Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL30666003M
Compliance #: HL30666004C

Date Concluded: June 21, 2022

Name, Address, and County of Licensee Investigated:
Maplewood's Assisted Living
40170 County Road 257
Cohasset, MN 55721
Itasca County

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

Evaluator's Name: Carol Moroney RN, Special Investigator
Jessica Sellner, RN, Rapid Response Supervisor

Finding: Substantiated, individual responsibility

Nature of Visit:
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): It is alleged the Alleged Perpetrator (AP) sexually abused the resident when the AP touched the residents' breasts and vagina.

Investigative Findings and Conclusion:
Abuse was substantiated. Based on a preponderance of evidence, the AP was responsible for the maltreatment. The resident reported to multiple people the AP touched (fondled) her bare breast and put his fingers inside her vagina. The residents' allegations of the sexual abuse remained consistent, and the resident reported to staff she was fearful of the AP and did not want him to provide cares to her. The AP had a prior, similar allegation of sexual abuse of putting his finger inside another resident's vagina.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. In addition, interviews with hospice personnel, the police investigator, the local sexual assault nurse examiner nurse (SANE), and the hospital personnel were also completed. The investigator reviewed the residents medical record, facility policy and procedures, staff training, hospital records, law enforcement reports, and prior facility incident reports.

The residents medical record indicated the resident's cognitive status varied from day to day. The resident had diagnosis including Alzheimer's disease, dementia, and depression. The resident required staff assistance with all activities of daily living including toileting and bed mobility.

The residents progress notes indicated one morning the resident told an unlicensed staff member she did not want the AP to assist her with cares. The resident stated the AP touched her inappropriately and she did not want him taking care of her.

The resident's hospice records indicated the resident told hospice staff the AP was checking the residents brief to see if it needed to be changed and the AP touched the resident's peri area and breast. The resident stated, the AP "feels me up" while checking her brief. The resident also reported the AP touched the resident's body and not just the brief when he checked to see if the brief was wet. The resident told the hospice staff she "feels dirty" when the AP touched her.

The police report indicated law enforcement contacted the facility regarding the alleged sexual assault. Law enforcement requested the resident be transported to the hospital for a sexual assault exam. Law enforcement met with the resident at the hospital who was accompanied by a SANE (sexual assault nurse examiner). The report indicated the resident was alert to person, place, and time; and was aware of the reason she was in the emergency room.

The police report indicated the resident stated the AP worked the overnight shift and the AP's "job" was to check the residents brief to see if the brief was soiled and needs to be changed. The resident stated last time the AP checked her he put his hand into her brief and "His hand ended up in my crotch". The resident stated the AP put his entire hand in her brief and felt around for approximately one minute. She said the AP stuck his finger(s) into her vagina. After

that the AP reached under the resident's T-shirt and touched her bare breast. The resident stated neither her nor the AP said anything during the incident. The resident stated the AP nor any other staff have previously checked her brief by putting their hand into the brief and touching her peri area. The resident was able to describe what she was wearing at the time of the incident and told law enforcement where the clothing was at the facility.

The police report indicated they interviewed the AP regarding the sexual assault allegation which he denied. The AP stated the resident wasn't always "All there;" which the AP clarified meant she was mentally unstable. The AP stated he is the only staff member working in the building from 11:00 p.m.- 7:00 a.m. to provide assistance to all the residents. However, the AP stated he did not provide the resident assistance with toileting and/ or cares because the resident was uncomfortable having the AP change her because she does not like male caregivers. The AP denied changing, attempting to change, or checking to see if the resident needed to be assisted to change her brief the night of the incident.

The residents medical record indicated the night of the incident the AP documented assisting the resident with toileting once, bed mobility 4 times, and provided assistance with medication administration twice.

The residents progress note indicated the resident was "upset" because the AP was coming back to work at the facility. The note indicated the management staff talked with the resident and reminded her she is confused. The management also reminded the resident the AP had worked at the facility for the prior 2 years and the resident had no prior issues with the AP. The owner of the facility spoke with law enforcement and told them he was "confident" the AP did not "hurt" the resident and the resident had recently made a statement about having a baby with a male hospice worker. However, the residents progress notes indicate the resident was asked if she and the male hospice worker had sexual contact and the resident told them no. There was no documentation the resident had ever made allegations of sexual abuse prior to reporting the incident with the AP.

The resident progress note written approximately 3-4 days after the incident indicated the resident was telling the night staff a male staff member touched her when he was checking to see if her brief was wet. Night shift told the resident they need to check her brief to see if she is wet. The progress note indicated when law enforcement spoke to the owner regarding the AP, the owner described the AP as a good employee, kind, prompt, and has family members working at the facility. The note indicated the resident was confused and on a lot of medication, and the AP would continue to work at the facility. The owner also indicated he spoke to the resident's family members and told them he trusted his staff.

When interviewed, management stated the AP had a prior sexual abuse allegation from a different resident at their other facility location. Management acknowledged the resident at the other facility's sexual abuse allegation was similar to the current allegation of the AP putting his finger in her vagina while assisting her with toileting. Management stated both residents were confused and had dementia and so the facility determined the allegations of sexual abuse did not occur.

When interviewed an unlicensed staff member stated when she arrived at work one morning the resident was in tears and told her the AP had touched her breasts and put his finger in her vagina. The staff member reported the resident did not seem confused when she reported the incident. The staff member stated after the alleged sexual abuse the resident would cry and appear upset. The resident told staff she wanted the AP to leave the facility and not provide cares to her.

When interviewed the resident was tearful and stated the AP touched her vagina and bare breasts.

When interviewed the AP denied touching the resident's breast or vagina. The AP stated he wasn't sure why the resident would accuse him of sexually touching her. The AP stated he thought maybe a coworker started "this" [the sexual assault allegation] and complained about him. The AP stated although the resident required assistance with brief change and bed mobility, he did not provide cares to the resident. If the resident needed assistance to change her soiled brief, The AP would tell the resident to wait until the next shift would come in. The AP stated a different resident accused him of sticking his finger in her vagina about a year prior, however, that resident was confused and kept "changing her story."

In conclusion, abuse was substantiated.

"**Substantiated**" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening;

(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult; and
(4) use of any aversive or deprivation procedures for persons with developmental disabilities or related conditions not authorized under section 245.825.
(c) Any sexual contact or penetration as defined in section 609.341, between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.
(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility removed the AP from the schedule, reassessed the resident, and ensured male caregivers did not provide assistance to the resident.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment. 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, or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

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

cc:
The Office of Ombudsman for Long-Term Care
The Office of Ombudsman for Mental Health and Developmental Disability
Itasca County Attorney
Cohasset City Attorney
Itasca county Sheriff's office

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30666	A. BUILDING: _____ B. WING _____	C 05/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE WOODS ASSISTED LIVING	40170 COUNTY ROAD 257 COHASSET, MN 55721

(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 Initial comments *****ATTENTION****** ASSISTED LIVING LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 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: #HL30666001M/ HL30666002C #HL30666003M/ HL30666004C #HL30666005M/ HL30666006C On April 19, 2022, the Minnesota Department of Health conducted an investigation at the above provider, and the following immediate correction orders are issued. At the time of the investigation, there were 17 residents receiving services under the provider's Assisted Living with Dementia Care license. The following immediate correction orders were issued on April 20, 2022, for #HL30666003M/ HL30666004C, tag identification 0110, 0630, and 2070. On April 27. 2022, the immediacy for tags 0630 and 2070 was removed. Non-compliance remained at a scope and severity of a G for tag	0 000	The Minnesota Department of Health documents the State Licensing 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that 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. Per Minnesota Statute §144G.30, Subd. 5 (c), the assisted living facilities must document any action taken to comply with the correction order. A copy of the provider ' s records documenting those actions may be requested for follow-up surveys. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider ' s Plan of Correction." The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144G.31, Subd. 2 and 3.	

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0 000	Continued From page 1 0630. Non-compliance remained at a scope and severity of a E for tag 2070. On May 6, 2022, the immediacy was removed for tag 0110 and the citation was corrected. The following immediate correction order was issued on May 13, 2022, for #HL30666001M/ HL30666002C, #HL30666003M/ HL30666004C, and #HL30666005M/ HL30666006C, tag identification 2310. On May 19th the facility submitted a plan of correction which indicated assessments, service plans, and staff training would be completed. The immediacy for tag identification 2310 remains and has not been removed. The following correction orders which are not immediate were issued for #HL30666001M/ HL30666002C, #HL30666003M/ HL30666004C, and #HL30666005M/ HL30666006C, tag identification 0620, 2360, and 3000.	0 000		
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employment of an assisted living director (LALD) licensed by the Board of Executives for Long Term Services and	0 110	The immediacy was removed and the citation was corrected on May 6, 2022, when the facility showed documentation of employment of a LALD.	

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0 110	Continued From page 2 Supports (BELTSS). This had the potential to affect all 17 residents receiving Assisted Living services. This resulted in an immediate correction order identified on April 20, 2022. The immediacy was removed and the citation was corrected on May 6, 2022, when the facility showed documentation of employment of a LALD. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings included: When interviewed on April 20, 2022, at 12:15 p.m. owner (O)-B stated licensed practical nurse (LPN)-C was the LALD for the facility. When interviewed on April 20, 2022, at 12:40 p.m. LPN-C stated she was the LALD for the facility but had not received any further information regarding the licensure. LPN-C stated she sent an application for the licensure in May 2021, but had not received her license yet. Review of BELTSS license verification website on April 20, 2022, at 10:00 a.m., did not indicate LPN-C was a LALD. No further information provided.	0 110		

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0 110	Continued From page 3 TIME PERIOD FOR CORRECTION: Immediate	0 110		
0 620 SS=E	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma 144G.42 Subd. 6. Compliance with requirements for reporting maltreatment of vulnerable adults; abuse prevention plan. (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 document review and interview, the licensee failed to comply with the requirements for reporting suspected maltreatment of vulnerable adults to the Minnesota Adult Abuse Reporting Center (MAARC) or Common Entry Point (CEP) for two of two residents (R1, R2), who reported abuse and maltreatment. In addition, the licensee failed to complete a thorough investigation following three of three, (R1, R2, R3) reportable events. 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 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:	0 620		

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0 620	Continued From page 4 R1's diagnoses included liver failure, essential hypertension, and hearing problems. R1's Individual Abuse Prevention Plan dated February 8, 2022, indicated R1 required assistance with all activities of daily living, dressing, had open areas on her lower legs, required assistance with repositioning and transferred with a mechanical lift. R1's progress notes indicated March 25, 2021, R1 asked staff to call the owner and stated she did not want a male staff member (ULP-A) in her room. The hospice social worker (SW)-E brought concerns to facility license practical nurse (LPN)-C that R1 stated a male staff touched her inappropriately. R1 told SW-E the staff was checking her brief but went "a little too deep." A police report dated March 25, 2022, indicated the police were investigating a report of ULP-A touching R1 sexually. The report indicated on April 8, 2022, ULP-A was interviewed by law enforcement. ULP-A stated he didn't change R1's brief "unless absolutely necessary." ULP-A stated R1 was uncomfortable having him change her brief "because he is a guy." ULP-A stated, "The only time [ULP-A] I actually do it [change the brief] is if she's used the other one, she hasn't pissed but she shit because then that's everywhere. And usually I [ULP-A] used to leave that too just because [ULP-A] I didn't want this to happen." ULP-A described his normal routine when he works the night shift with R1 and stated he pokes his head into the room to check "if she's [R1] breathing." ULP-A stated again R1 was uncomfortable having him change her brief. R1's hospital records dated March 25, 2022,	0 620		

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0 620	Continued From page 5 indicated R1 presented to emergency department by ambulance for evaluation of an alleged sexual assault that occurred at the facility. The notes indicated R1 stated she was sexually assaulted by a staff member between 12:00 a.m.- 1:00 a.m. R1 spoke to the Itasca County investigator and was evaluated by the "SANE" (sexually assault nurse evaluation) and DNA samples were obtained. The hospital records indicated R1 was orientated to person, place, and time. R1 stated she was ready to go back to the facility because ULP-A was no longer going to be at the facility. During an interview on April 19, 2022, at approximately 10:00 a.m., registered nurse (RN)-D indicated the allegation of sexual assault was not reported to MAARC because the faciltiy thought hospice reported it. In addition, RN-D verified the facility did not have a thorough investigation because they spoke to the resident and ULP-A and the facility determined it was a false accusation. R2's Individual Abuse Prevention Plan dated March 9, 2022, indicated R2 was vulnerable and required assistance with all activities of daily living including dressing, repositioning, ambulating, and transfers. R2's facility progress note dated March 10, 2022, at 9:25 a.m. indicated staff reported the resident called 911 on her own accord. R2 told 911 she is in so much pain and she could not stand it. Staff reported the resident was given a PRN (as needed) Oxycodone (pain reliever) earlier that morning. Staff reported R2 was stumbling when ambulating to breakfast but told the emergency personal she had fallen in the dining room; which staff say did not occur. The note indicated, "This is a common occurrence for the resident. Staff	0 620		

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0 620	Continued From page 6 reported she did not take any of her morning medications as well." R2's ambulance transport sheet dated May 10, 2022, indicated they were dispatched at 8:56 a.m. to the facility responding to a resident who fell and was complaining of overall pain and pain in her left shoulder/ arm. When the ambulance staff entered the facility, staff were not aware R2 called 911. The facility staff told the emergency services R2 initially refused to get out of bed, however, after staff encouragement R2 agreed to get up. The staff stated R2 was walking in the hallway and the resident "Put herself against the wall." Staff assisted R2 to a chair in the dining room, left the resident alone, and R2 called 911. R2 told the ambulance staff the facility staff jerked her out of bed, threw her on the floor, wouldn't help her "for awhile", and "drug her to the chair in the dining room and left her there. R2 had a urinary catheter bag "tied to her leg" with dark and cloudy urine. The resident stated she didn't feel like the staff at the facility were able to take care of her. R2 was transported to the hospital. R2's emergency room notes dated March 10, 2022, indicated R2 reported the staff at the facility were not caring for her adequately. R2 stated staff pulled her out of bed that morning and staff were "rough handling." The resident stated she fell earlier that morning due to the incorrect type of walker being given to her and "prodding" by staff to ambulate faster than she was able. R2 was alert and orientated x2 (place and self, not orientated to time). The resident had several open areas on her upper thighs and peri-area and had dried stool in her peri-area. The urinary catheter securing device was dislodged with a large amount of residual adhesive still attached to the residents skin. R2's indwelling urinary	0 620		

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0 620	Continued From page 7 catheter was kinked and not draining urine. R2 also had redness, warmth, swelling and tenderness in her right lower leg, and complained of left shoulder pain. R2 told hospital staff she was scared for her safety at the facility and felt she needed a higher level of care. The physician note indicated, "I agree with that [higher level of care needed] in the condition she was found (Cellulitis, Foley [urinary catheter] that was kinked, open skin on her peri-area, dried stool on her skin) it seems that she needs a higher level of care." R2 was diagnosed with cellulitis, a urinary tract infection, and a new dislocated left shoulder. The resident was admitted to the hospital and did not return to the facility. During interview on April 19, 2022, RN-D confirmed the facility did not report R2's injury to MAARC and did not complete a thorough investigation of this event. R3's Individual Abuse Prevention Plan dated March 15, 2022, indicated R3 was vulnerable and required assistance with all activities of daily living, including, dressing, repositioning, ambulating, and transfers. R3 did not have a call pendant to call for assistance. A facility document titled Other injury dated 4/16/22, at 6:22 p.m. indicated staff reported R3 had a large bruise of unknown origin to her back and had complaints of pain. The staff were not aware of any recent falls, however, the resident stated she thought she fell yesterday. Morning staff stated they did not see the bruise earlier that morning. R3 was transported to the emergency room for evaluation and staff would be provided education on notifying the nurse of injury's and change of condition.	0 620		

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0 620	Continued From page 8 A text message dated 4/16/22, at 6:28 p.m. indicated registered nurse (RN)-D sent R3's family member a text indicating R3 had a large bruise on her back. RN-D indicated she "would assume" the resident fell and was able to get herself up off the floor. Day shift had not mentioned anything regarding the bruise, and "a few days ago" staff did not see the bruise on the resident when assisting her with a bath. RN-D stated the bruise looked pretty "fresh" and R3 was complaining of a lot of pain. RN-D asked the family member if they wanted R3 sent to the hospital to be evaluated. R3's facility Discharge/ Transfer Summary indicated the resident was discharged on 4/28/22, to a nursing home. R3 was transported to the emergency room by her guardian on 4/16/22, at 7:40 p.m. for a bruise of unknown origin on the left side of her back. The evening staff noticed the bruise while assisting the resident with toileting. R3 was admitted to the hospital for weakness and acute femur fracture. R3 was at risk for falls and staff were directed to provide "frequent safety checks." The resident only used a wheelchair for long distance or outside appointments. The summary indicated R3 was unable to use a call pendent and the resident did not have a call pendent to request staff assistance. Staff were to ensure R3 was monitored, "with regular checks to assure safety." The facility had no further investigation regarding the bruise and injury of unknown origin. The facility policy and procedure titled Vulnerable Adult Maltreatment dated January 2, 2022, indicated: -the staff person will intervene to stop the maltreatment while it is occurring;	0 620		

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0 620	Continued From page 9 -the staff person shall take appropriate steps to get the vulnerable adult to a place of safety; -call 911 if a crime is suspected; -the alleged perpetrator will be directed to leave the premises, or the police will be called to escort the person out. If it is unclear whether maltreatment has occurred, an investigation into the incident will begin immediately. A report will be made to MAARC within 24 hours. Staff will complete an incident report. The facility staff will complete a thorough investigation. Time Period for Correction: Fourteen (14) days.	0 620		
0 630 SS=J	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 observation, interview, and record review, the licensee failed to develop and implement a safety plan with specific interventions for each known vulnerability for one	0 630		

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0 630	Continued From page 10 of one resident (R1) reviewed for safety. This resulted in an immediacy when R1's plan of care lacked specific interventions to ensure the residents safety after the resident accused a staff member, unlicensed personal (ULP)-A, of sexual abuse. R1 requested ULP-A no longer provide cares for her. However, ULP-A continued to work nights as the only staff in the building to assist R1 with cares. The facility was notified of the immediacy on April 20, 2022. The immediacy was removed on April 27, 2022, when the facility developed a safety plan for R1 related to the residents vulnerabilities. The facility removed ULP-A from the schedule. Non-compliance remains at a scope and severity of a G. This practice resulted in a level four violation (a violation that results in serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's service plan dated December 8, 2021, indicated the resident required staff assistance with dressing, showering, bed mobility, drinking and eating assistance, and toileting three times a day. R1's Individual Abuse Prevention Plan (IAPP) dated March 28, 2022, indicated R1 had diagnoses including anxiety, depression, nonalcoholic liver disease, and dysphagia. The	0 630		

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0 630	Continued From page 11 assessment indicated R1 was at risk to be abused. Staff were to monitor for signs and symptoms of abuse and report any concerns to the nursing staff. The assessment indicated some examples of showing signs of abuse are R1 cowering when certain staff are around, or the resident stating they are afraid of a staff member. The assessment indicated staff would help reposition the resident "frequently" while in bed, provide peri-care on R1 with each continent and incontinent void/bowel movement, and check and change resident's brief "frequently." R1 preferred not to have male caregivers and male caregivers were directed to ask the resident if they are allowed to assist her with brief changes and document refusal and report to the nurse. The IAPP indicated R1 reported a possible sexual assault on 3/25/22. R1 told the morning staff the night shift staff had touched her inappropriately. The IAPP did not identify specific measures to be taken to minimize the risk of sexual abuse to R1, nor did it identify how R1 would receive assistance with cares if there is only male staff working at the facility. A police report dated March 25, 2022, indicated the police were investigating a report of ULP-A touching R1 sexually. The report indicated on April 8, 2022, ULP-A was interviewed by law enforcement. ULP-A stated he didn't change R1's brief "unless absolutely necessary." ULP-A stated R1 was uncomfortable having him change her brief "because he is a guy." ULP-A stated, "The only time [ULP-A] I actually do it [change the brief] is if she's used the other one, she hasn't pissed but she shit because then that's everywhere. And usually I [ULP-A] used to leave that too just because [ULP-A] I didn't want this to happen." ULP-A described his normal routine when he works the night shift with R1 and stated	0 630		

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0 630	Continued From page 12 he pokes his head into the room to check "if she's [R1] breathing." ULP-A stated again R1 was uncomfortable having him change her brief. R1's hospital records dated March 25, 2022, indicated R1 presented to emergency department by ambulance for evaluation of an alleged sexual assault that occurred at the facility. The notes indicated R1 stated she was sexually assaulted by a staff member between 12:00 a.m.- 1:00 a.m. R1 spoke to the Itasca County investigator and was evaluated by the "SANE" (sexually assault nurse evaluation) and DNA samples were obtained. The hospital records indicated R1 was orientated to person, place, and time. R1 stated she was ready to go back to the facility because ULP-A was no longer going to be at the facility. Review of R1's progress notes included the following: - March 25, 2021, R1 asked staff to call the owner and stated she did not want a male staff member (ULP-A)in her room. The St Croix hospice social worker (SW)-E brought concerns to facility license practical nurse (LPN)-C that R1 stated a male staff touched her inappropriately. R1 told SW-E the staff was checking her brief but went "a little too deep." - March 25, 2022, the Itasca County sheriff's investigator (I)-F stated a MAARC report was filed today and wondered how ULP-A was at work. Owner (O)-B and LPN-C explained ULP-A was prompt, has been observed to be kind to the residents, and also has two sisters working in the facility. I-F requested R1 be taken to the hospital for a SANE exam. - March 25, 2022, family (F)-G called O-B to discuss the sexual assault allegation. O-B explained he trusted his staff. F-G stated R1 had	0 630		

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0 630	Continued From page 13 been lucid the day she made the sexual assault allegation. F-G asked if ULP-A would be kept away from R1 during the investigation and O-B assured her ULP-A would not be providing cares to R1. - March 28, 2022, R1's new plan was for morning staff to come to work and assist R1 with a brief change at 7:00 a.m., evening staff are to change R1 at 11:00 p.m. before night shift arrives. Night shift is to ask R1 at 3:00 a.m. if they can assist her with a brief change. R1 preferred female care givers only. Male caregivers were to ask R1 if they may assist her. Review of the facility schedule dated April 11-April 24, 2022, indicated ULP-A worked alone in the facility from 11:00 p.m.- 7:00 a.m. on April 11, April 13, April 17, and April 20, 2022. ULP-A was the only staff in the building to assist R1 with cares. During interview and observation on April 19, 2022, at 9:30 a.m., R1 was sitting in her room in a Broada chair (a wheelchair that leans back). R1 stated recently ULP-A was changing her brief and he touched her "down there" with his bare fingers and also touched her breasts with his bare fingers. When asked to clarify what he touched, R1 stated it was her vagina and began to cry. During an interview on April 19, 2022, at 10:20 a.m., O-B and LPN-C stated R1 did not want ULP-A to assist her with cares. ULP-A is scheduled to work alone at night from 11:00 p.m.-7:00 a.m. LPN-C stated a staff member who lives near the facility comes into the facility at 3:00 a.m. to change R1's brief the nights ULP-A is working. LPN-C stated if R1 required assistance when ULP-A was the only staff working, ULP-A was instructed to stand in the	0 630		

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0 630	Continued From page 14 resident's doorway and ask what she needs. O-B stated ULP-A was a good person and he did not touch R1 sexually. O-B stated R1 was confused and had "delusions" in the past. When asked about the lack of facility investigation O-B stated they didn't feel they needed to go any further in the investigation because they didn't feel it was a valid report. During a follow up interview on April `19, 2022, at 10:45 a.m., O-B stated ULP-H reported R1 stated ULP-A sexually touched the resident. O-B stated he put a camera in the hallway by R1's room that family could view as well. O-B stated RN-D completed the investigation and did not find anything wrong with the care ULP-A gave to R1, so he returned back to work. O-B stated when ULP-A works the 11:00 p.m.- 7:00 a.m. shift he does not provide cares to R1. The facility policy titled Vulnerable Adult Maltreatment Policy, dated April 1, 2022, indicated staff will complete an internal investigation including: an incident report; internal investigation pertaining to the report of potential or suspected maltreatment. The staff will intervene to stop the maltreatment; The staff person shall take appropriate steps to get the vulnerable adult to a place of safety; If the staff person is the alleged perpetrator, the staff person will be directed to leave the building immediately and will be instructed not to come to work until further notice. TIME PERIOD TO CORRECT - Immediate	0 630		
02070 SS=I	144G.81 Subd. 4 Awake staff requirement An assisted living facility with dementia care	02070		

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02070	Continued From page 15 providing services in a secured dementia care unit must have an awake person who is physically present in the secured dementia care unit 24 hours per day, seven days per week, who is responsible for responding to the requests of residents for assistance with health and safety needs, and who meets the requirements of section 144G.41, subdivision 1, clause (12). This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the facility was staffed twenty-four hours a day, seven days a week. This had the potential to affect all 17 residents residing at the facility. The immediacy was identified on April 21, 2022. The immediacy was removed on April 27, 2022, when the facility reassessed staffing needs, combined two units together, and ensured two staff were available at all times. Non-compliance remained at a scope and severity of a F. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment,or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During observation on 4/19/22, at approximately 11:00 a.m. the facility was observed to have 2 locked units separated by a short hallway; unit B	02070		

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02070	Continued From page 16 and unit C. The licensee held an assisted living with dementia care license and had a current census of 17 residents. The facility staffing schedule dated April 11- April 24, 2022, indicated one staff was scheduled to work from 11:00 p.m.- 7:00 a.m., or 9:00 p.m.- 7:00 a.m. on all 13 days. During interview on April 21, 2022, at 12:30 p.m., owner (O)-B stated the facility was split up into 3 separate units. Two of those units, units B and C, were both secured, locked memory care units which required a code to be entered to get into or out of the units. One of the units had 7 residents and the other had 3. O-B stated the facility only had one staff member working the over-night shift (11:00 p.m.-7:00 a.m.). O-B stated the night shift provided cares to residents on all 3 units. O-B verified there are residents in the facility who require assistance of two staff for transfers and/ or cares. On April 21, 2022, at 12:45 p.m., licensed practical nurse (LPN)-C stated only one staff worked on the night shift and provided cares on all 3 units. LPN-C stated the facility didn't have a specific staffing plan but had a staffing policy which she would send for review. No staffing policy was received. TIME PERIOD FOR CORRECTION: Immediate	02070		
02310 SS=K	144G.91 Subd. 4 Appropriate care and services (a) Residents have the right to care and assisted	02310		

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02310	Continued From page 17 living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure appropriate care and services were provided to 3 of 3 residents, R1, R2, and R3, reviewed for staff services provided. The facility failed to ensure R1, R2, and R3 were assessed to determine the individualized plan of care to ensure staff provided appropriate care and services. The facility was notified of the immediate correction order on May 13, 2022, when it was determined the facility had no assessments completed to determine resident specific needs to ensure individualized, appropriate care and services were provided by staff This practice resulted in a level four violation (a violation that results in serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of clients 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: During interview on April 19, 2022, at 9:15 a.m.., registered nurse (RN)-D stated the resident documents titled Services Provided is how the staff document services that were provided to the residents, which is based off the residents individualized assessment. RN-D also stated the resident assessments are considered the	02310		

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02310	Continued From page 18 residents care plan which directs staff on the individual needs of the resident. R1's service plan dated December 8, 2021, indicated the resident had diagnosis including dysphagia, chronic nonalcoholic liver disease, and chronic renal impairment. The service plan indicated R1 required assistance with eating, drinking fluids, bed mobility, dressing, hygiene, safety checks, skin check, support stockings, toileting assistance, and transfer assistance. R1's facility assessment dated February 10, 2022, indicated under bed mobility staff would help reposition the resident while in bed. The assessment also directed staff to turn and reposition the resident "frequently," while in bed and to complete "frequent, random" safety checks. Staff were directed to assist the resident with transfers using the mechanical hoyer lift. However, the assessment also indicated if "tolerated," staff could use 1-2 staff to assist with transfers. Under the mobility section, it directed staff to use a mechanical hoyer lift for all transfers. However, the assessment also went on to direct if the resident had enough strength in her upper arms and legs staff could use a sit to stand lift for transfers. R1 required assistance of 1-2 staff to transfer to the toilet using the sit to stand mechanical lift when resident was "physically able to use safely." R1 was assessed to require one staff assistance for checking and changing R1's incontinence product while in bed. Staff were directed to perform peri-care with each void and/or bowel movement, and alert the nurse of any skin issues. R1 would be "checked and changed frequently to avoid skin break down and urinary tract infections." The assessment also indicated staff were to "check and change" R1 every 2 hours. R1's skin was "dry," and the	02310		

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02310	Continued From page 19 resident had a history of skin issues with a history of possible deep tissue injury on the left buttock. Staff were directed to reposition R1 "frequently" to avoid skin breakdown. Under the assessment for "safety" and "falls" staff were to remind R1 to call for staff assistance when needed, and staff would use the mechanical lift as needed to transfer R1 with assistance of 1-2 "trained staff members." The assessment also indicated R1 could also be transferred with the full assist of one to two staff members, a walker, and a transfer belt "as appropriate." The assessment had conflicting information and it could not be determined how often or what specific cares should be completed based on R1's assessment. R1's Services Provided dated March 23, 2022, indicated staff documented completing the following: Bed mobility was documented as completed at 12:38 a.m., 3:02 a.m., 4:39 a.m., 6:55 a.m., 9:32 a.m., twice at 10:26 p.m., and 10:31 p.m. Transfer assistance was documented as completed at 6:54 a.m., 9:32 a.m. and 10:30 p.m. Safety checks were documented as completed at 6:55 a.m., 9:32 a.m. and 6:19 p.m. Toileting and/or brief changes were documented as completed at 6:55 a.m., 9:32 a.m., and 10:30 p.m. R1's Services Provided dated March 24, 2022, indicated staff documented completing the following: Bed mobility was documented as completed at 2:08 a.m., twice at 2:09 a.m., 5:23 a.m. 5:39 a.m., 8:31 a.m., and twice at 4:17 p.m., twice at 4:18 p.m. Transfer assistance was documented completed at 2:08 a.m., 8:32 a.m., and 4:17 p.m. Safety checks was documented completed at	02310		

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02310	Continued From page 20 2:08 a.m., 8:31 a.m., and 4:17 p.m. Toileting and/ or brief change was documented completed at 2:08 a.m., 8:32 a.m., and 4:17 p.m. R1's Services Provided dated March 25, 2022, indicated staff documented completing the following: Bed mobility was documented completed at 12:16 a.m., 2:58 a.m., 3:11 a.m., 4:21 a.m., 6:52 a.m., 7:34 a.m., 12:18 p.m, 9:42 p.m.,and 9:58 p.m. Transfer assistance was documented as being completed at 3:12 a.m., 7:34 a.m., and 9:45 p.m. Safety checks were documented completed at 3:12 a.m., 7:34 a.m., and 9::45 p.m. Toileting/brief change was documented as completed at 6:53a.m., 7:34 a.m., and 9:45 p.m. R1's skin note dated February 2, 2022, documented by an outside hospice agency indicated "Wound to right calf; clean with wound cleanser and apply thin layer of Bacitracin to site and cover with ABD pad and Kerlix daily and as needed (PRN). Cover abrasions to [R1] toes on her right foot. Place Bacitracin on the abrasion on the toes and cover with a sock." R1's facility skin note dated February 2, 2022, indicated the registered nurse (RN) completed the dressing changes to the right knee and right shin wounds. The residents' wounds were cleaned with soap, water, and wound spray; and a layer of triple antibiotic ointment was placed on the wound bed. The wound to the knee was covered with a bandage, and the wound to R1's upper chin was covered with an ABD pad and wrapped with gauze. R1's toes on her right foot were cleaned with soap and water, dried, and triple antibiotic ointment was applied to the wounds. There was no documentation regarding what these wounds were caused from,	02310		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE WOODS ASSISTED LIVING	40170 COUNTY ROAD 257 COHASSET, MN 55721

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02310	Continued From page 21 notification to the physician, or interventions to prevent further wounds. A hospice note dated February 8, 2022, indicated R1's heels and wounds were assessed. The note indicated R1's heels were not open yet, and staff need to float the residents heels off of bed to prevent worsening of the wound. There was a new open area to the anterior left calf. Staff were directed to care for the area the same as the other wounds, which included applying Bacitracin, ABD, and Kerlix. No more documentation was found regarding R1's heel wounds and there was no documentation to instruct staff to ensure R3's heels were floated. R1's skin note dated February 10, 2022, indicated a facility staff was removing the residents blankets and R1's wound on her right calf was covered with a ABD pad and masking tape to hold it in place. The building manager, Licensed Practical Nurse (LPN)-C, and O-B were updated "as soon as possible", and staff education was completed with the staff who applied the dressing to the wound with masking tape. The resident ABD was removed and the wound was described as "yellow, and green discharge." The nurse used wound cleaner to clean the discharge and dry the skin. The wound measured 11 centimeters (cm) by 5 cm, with a 0.25 cm red ridge around the wound. The wound was warm to the touch. The nurse reapplied Bacitracin ointment, covered the wound with a ABD and wrapped with cowbane (a type of medical wrap). The residents' toes on her right foot were cleaned with wound cleaner, Bacitracin ointment was applied, and R1's foot was covered with a clean sock. Booties were applied to protect R1's heels when in bed, the	02310		

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02310	Continued From page 22 resident was re-positioned, and morphine was administered for pain. .There was no documentation or assessment of R1's heel nor any specific direction on when or how to apply the "booties" for R1. R1's facility Wound Assessment dated February 10, 2022, indicated wound #1 on the upper calf had an open area measuring 10 cm by 4.5 cm. There was also a 12 cm by 11.5 cm bruise around the open area. Wound #2 on R1's middle toes measured 2.5 cm by 1 cm, 4th digit measured 2 cm by 1 cm, and the 5th digit measured 0.5 cm by 0.5 cm. The documentation regarding R1's toes did not indicated if these were open areas or how the wounds occurred. R1's facility skin notes dated February 15, 2022, indicated R1's toes were dry when the RN assessed the residents wound to her right shin. R1's right shin was washed with wound cleaner, triple antibiotic ointment was applied, and a new bandage wrapped with Kerlix was applied. R1's wound on her left calf/ankle was washed with wound cleaner, triple antibiotic ointment was applied, and the wound was covered with a bandage. R1's toes on her right foot were washed with wound cleaner and triple antibiotic ointment was applied with a new sock. R1's medical record reviewed on April 19, 2022, lacked any further documentation of a follow up assessment regarding any of R1's wounds, notification to the physician, and specific direction to staff regarding interventions to prevent worsening of the wounds. When interviewed on April 29, 2022 at 10:10 a.m., unlicensed personnel (ULP)-A stated several weeks prior, around the beginning of	02310		

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02310	Continued From page 23 March, staff were directed to reposition and toilet R1 three times during the night shift. ULP-A stated R1 became anxious during the night so if R1 was sleeping ULP-A did not turn or toilet the resident. ULP-A stated he did not check her brief to see if she needed to be changed but he would know if it was "really bad" because R1 would tell him or "it would smell." If R1 requested to be changed or had "stool up her back" ULP-A would give the resident wipes so she could "wipe herself off." If it was "super bad" he would stick pads in her brief because R3's care plan indicated the resident required 1-2 staff to provide assistance and it was hard to do without assistance from a second staff . ULP-A stated he would tell R1 when the next shift was coming in to see if she could wait until they arrived. ULP-A stated even if the cares were not completed he would document them as being complete on the residents Services Provided information so the documentation was complete. ULP-A stated the nurse and administration were aware cares were not being completed for R1 at night because ULP-A had told the nurse it was difficult for him to turn or change the resident without a second staff to assist. ULP-A stated the staff who came in on the next shift would get angry because R1 was "soaked" (full of urine) frequently. During interview on 4/19/22 at 9:45 a.m. ULP-H stated when she comes to work in the morning R1 was often very wet with urine and all of the bedding would need to be changed. ULP-H stated the staff working the night shift have complained they have bad backs so they cant change her brief at night. ULP-H stated R1 was especially wet and/ or full of stool after ULP-A worked the night shift. During interview on 4/26/22, at 2:30 p.m. a	02310		

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02310	Continued From page 24 hospice social worker (SW)-J stated the hospice registered nurse (RN) went to the facility a couple months ago and R1 was laying in bed and was soaked with urine from head to toe. R1 stated she had not eaten and was very hungry. The hospice RN requested staff assistance to change and clean up R1. The hospice aides have also reported R1 often has 2 soaker pads (absorbent pads placed on the bed) and 2 briefs on. Although R1 had "wounds" and required staff assistance for toileting and repositioning, the resident had no individualized assessment to ensure R1 was receiving appropriate care and services to prevent further wounds and/or promote healing of the current wounds. R2's face sheet dated February 11, 2022, indicated the resident had diagnoses including anemia of chronic disease, knee pain, and a complete tear of the left rotator cuff. R2's service plan was requested and not provided. R2's facility wound assessment dated March 3, 2022, indicated the resident had no wounds. R2's facility assessment dated March 9, 2022, indicated the resident required extensive staff assistance with dressing, wore an arm sling for a left arm fracture, and staff were directed to keep R2's arm stabilized and offer assistance to put on and remove the arm sling. Staff were directed to assist the resident to sit up in bed and to transfer R2 using a gait belt and cane. Staff will "round" on resident to make sure she is not independently transferring. R2 was unsteady when walking due to weakness, and staff were to use a gait belt and provide stand by assistance while R2 was	02310		

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02310	Continued From page 25 ambulating. R2's toileting needs were identified as one staff assistance, staff to remind the resident to use the bathroom, staff will assist R2 with the incontinent products, and staff to empty R2's indwelling urinary catheter bag frequently. Staff were directed to assist R2 with peri-care after assisting the resident with toileting and to complete urinary catheter care twice a day. R2 was at high risk for falls and staff were directed to complete "frequent" safety checks, ensure R2 was wearing proper footwear when ambulating, and encourage the resident to ask for staff assistance if needed. No current wounds or skin integrity issues were documented. The assessment had conflicting information and it could not be determined how often and what specific cares should be completed based on R2's assessment. R2's Services Provided dated March 7, 2022, indicated staff documented completing the following: Bed mobility was documented completed at 6:31a.m., 1:10 p.m., and 3:35 p.m. Transfer assistance was documented completed at 6:29 a.m., 2:20 p.m., and 3:35 p.m. Toileting/ brief check was documented completed at 6:29 a.m., and 3:35 p.m. No safety checks were documented. No urinary catheter care was documented. R2's Services Provided dated March 8, 2022, indicated staff documented completing the following: Bed mobility was documented completed at 2:23 a.m., 11:29 a.m., and 10:53 p.m. Transfer assistance was documented completed at 2:09 a.m., 11:29 a.m., and 10:53 p.m. Toileting/brief change was documented as completed at 1:59 a.m., 11:29 a.m., and 10:53	02310		

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02310	Continued From page 26 p.m. No safety checks were documented. No urinary catheter care was documented. R2's Services Provided dated March 9, 2022, indicated staff documented completing the following: Bed mobility was documented completed at 5:57a.m., 11:36 a.m., and 3:05 p.m.. Transfer assistance was documented as being completed at 3:12 a.m., 7:34 a.m., and 9:45 p.m. Toileting/brief change was documented as completed at 5:57 a.m., 11:36 a.m., and 3:05 p.m. No safety checks were documented. No urinary catheter care was documented. R2's facility progress note dated March 10, 2022, at 9:25 a.m. indicated staff reported the resident called 911 on her own accord. R2 told 911 she is in so much pain and she could not stand it. Staff reported the resident was given a PRN (as needed) Oxycodone (pain reliever) earlier that morning. Staff reported R2 was stumbling when ambulating to breakfast but told the emergency personal she had fallen in the dining room; which staff say did not occur. The note indicated, "This is a common occurrence for the resident. Staff reported she did not take any of her morning medications as well." R2's ambulance transport sheet dated May 10, 2022, indicated they were dispatched at 8:56 a.m. to the facility responding to a resident who fell and was complaining of overall pain and pain in her left shoulder/ arm. When the ambulance staff entered the facility, staff were not aware R2 called 911. The facility staff told the emergency services R2 initially refused to get out of bed, however, after staff encouragement R2 agreed to get up.	02310		

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02310	Continued From page 27 The staff stated R2 was walking in the hallway and the resident "Put herself against the wall." Staff assisted R2 to a chair in the dining room, left the resident alone, and R2 called 911. R2 told the ambulance staff the facility staff jerked her out of bed, threw her on the floor, wouldn't help her "for awhile", and "drug her to the chair in the dining room and left her there. R2 had a urinary catheter bag "tied to her leg" with dark and cloudy urine. The resident stated she didn't feel like the staff at the facility were able to take care of her. R2 was transported to the hospital. R2's emergency room notes dated March 10, 2022, indicated R2 reported the staff at the facility were not caring for her adequately. R2 stated staff pulled her out of bed that morning and staff were "rough handling." The resident stated she fell earlier that morning due to the incorrect type of walker being given to her and "prodding" by staff to ambulate faster than she was able. R2 was alert and orientated x2 (place and self, not orientated to time). The resident had several open areas on her upper thighs and peri-area and had dried stool in her peri-area. The urinary catheter securing device was dislodged with a large amount of residual adhesive still attached to the residents skin. R2's indwelling urinary catheter was kinked and not draining urine. R2 also had redness, warmth, swelling and tenderness in her right lower leg, and complained of left shoulder pain. R2 told hospital staff she was scared for her safety at the facility and felt she needed a higher level of care. The physician note indicated, "I agree with that [higher level of care needed] in the condition she was found (Cellulitis, Foley [urinary catheter] that was kinked, open skin on her peri-area, dried stool on her skin) it seems that she needs a higher level of care." R2 was diagnosed with cellulitis, a urinary	02310		

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02310	Continued From page 28 tract infection, and a new dislocated left shoulder. The resident was admitted to the hospital. The facility had no investigation or assessment to determine how R2 dislocated her shoulder, what cares staff were completing, and if the resident had a fall. The resident did not return to the facility. During interview on April 29, 2022, at 10:10 a.m., ULP-A stated R2 did not require schedule cares to be completed during the night. ULP-A stated R2 had no scheduled toileting schedule/ and or brief change at night and the only cares provided for R2 during the night were staff emptied the urinary catheter bag in the morning. When interviewed on May 10, 2022, at 10:05 a.m., R2's family member (F)-O stated R2 was very unhappy with the care she was getting at the facility. F-O stated the resident often had food on her shirt, her teeth were black from not being brushed, and she was "dirty." R2 complained about not being bathed and stated during the night they only had one staff working to assist with care for all the residents on all three units. F-O stated a few days before R2 went to the hospital she was still in bed at 3:00 p.m.. F-O stated R2 was in a lot of pain, had multiple falls, and staff didn't provide the assistance R2 required. R3's face sheet indicated the resident had diagnoses including Alzheimer's disease, chronic obstructive pulmonary disease, and asthma. R3's service plan was requested and not provided.	02310		

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02310	Continued From page 29 R3's skin assessment dated December 24, 2021, indicated the resident had a reddened area on her coccyx measuring 1.25 cm by 0.75 cm. Staff were instructed to apply hydrocortisone cream 1% twice a day. R3's progress note dated March 14, 2022, indicated the wound on the residents coccyx measured 1.25 cm by 0.75 cm., the same as the last assessment done almost 3 moths prior. Staff were instructed to continue applying "barrier cream" and doing "frequent" reposition and toileting. R3's assessment dated March 15, 2022 indicated the resident had "reddened buttocks." R3's progress notes dated April 5, 2022, indicated the residents skin was clear and had no open areas. Staff were applying hydrocortisone cream for R2's "hemorrhoids." R3's progress notes reviewed on April 25, 2022, contained no further documentation regarding R3's coccyx area and/or skin concerns. R3's facility assessment dated Mach 15, 2022, indicated staff would assist the resident with grooming morning and night and as needed. Staff were directed to assist R3 with position changes as needed to maintain skin integrity. R3 was able to self- transfer but could be unsteady. Staff were to provide stand by assistance and encourage use of the walker when R3 was self-transferring. R3's assessment indicated the resident required "frequent safety checks." Staff were directed to monitor R3 "frequently" to ensure the resident was free from urine and/ or stool. R3 required assistance from one staff with her toileting needs. Staff would remind the resident to use the	02310		

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02310	Continued From page 30 bathroom, perform peri-care with each continent or incontinent void or bowel movement, and check and change the resident "frequently" to avoid skin break down and urinary tract infections. The staff were directed to notify the nurse of any skin integrity issues. The assessment indicated R3 had a reddened area on her coccyx and staff were to apply cream to the area after assisting R3 with toileting. The assessment indicated R3 was incontinent of bowel and bladder, staff needed to "check and change frequently," and apply barrier cream to R3's buttocks. The resident was at risk for falls and staff would provide "random, frequent" safety checks.. The resident needed verbal reminders from staff to use the walking cane and walker in her room. The assessment indicated R3 did not have a pendent call light available to call for staff assistance. The assessment had conflicting information and it could not be determined how often or what specific cares should be completed based on R3's assessment. R3's Services Provided dated March 16, 2022, indicated staff documented completing the following: . Bed mobility was documented completed at 7:29 a.m., 11:24 a.m., and 8:14 p.m. Transfer assistance was documented completed at 7:28 a.m., 11:24 a.m., and 8:14 p.m. Toileting/brief check was documented completed at 7:28 p.m., 11:24 a.m., and 8:14 p.m. Ambulation was documented completed at 7:29 a.m., 1:00 p.m., 1:03 p.m., and 8:20 p.m. No safety checks were documented as being completed. R3's Services Provided dated March 17, 2022, indicated staff documented completing the following:	02310		

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02310	Continued From page 31 Bed mobility was documented completed at 2:12 a.m., and 8:05 a.m. Transfer assistance was documented completed at 2:12 a.m., and 8:05 a.m. Toileting/brief check was documented completed at 2:12 a.m., and 8:05 a.m. Ambulation was documented as completed at 5:14 a.m., and 11:04 a.m. No safety checks were documented as being completed. R3's Services Provided dated March 18, 2022, indicated staff documented completing the following: Bed mobility was documented completed at 4:25 a.m., 7:39 a.m., 11:59 p.m. and 12:53 p.m. Transfer assistance was documented completed at 4:26 a.m., 7:39 a.m., 12:53 p.m., and 11:50 p.m. Toileting/brief check was documented completed at 4:36 a.m., 7:39 a.m., 11:50 p.m., and 12:53 p.m. Ambulation was documented completed at 4:25 a.m., 9:35 a.m., and 5:44 p.m. No safety checks were documented as being completed. A facility document titled Other injury dated 4/16/22, at 6:22 p.m. indicated staff reported R3 had a large bruise of unknown origin to her back and had complaints of pain. The staff were not aware of any recent falls, however, the resident stated she thought she fell yesterday. Morning staff stated they did not see the bruise earlier that morning. R3 was transported to the emergency room for evaluation and staff would be provided education on notifying the nurse of injury's and change of condition. A text message dated 4/16/22, at 6:28 p.m.	02310		

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02310	Continued From page 32 indicated registered nurse (RN)-D sent R3's family member a text indicating R3 had a large bruise on her back. RN-D indicated she "would assume" the resident fell and was able to get herself up off the floor. Day shift had not mentioned anything regarding the bruise, and "a few days ago" staff did not see the bruise on the resident when assisting her with a bath. RN-D stated the bruise looked pretty "fresh" and R3 was complaining of a lot of pain. RN-D asked the family member if they wanted R3 sent to the hospital to be evaluated. R3's services provided indicated on April 16, 2022, R3 was assisted with toileting at 7:00 a.m., and 8 hours later at 3:00 p.m. The only other cares documented as being completed for R3 between 7:00 a.m. and 3:00 p.m. was medication administration at 8:00 a.m. and staff recorded R3's intake at 12:00 p.m. Although the residents assessment indicated R3 was required to have frequent safety checks, there was no individualized assessment to indicate how often safety checks were to be completed, and the facility lacked any documentation staff were completing any safety checks for R3. The facility had no documentation regarding R3's condition or complaints of pain prior to the evening of 4/16/22. A MAARC (Minnesota adult abuse reporting center) dated April 18, 2022, indicated R3 had "serious" bruising on the left side of her back which appeared to be days old as the bruising was yellowing. R3 was extremely unkept and was sitting in her own waste. Family brought R3 to the clinic for evaluation. R3 was then sent by ambulance to the hospital and was found to have a left hip fracture, an impacted left femoral neck	02310		

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	30666	A. BUILDING: _____ B. WING _____	C 05/19/2022

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02310	Continued From page 33 fracture, bruising on her back and left side (armpits to hip), highly inflamed genital regions, and severe dehydration. R3's facility Discharge/ Transfer Summary indicated the resident was discharged on 4/28/22, to a nursing home. R3 was transported to the emergency room by her guardian on 4/16/22, at 7:40 p.m. for a bruise of unknown origin on the left side of her back. The evening staff noticed the bruise while assisting the resident with toileting. R3 was admitted to the hospital for weakness and acute femur fracture. R3 was at risk for falls and staff were directed to provide "frequent safety checks." The resident only used a wheelchair for long distance or outside appointments. The summary indicated R3 was unable to use a call pendent and the resident did not have a call pendent to request staff assistance. Staff were to ensure R3 was monitored, "with regular checks to assure safety." Although R3 had painful bruising of unknown origin and a broken femur, the facility had no further investigation or documentation regarding R3's injury's. R3 did not have a call light to request staff assistance and had been assessed to require "frequent safety checks." R3's did not have an individualized assessment completed to ensure the resident was receiving the appropriate care and services. During interview on May 2, 2022, at 3:00 p.m., ULP-H stated she was not working directly with R3 on April 16, 2022, however, she came to R3's unit and noticed R3 was sitting in a wheelchair which was unusual for R3. During interview on May 2, 2022, at 1:45 p.m., R3's family member, (F)-P, stated R3's care	02310		

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02310	Continued From page 34 provided at the facility was "minimal." In March 2022, F-P went to the facility and when arriving R3 was soiled with stool and urine and her peri area was red and inflamed and had random open areas. F-P stated she talked to LPN-C and asked that staff not leave R3 soiled and to assist the resident with toileting and pericare at least every 2 hours. LPN-C stated she would assure staff were aware to assist R3 at least every 2 hours with toileting/ pericare. F-P stated RN-D text her a picture of a very large bruise on R3's back. F-P picked up R3 at the facility and transported her to the clinic. The clinic sent R3 to the hospital due to her condition. R3 was in a lot of pain and was diagnosed with a left hip fracture. R3 had a surgical hip repair and discharged from the hospital to a nursing home for higher level of care. During interview on 5/13/22 at 1:30 p.m. LPN-C stated if the resident does not have specific time frames to provide cares and/ or toileting assistance, staff are instructed to toilet the resident "at least every 3 hours," morning and night. LPN-C stated staff have access to the residents assessment, however, the Services Provided document is what instructs staff on the specific cares a resident requires. LPN-C verified the care documented on the resident Service Plans was not consistent, and was not driven by a comprehensive, individualized assessment to ensure the appropriate care and services were provided. The undated facility policy titled Initial and On-Going Nursing Assessment of Resident indicated the RN will complete the following comprehensive nursing assessments of the resident's physical, mental, and cognitive needs as required: Pre-Admission Assessment; 14-day	02310		

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02310	Continued From page 35 assessment: completed up to 14-days after start of services; Ongoing assessment completed periodically but no less than every 90-days; Change in resident condition. Ongoing monitoring and review will be conducted as needed based on changes in the resident needs and will not exceed 90 calendar days from the last review date. The RN will reassess the resident if the resident had a change in condition. At these re-assessments, the RN will: Review the resident's service plan; Evaluate the resident's medication management services and the resident's medications; Evaluate the resident's treatments, if any; Communicate any new problems or concerns to the resident's physician or health care providers, and; update the service plan as necessary based on the resident's needs. The facility policy titled Reporting, Documenting and reviewing incidents involving Residents dated August 1, 2021, indicated all incidents involving a resident will have a corresponding incident report and follow-up will be completed as appropriate. The staff discovering an incident involving a resident will ensure the resident is safe. Staff will notify the licensed nurse. Staff discovering the incident will complete an incident report. The RN will complete an assessment of the resident in a timeframe that is reasonable following the incident. The RN will document in the resident's chart the details of any incident involving the resident and their assessment including the follow-up actions that were taken. The physician, resident representative, and the clinical nurse supervisor or designee will be notified of the incident and notifications will be documented. The RN will review the incident report with quality	02310		

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02310	Continued From page 36 management team and document the review. The facility undated policy titled Pressure Ulcer Prevention and Managing Skin Integrity indicated nursing would assess and manage skin integrity for all residents. The risk for pressure ulcer development would be evaluated upon admission to the facility and on a routine basis using the Braden scale. Risk assessments would be done more often if the residents condition warrants more frequent assessments. Skin assessments would be completed based on Braden scale and/or change in condition. The RN will do routine skin checks on the residents at risk to include: 1. Nutritional deficits 2. Cognitive changes or impairment of the resident 3. Risk for pressure ulcer development 4. Poor personal hygiene practices of the patient that impact skin health 5. Cultural practices that impact the health or integrity of the skin On May 12, 2022, at 11:57 a.m., the facility nurse consultant stated all of the requested documents were sent and there was no further information regarding assessments, plan of care, investigations, and/ or policy's. Time period for correction: Immediate	02310		
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.	02360		

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02360	Continued From page 37 This MN Requirement is not met as evidenced by: Based on interviews and document review, the facility failed to ensure three of three residents reviewed, (R1, R2, R3) were free from maltreatment. R1 was abused. R2 and R3 were neglected. Findings include: On May 19, 2022, the Minnesota Department of Health (MDH) issued a determination that abuse occurred for R1 and an individual was responsible for the abuse, and neglect occurred for R2 and R3, and the facility was responsible for the neglect, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	02360		
03000 SS=E	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	03000		

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03000	Continued From page 38 that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on document review and interview, the licensee failed to ensure allegations of abuse or neglect were immediately reported to the Minnesota Adult Abuse Reporting Center (MAARC) or Common Entry Point (CEP) for two of two residents (R1, R2), who reported abuse	03000		

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03000	Continued From page 39 and maltreatment. In addition, the licensee failed to complete a thorough investigation following three of three, (R1, R2, R3) reportable events. 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 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: R1's diagnoses included liver failure, essential hypertension, and hearing problems. R1's Individual Abuse Prevention Plan dated February 8, 2022, indicated R1 required assistance with all activities of daily living, dressing, had open areas on her lower legs, required assistance with repositioning and transferred with a mechanical lift. R1's progress notes indicated March 25, 2021, R1 asked staff to call the owner and stated she did not want a male staff member (ULP-A) in her room. The hospice social worker (SW)-E brought concerns to facility license practical nurse (LPN)-C that R1 stated a male staff touched her inappropriately. R1 told SW-E the staff was checking her brief but went "a little too deep." A police report dated March 25, 2022, indicated the police were investigating a report of ULP-A touching R1 sexually. The report indicated on April 8, 2022, ULP-A was interviewed by law enforcement. ULP-A stated he didn't change R1's	03000		

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03000	Continued From page 40 brief "unless absolutely necessary." ULP-A stated R1 was uncomfortable having him change her brief "because he is a guy." ULP-A stated, "The only time [ULP-A] I actually do it [change the brief] is if she's used the other one, she hasn't pissed but she shit because then that's everywhere. And usually I [ULP-A] used to leave that too just because [ULP-A] I didn't want this to happen." ULP-A described his normal routine when he works the night shift with R1 and stated he pokes his head into the room to check "if she's [R1] breathing." ULP-A stated again R1 was uncomfortable having him change her brief. R1's hospital records dated March 25, 2022, indicated R1 presented to emergency department by ambulance for evaluation of an alleged sexual assault that occurred at the facility. The notes indicated R1 stated she was sexually assaulted by a staff member between 12:00 a.m.- 1:00 a.m. R1 spoke to the Itasca County investigator and was evaluated by the "SANE" (sexually assault nurse evaluation) and DNA samples were obtained. The hospital records indicated R1 was orientated to person, place, and time. R1 stated she was ready to go back to the facility because ULP-A was no longer going to be at the facility. During an interview on April 19, 2022, at approximately 10:00 a.m., registered nurse (RN)-D indicated the allegation of sexual assault was not reported to MAARC because the faciltiy thought hospice reported it. In addition, RN-D verified the facility did not have a thorough investigation because they spoke to the resident and ULP-A and the facility determined it was a false accusation. R2's Individual Abuse Prevention Plan dated March 9, 2022, indicated R2 was vulnerable and	03000		

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03000	Continued From page 41 required assistance with all activities of daily living including dressing, repositioning, ambulating, and transfers. R2's facility progress note dated March 10, 2022, at 9:25 a.m. indicated staff reported the resident called 911 on her own accord. R2 told 911 she is in so much pain and she could not stand it. Staff reported the resident was given a PRN (as needed) Oxycodone (pain reliever) earlier that morning. Staff reported R2 was stumbling when ambulating to breakfast but told the emergency personal she had fallen in the dining room; which staff say did not occur. The note indicated, "This is a common occurrence for the resident. Staff reported she did not take any of her morning medications as well." R2's ambulance transport sheet dated May 10, 2022, indicated they were dispatched at 8:56 a.m. to the facility responding to a resident who fell and was complaining of overall pain and pain in her left shoulder/ arm. When the ambulance staff entered the facility, staff were not aware R2 called 911. The facility staff told the emergency services R2 initially refused to get out of bed, however, after staff encouragement R2 agreed to get up. The staff stated R2 was walking in the hallway and the resident "Put herself against the wall." Staff assisted R2 to a chair in the dining room, left the resident alone, and R2 called 911. R2 told the ambulance staff the facility staff jerked her out of bed, threw her on the floor, wouldn't help her "for awhile", and "drug her to the chair in the dining room and left her there. R2 had a urinary catheter bag "tied to her leg" with dark and cloudy urine. The resident stated she didn't feel like the staff at the facility were able to take care of her. R2 was transported to the hospital.	03000		

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03000	Continued From page 42 R2's emergency room notes dated March 10, 2022, indicated R2 reported the staff at the facility were not caring for her adequately. R2 stated staff pulled her out of bed that morning and staff were "rough handling." The resident stated she fell earlier that morning due to the incorrect type of walker being given to her and "prodding" by staff to ambulate faster than she was able. R2 was alert and orientated x2 (place and self, not orientated to time). The resident had several open areas on her upper thighs and peri-area and had dried stool in her peri-area. The urinary catheter securing device was dislodged with a large amount of residual adhesive still attached to the residents skin. R2's indwelling urinary catheter was kinked and not draining urine. R2 also had redness, warmth, swelling and tenderness in her right lower leg, and complained of left shoulder pain. R2 told hospital staff she was scared for her safety at the facility and felt she needed a higher level of care. The physician note indicated, "I agree with that [higher level of care needed] in the condition she was found (Cellulitis, Foley [urinary catheter] that was kinked, open skin on her peri-area, dried stool on her skin) it seems that she needs a higher level of care." R2 was diagnosed with cellulitis, a urinary tract infection, and a new dislocated left shoulder. The resident was admitted to the hospital and did not return to the facility. During interview on April 19, 2022, RN-D confirmed the facility did not report R2's injury to MAARC and did not complete a thorough investigation of this event. R3's Individual Abuse Prevention Plan dated March 15, 2022, indicated R3 was vulnerable and required assistance with all activities of daily living, including, dressing, repositioning,	03000		

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03000	Continued From page 43 ambulating, and transfers. R3 did not have a call pendant to call for assistance. A facility document titled Other injury dated 4/16/22, at 6:22 p.m. indicated staff reported R3 had a large bruise of unknown origin to her back and had complaints of pain. The staff were not aware of any recent falls, however, the resident stated she thought she fell yesterday. Morning staff stated they did not see the bruise earlier that morning. R3 was transported to the emergency room for evaluation and staff would be provided education on notifying the nurse of injury's and change of condition. A text message dated 4/16/22, at 6:28 p.m. indicated registered nurse (RN)-D sent R3's family member a text indicating R3 had a large bruise on her back. RN-D indicated she "would assume" the resident fell and was able to get herself up off the floor. Day shift had not mentioned anything regarding the bruise, and "a few days ago" staff did not see the bruise on the resident when assisting her with a bath. RN-D stated the bruise looked pretty "fresh" and R3 was complaining of a lot of pain. RN-D asked the family member if they wanted R3 sent to the hospital to be evaluated. R3's facility Discharge/ Transfer Summary indicated the resident was discharged on 4/28/22, to a nursing home. R3 was transported to the emergency room by her guardian on 4/16/22, at 7:40 p.m. for a bruise of unknown origin on the left side of her back. The evening staff noticed the bruise while assisting the resident with toileting. R3 was admitted to the hospital for weakness and acute femur fracture. R3 was at risk for falls and staff were directed to provide "frequent safety checks." The resident only used	03000		

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03000	Continued From page 44 a wheelchair for long distance or outside appointments. The summary indicated R3 was unable to use a call pendent and the resident did not have a call pendent to request staff assistance. Staff were to ensure R3 was monitored, "with regular checks to assure safety." The facility had no further investigation regarding the bruise and injury of unknown origin. The facility policy and procedure titled Vulnerable Adult Maltreatment dated January 2, 2022, indicated: -the staff person will intervene to stop the maltreatment while it is occurring; -the staff person shall take appropriate steps to get the vulnerable adult to a place of safety; -call 911 if a crime is suspected; -the alleged perpetrator will be directed to leave the premises, or the police will be called to escort the person out. If it is unclear whether maltreatment has occurred, an investigation into the incident will begin immediately. A report will be made to MAARC within 24 hours. Staff will complete an incident report. The facility staff will complete a thorough investigation. Time Period for Correction: Fourteen (14) days.	03000		