Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306211881M
Compliance #: HL306219669C

Date Concluded: September 9, 2024

Name, Address, and County of Licensee Investigated:
Golden Horizons
13631 East Shore Road
Crosslake, MN 56442
Crow Wing County

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

Evaluator's Name:
Katherine Barnhardt RN, Special Investigator

Finding: Not Substantiated

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 to provide services for the resident causing the resident to develop pressure sores and have a decline in health status.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Facility staff provided care based on the resident's plan of care, the resident's preferences, and collaborated with outside agencies to support the resident's needs.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, unlicensed staff, and a family member. The investigation included review of the resident record, death record, pharmacy records, facility incident reports, personnel files, staff schedules, hospice records, video, pictures and related facility policy and procedures. Also, the investigator observed interactions between staff members and residents.

The resident resided in an assisted living facility. The resident's diagnoses included stomach cancer and left sided stroke. The resident's service plan included assistance with ambulation, toileting, transferring and repositioning. The resident's assessment indicated he was slowly declining physically, refused position changes, and enjoyed sitting in his recliner. The resident had minor forgetfulness, weight was stable, and clearly communicated needs to staff.

A review of the resident's record indicated the resident had a steady decline in health. The resident often declined meals or consumed minimal amounts of food and when the resident declined facility meals family would bring him foods he preferred. A weight report indicated the resident had a ten-pound weight loss from admission in 2022 to discharge winter 2024. The resident often refused repositioning and preferred to sit in his recliner throughout the day. Due to immobility and refusals to "offload" (change position) as ordered by a provider, the resident intermittently developed pressure sores. When pressure sores appeared, nursing care was provided, wound care consults were implemented, and the resident's pressure sores resolved over time. The facility recommended home care and hospice supplemental services on two occasions as the resident's health declined. The resident's family started and then stopped supplemental services the first time.

The resident's hospice records indicated the resident admitted to a hospice agency during the early fall of 2023 and discharged two months later due to "indecisiveness" about supplemental services. The day after discharge from the first hospice agency, a second home care and hospice agency admitted the resident and provided supplemental cares at the facility. Hospice and home health services included nursing and aide assistance with bathing, grooming, wound management, monitoring cares, and agency licensed nurses provided education to facility staff. The hospice agency provided medications to protect the resident's skin from breakdown and supplied assistive medical devices to prevent pressure sores from developing. Hospice records indicated the resident's skin condition was poor, he often refused to be weighed and refused showering. Preventions were put in place to prevent pressure sores and when pressure sores did develop, they were treated and resolved.

During an interview, an unlicensed staff member stated the resident was frail, had a progressive health decline and spent a lot of time in bed towards the end. The staff member stated the resident had a pressure sore that was not healing and repositioning was offered or completed frequently at the direction of hospice. The staff member stated hospice assisted the facility with services and provided bathing, care monitoring and medications for the resident. The staff member stated at times the resident was verbal and would yell at staff to get out of his room, but services were offered.

During an interview, a family member stated she eventually moved the resident to another facility type that provided the resident with a higher level of care.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

“Not Substantiated” means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

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

Vulnerable Adult interviewed: No, deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not applicable

Action taken by facility:
The facility notified providers and collaborated with outside agencies to support the resident’s increasing care needs.

Action taken by the Minnesota Department of Health:
No further action taken at this time.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30621	A. BUILDING: _____ B. WING _____	C 07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN HORIZONS	13631 E SHORE RD CROSS LAKE, MN 56442

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION****** ASSISTED LIVING LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.01 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL306211881M/#HL306219669C #HL306213522M/#HL306213825C On July 31, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 32 residents receiving services under the assisted living with dementia license. The following correction order is issued for # HL306213522M/#HL306213825C, tag identification 1370, 1380 and 1460.	0 000	Assisted Living Provider 144G. Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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01370	Continued From page 1	01370		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and	01370		

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01370	Continued From page 2 (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training was completed in all required areas for one of one unlicensed personnel (ULP)-H. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-H was hired on January 4, 2024, to provide direct cares to licensee's residents. ULP-H's employee file lacked documentation of training and competency evaluations for the following topics: - documentation requirements for all services provided; - appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; and (iv) dressing and assisting with toileting. - standby assistance techniques and how to perform them; - basic nutrition, meal preparation, and assistance with eating;	01370		

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01370	Continued From page 3 - preparation of modified diets as ordered by a licensed health professional; - awareness of confidentiality and privacy; and - awareness of commonly used health technology equipment and assistive devices. On August 2, 2024, at 9:45 a.m., ULP-H stated she provided assistance for residents to include; medication administration, dressing, grooming, bathing, toileting, feeding, ambulation and transfers. ULP-H stated she had an out of state certified nursing assistant certification and applied for a Minnesota certification when hired. The Minnesota certification was effective February 9, 2024, (34 days following employment.) On August 8, 2024, at 12:27 p.m., director of nursing (DON)-F confirmed ULP-H personnel records did not contain documentation ULP-H completed training in all required areas. DON-A stated, ULP-H was hired during a leadership transition period at the same time as DON-F and ULP-H's training may have been missed. The licensee's Orientation and Training Policy dated March 18, 2020, indicated all staff must be trained and competent in services consistent with current practice standards and appropriate to resident needs. Orientation must be completed once for each staff person. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01370		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn	01380		

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01380	Continued From page 4 (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency was completed for one of one unlicensed personnel (ULP)-H to include all required content. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-H was hired on January 4, 2024, to provide direct cares to licensee's residents.	01380		

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01380	Continued From page 5 ULP-H's employee file lacked documentation of competency evaluations by a registered nurse (RN) for the following topics: - reading and recording temperature, pulse and respirations of the resident; - recognizing physical, emotional, cognitive, and developmental needs of the resident; - safe transfer techniques and ambulation; - range of motioning and positioning; and - other RN/professionally delegated tasks. On August 2, 2024, at 9:45 a.m., ULP-H stated she provided assistance for residents to include; medication administration, dressing, grooming, bathing, toileting, feeding, ambulation and transfers. ULP-H stated she had an out of state certified nursing assistant certification and applied for a Minnesota certification when hired. The Minnesota certification was effective February 9, 2024. On August 8, 2024, at 12:27 p.m., director of nursing (DON)-F confirmed ULP-H personnel records did not contain documentation ULP-H completed training in all required areas. DON-A stated, ULP-H was hired during a leadership transition period at the same time as DON-F and ULP-H's training may have been missed. The licensee's Orientation and Training Policy dated March 18, 2020, indicated all staff must be trained and competent in services consistent with current practice standards and appropriate to resident needs. Orientation must be completed once for each staff person. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01380		

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01460 SS=F	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide staff orientation to assisted living licensing requirements and regulations for one of one unlicensed personnel (ULP)-H. This has the potential to affect all thirty-one (31) residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-H's employee record did not contain documentation of completed orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. ULP-H's record failed to contain the following: - an overview of this chapter;	01460		

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01460	Continued From page 7 - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; - handling of emergencies and use of emergency services; - compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; - the handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; - consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and - a review of the types of assisted living services the employee will be providing and the facility's category of licensure. On August 2, 2024, at 9:45 a.m., ULP-H stated she provided assistance for residents to include; medication administration, dressing, grooming, bathing, toileting, feeding, ambulation and transfers. On August 8, 2024, at 12:27 p.m., director of nursing (DON)-F confirmed ULP-H personnel records did not contain documentation ULP-H	01460		

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01460	Continued From page 8 completed training in all required areas. DON-A stated, ULP-H was hired during a leadership transition period at the same time as DON-F and ULP-H's training may have been missed. The licensee's Orientation and Training Policy dated March 18, 2020, indicated all staff must be trained and competent in services consistent with current practice standards and appropriate to resident needs. Orientation must be completed once for each staff person. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01460		