventions used included sending her to her room to relax, redirecting, and calling family to come in and sit with her. ULP-F stated the police had to be called after R2 wouldn't stay in her room after being diagnosed with COVID-19. ULP-F stated police didn't come as they stated, "there was nothing they could do because I worked in a memory care unit." ULP-F stated she didn't get any other guidance or direction from the nurse on how to handle either resident's	03000		

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03000	Continued From page 79 challenging behaviors and could not recall getting any training on MAARC reporting. ULP-F stated she didn't feel like she could care for R2 towards the end because it was too dangerous and she still had scars on her arms from being scratched and hit by R2. On March 21, 2023, at 9:30 a.m., ULP-J stated R2's behaviors depended on the day, sometimes she'd be great other times everything was wrong. ULP-J stated R2 would hit and pinch staff and would go after other residents at times. ULP-J stated R2 had some other episodes of inappropriate behavior towards other residents and that they had caught her giving oral sex to another resident once. ULP-J stated R2 would try to touch several other male residents and they would tell her no and to stop but she wouldn't and they were in wheelchairs so not able to get away. ULP-J was not sure if any of the incidents had been reported to MAARC but thought since R2's guardian was ok with it, it was fine. ULP-J stated the police had to be called on R2 after she hit and spit on staff and she did the same to the responding officers. ULP-J stated when both R1 and R2 returned from the ER, they did not get any new interventions or new direction on how to manage either resident's behaviors. ULP-J stated she knew R2 had dementia but didn't know anything else on what she had. On March 21, 2023, at 10:45 a.m., LALDIR-B stated R2 would go from 0 to 60, she'd be laughing then smack you in the face. LALDIR-B stated if R2 had bad behaviors, they'd try to redirect or try activities like coloring or music but it wasn't always effective. LALDIR-B stated she was not sure if any MAARC reports had been submitted for any of the resident to resident altercations. LALDIR-B stated she was not aware	03000		

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03000	Continued From page 80 of any new interventions or changes to either residents plan of care after they returned from the hospital. On March 21, 2023, at 11:15 a.m., regional director of operations (RDO)-A stated she was not sure if R1 or R2 had service plans, individual abuse prevention plans, behavioral assessments, or other assessments. RDO-A stated with the change of ownership on June 1, 2022, they did not get a lot of the records from the prior owner and was not sure what had been completed by facility staff. RDO-A stated she did not realize the resident record was missing those documents until they were requested by the investigator. RDO-A confirmed the September 13, 2022, assessment was not an accurate reflection of R1 and R2's current condition as both the change in condition assessments were completed remotely by an on call nurse who was not close to the facility. RDO-A stated using the police as an intervention for behaviors was not idea but every situation was different and it depended on the staff member's comfort level with the behavior and if there was a safety issue. RDO-A confirmed an intervention used for R1 after her return from the hospital was keeping her in her room as that's what her family had requested. RDO-A confirmed the facility had not assessed if this was a restraint or if other interventions would have been more effective and they had only implemented it because family requested they do so. RDO-A stated she was aware of incident reports for both R1 and R2 and there was a history of resident to resident altercations for both residents. RDO-A stated she was not sure if they had been reported to MAARC but the facility had done in house investigations. Copies of the investigations were requested however RDO-A stated they did not document their investigations	03000		

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03000	Continued From page 81 and did not have any records to show what their investigations entailed. RDO-A confirmed many of the incident reports were only partially filled out. RDO-A confirmed several of the incidents would be reportable but that direction would come from nursing, not the regional director as the regional director is not responsible for nursing. RDO-A confirmed she was a mandated reporter. RDO-A stated there were concerns about readmitting R1 and R2 due to safety concerns for the other residents and they were not sure they could keep the other residents safe from R1 and R2. RDO-A confirmed a MAARC report on behalf of the other residents and their safety concerns were not completed after R1 and R2 readmitted to the facility. The licensee's 2.49 Vulnerable Adult Maltreatment - Prevention & Reporting policy, dated August 1, 2021, indicated that "in accordance with state and federal vulnerable adult laws, our agency's employees will report any suspected maltreatment (abuse, neglect or financial exploitation of our home care clients [assisted living residents]." In addition, "if the incident appears to be suspected abuse, neglect or financial exploitation, the Director of Health Services or Community Director shall immediately make an oral report to the CEP [common entry point]." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	03000		