Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306893841M
Compliance #: HL306894289C

Date Concluded: September 30, 2024

Name, Address, and County of Licensee Investigated:
Boden Senior Living
1132 Robinson Drive Northwest
Coon Rapids, MN 55433
Anoka County

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

Evaluator's Name: Lissa Lin, RN
Special Investigator

Finding: Inconclusive

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

Initial Investigation Allegation(s):
The facility neglected the resident when he fell and was hospitalized with a fractured hip. The resident fell a second time and was hospitalized with a UTI.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. The resident had a history of unwitnessed falls attributed to impulsiveness and not using his call pendant. Staff contacted the nurse when the resident fell and provided care. The nurse assessed and monitored the resident and sent him to the hospital as needed. The facility lacked a process for documenting resident safety checks and lacked documentation of provided services. The nurse stated she verbalized an increase in safety checks to unlicensed personnel (ULP) and when interview, ULP stated they received verbal direction to increase the frequency of safety checks. The facility failed to complete readmission assessments from both hospitalizations, however the facility added additional services to the resident's service plan in between the two hospitalizations.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member. The investigation included review of the resident records, hospital records, facility incident reports, staff schedules, related facility policy and procedures. Also, the investigator observed staff administering medications, and interacting with residents during activities.

The resident resided in an assisted living facility. His diagnosis included type 2 diabetes, enlarged prostate, congestive heart failure and stroke. The resident's service plan included assistance with bathing and medication administration.

The facility did not have an available assessment on the resident prior to the first hospitalization. Management staff indicated they acquired the facility through a change in ownership and the previous owner took all of the paper records.

The resident's progress noted indicated he had an unwitnessed fall in his bathroom while picking something up from the floor. The following day the resident reported left foot pain. The nurse contacted the on-call provider to get an order for a portable x-ray. The on-call provider returned the nurse's call the next day. The on-call provider stated the resident could go to the emergency department (ED) for evaluation or "until Monday" and contact his regular primary care provider (PCP). The resident declined going to the ED. Two days later, the resident had a second unwitnessed fall while pulling up his pants. ULP assisted the resident into his wheelchair from the floor and notified the nurse who assessed the resident. He complained of left hip pain. Staff administered scheduled and as needed pain medications and sent the resident to the hospital.

Hospital records indicated the resident had suffered a non-displaced fracture of his right hip. After hospitalization, he transferred to a transitional care unit (TCU) almost one month before he readmitted to the facility.

An incident report indicated one day after the resident returned to the facility, he fell in his room. He was not injured. The nurse notified family and the PCP. A family member said the resident's pendant was left behind at the TCU. She picked it up and returned it to the resident (at the facility).

During an interview, an ULP said the resident was alert and knew how to use the call pendant. She said he had a wheeled walker but did not use it properly; he tended to push it away from himself. She reminded him to keep the walker close to his body for support. The staff member said the resident had a few falls and when he returned from the hospital, he seemed much weaker. The nurse told her the resident needed more cares and more toileting checks. The ULP said safety checks increased to hourly from every two hours.

The facility failed to conduct a readmission assessment upon his return from the hospital following a hip fracture. The facility also failed to update the resident's service plan with safety checks and an increased frequency of safety checks as indicated by the ULP.

Three weeks later, the nurse completed a change in condition assessment. The assessment indicated the resident received outside services from skilled nursing for wound care, and physical and occupational therapy. The assessment indicated the resident continued to be partially incontinent, was at risk for falls with intermittent confusion or disorientation. The resident had mild cognitive impairment and 3 or more falls in past three months. The resident had gait, balance, impaired functional mobility balance problem while standing, balance problem while walking, and used assistive devices. The assessment did not include any information about the resident's level of assistance needs or services required for activities of daily living, or transfers. The assessment section "review service plan" indicated the service plan did not match the scheduled services for the staff to provide and indicated the resident "required more care." The assessment lacked any specific evaluation of what "more care" the resident required.

The same date as the assessment, the facility added additional services to the resident's service plan. The additional services included toileting and incontinence assistance, monthly vital signs, wound management, skin care, escort assistance, meal assistance, nail care, turning and repositioning, and physical assist of one with grooming, dressing and transfers. However, the additional services were not included on the service delivery records. The only service on the service delivery record for documentation services received was turning/repositioning.

Six weeks after the resident's hospital return, the progress notes indicated the resident had an unwitnessed fall with no injury. The next day, the facility received verbal orders from the resident's PCP that directed it was ok to transfer the resident to a long term care or transitional care unit for skilled services.

The resident's record lacked an assessment of the resident's need to transfer to a higher level of care facility.

Five days later, the progress notes indicated the resident attended a telehealth visit with his PCP who ordered a hospital bed with side rails. The next day, the resident had another unwitnessed fall. The ULP documented on the incident report the resident was found during a safety check, was unharmed but sweaty. The resident had a low blood pressure and the nurse directed staff to send him to the hospital.

The resident's hospital records indicated the resident was hospitalized with rectal colitis and dehydration. Eight days later, the resident returned to the facility.

The facility failed to conduct a readmission assessment following the resident's second hospital return. However, the facility updated the resident's services three days later to increased the resident transfer assistance of one person to two people.

During an interview, the interim nurse said staff conducted resident safety checks but those were "folded" in with other tasks like toileting or repositioning and not stand-alone services. The nurse said she worked when the resident fell and hurt his hip. When she assessed him, he did not report pain. Later in the day he said his left foot hurt. It looked slightly swollen, so she contacted the on-call PCP to get a portable x-ray. The nurse said readmission assessments were completed each time a resident returned from a hospitalization. She was not working at the facility when the resident returned after his hip fracture and did not know if a reassessment was done. The nurse said staff could not prevent the resident from falling but they anticipated them and provided the resident with proper footwear, grippy socks, and reminders to use his call pendant for help.

During an interview, a former nurse said was not sure the resident's safety checks were consistently done during overnight shifts. Safety checks were stand-alone services documented separately. She said staff were responsive when the resident fell and followed fall protocols. The former nurse said the resident needed a higher level of care, but his family member declined to transfer him to a skilled nursing facility.

During an interview, a manager said staff have a fall meeting every morning to review resident falls. The manager said he recalled discussions about the resident in particular and his falls were mostly in the middle of the night while going to the bathroom.

During an interview, the resident's family member said the resident fell because staff did not come when he used his call button. She said management told her there was a safety plan for checks every two hours, but she did not know if those checks happened. The family member said the resident had broken ribs from one fall but was unsure when that injury happened. She said the resident has since transferred to a different facility and was doing well.

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

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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, due to cognition per family member.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
Nurses assessed the resident, contacted his primary care provider and sent him to the hospital when appropriate. The resident's services plans were updated with additional services after the hospitalizations. Staff documented his falls in progress notes and incident reports.

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

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

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

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

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
	30689	A. BUILDING: _____ B. WING _____	C 09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BODEN SENIOR LIVING - COON RAPIDS	11372 ROBINSON DRIVE NW COON RAPIDS, MN 55433

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: HL306894289C/HL306893841M On September 11, 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 47 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for HL306894289C/HL306893841M, tag identification 1620, 1640 and 1650.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring	01620		

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01620	Continued From page 1 (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to conduct resident readmission assessments for one of one (R1) residents reviewed. R1 had two hospitalizations within three months and two different registered nurses (RN)s failed to conduct readmission assessment to address a change in condition. In addition, the licensee updated R1's service plan with new services, but lacked an assessment to indicate R1's functional status that determined the need for that services. This deficient practice had the potential to affect all residents.	01620		

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01620	Continued From page 2 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). This had the ability to effect all residents. The findings include: R1's diagnoses included type 2 diabetes with diabetic neuropathy, congestive heart failure, stroke, and benign enlarged prostate with lower urinary tract symptoms. R1's service plan agreement dated February 17, 2024, indicated R1 received staff assistance with bathing and medication administration. February 2024 Hospitalization and Readmission A progress note dated February 15, 2024, at 11:3 a.m., indicated R1 had an unwitnessed fall in his bathroom. He reported he tried to pick a napkin up off the floor. Interim director of health services (DHS)-A assessed R1, updated his family and primary care provider. A fall report was completed. A progress note by DHS-A on February 20, 2024, at 12:42 p.m., indicated it was a late entry for February 19, 2024, at 9:00 a.m., when R1 had an unwitnessed fall in his bathroom on February 17, 2024. R1 said he fell while pulling up his pants. DHS-A wrote family notified, R1 complained of hip pain, 911 called and transported him to the hospital. R1's service plan agreement updated March 5,	01620		

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01620	Continued From page 3 2024, while R1 was hospitalized, did not include any new services added in March. The document included services added in April 2024 and later. A progress note dated March 26, 2024, at 3:53 p.m., indicated R1 returned from his hospital admission after a fall resulting in a displaced fracture of base of neck of right femur and rehabilitation. A progress note dated March 27, 2024, at 4:46 p.m., indicated R1 fell that morning when he attempted to get himself to the bathroom and had no call pendant. The pendant was left behind at rehabilitation facility. Family picked up call pendant and returned it to R1. R1 was not injured. An incident report dated March 27, 2024, indicated R1 fell attempting to use the bathroom. He had a history of not using his call pendant or calling for help. R1 left his call pendant behind at rehabilitation facility. Nursing to monitor need for additional services if resident continues not to use pendant. R1's record lacked a readmission assessment including an assessment of R1's functional physical, mental and emotional status and assess for change in needs since his fall with a fracture, surgery and hospitalization. R1's nursing assessment dated April 18, 2024, indicated the review was needed for a change in condition and required a care conference. The assessment indicated R1 received outside services from skilled nursing for wound care, and physical and occupational therapy. The assessment indicated R1 continued to be partially incontinent, was at risk for falls with intermittent	01620		

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01620	Continued From page 4 confusion or disorientation. R1 had mild cognitive impairment and 3 or more falls in past three months. R1 had gait, balance, impaired functional mobility balance problem while standing, balance problem while walking, and used assistive devices. The assessment did not include any information about R1's level of assistance needs or services required for activities of daily living, or transfers. The assessment section "review service plan" indicated the service plan did not match the services that are scheduled for the staff to provide and indicated R1 "required more care." The assessment lacked any specific evaluation of what "more care" R1 required. R1's service plan agreement dated March 5, 2024, included the following services added in April 2024: -Toileting and incontinence assistance services effective April 4, 2024 - Monthly vital signs effective April 18, 2024 - Wound management effective April 18, 2024 - Skin care effective April 4, 2024 and April 18, 2024 - Escort assistance effective April 18, 2024 - Grooming/physical assist effective April 18, 2024 - Turning and repositioning effective April 18, 2024 - Meal assist/set up effective April 18, 2024 - Nail care effective April 18, 2024 - Dressing physical assist of one effective April 18, 2024 - Transfer assist of one effective April 18, 2024. May 2024 Hospitalization and Readmission An incident report dated May 8, 2024, at 2:17 p.m., indicated R1 had an unwitnessed fall in his bedroom when he tried to answer his cell phone. Family and primary care provider notified. The	01620		

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01620	Continued From page 5 nurse assessed R1 with no physical injuries or bruises noted. A progress note dated May 9, 2024, at 12:53 p.m., indicated verbal orders from R1's primary care provider (PCP) directed it was ok to transfer R1 to a long term care or transitional care unit for skilled services. R1's record lacked an assessment of R1's needs to transfer to a higher level of care facility. A progress note by DHS-H dated May 17, 2024, at 1:53 p.m., indicated she and R1 participated in a telehealth visit one day earlier, on May 16, 2024, with R1's new PCP who ordered a semi electric hospital bed with mattress and side rails. A progress note dated May 17, 2024, at 6:23 a.m., indicated R1 had an unwitnessed fall incident on May 17, 2024, at 4:39 a.m., in his room. Staff found R1 during a safety check. R1 was unharmed but sweaty. An incident report dated May 17, 2024, indicated R1 had an unwitnessed fall that morning. The incident report indicate the unlicensed personnel (ULP) evaluated R1 to not have any injury, but was "very sweaty". The incident report indicated the RN who advised staff to call 911 due to a low blood pressure of 82/35 and pulse of 91. Family and PCP notified. A progress note dated May 19, 2024, at 8:42 a.m., indicated DHS-H was not informed R1 was in the hospital. A progress note dated May 22, 2024, at 3:56 p.m., indicated R1 was admitted to the hospital for dehydration and rectal colitis.	01620		

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01620	Continued From page 6 A progress note dated May 25, 2024, at 4:29 p.m., indicated R1 was discharged from the hospital and readmitted to the licensee with medications and discharge orders. R1's service plan dated May 30, 2024, indicated R1's transfer assistance increased to an assist of two effective May 28, 2024. Services included on the service plan added after May 30, 2024, included: - Homemaking/bedmaking effective June 11, 2024 - Housekeeping effective June 11, 2024 - Control drug count effective June 11, 2024 R1's record lacked documentation of an readmission assessment for R1's functional physical, mental and emotional status and assess for change in needs since his hospitalization for recent infection. In addition, R1's record lacked an assessment for side rails that were newly added with a hospital bed. During an interview on September 11, 2024, at 1:35 p.m., DHS-A said anyone hospitalized should be reassessed on admission, even if they just went in for a cough. DHS-A stated anybody who gets admitted to the hospital needs a new assessment when they come back, because it is like a discharge when they get admitted (to hospital) and then readmitted when they return. During an interview on September 11, 2024, at 2:20 p.m., ULP-D said R1 fell and when he returned from the hospital he was much weaker. The nurse said R1 needed more cares, like toileting, and increased his safety checks to hourly instead of every two hours.	01620		

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01620	Continued From page 7 A policy, titled Change in Condition, revised date May 5, 2024, indicated evaluation for a change in condition is to be completed for resident who has had a decline or improvement in their status that: will not resolve by itself without clinical interventions, impacts one or more areas of the resident physical, functional, emotional or cognitive status. A change of condition may include an acute care transfer due to an acute change resulting in admission to the hospital, evaluation in the Emergency Department three or more times in a 90 day period. TIME PERIOD TO CORRECT: Seven (7) Days	01620		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees	01640		

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01640	Continued From page 8 when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a system of documenting services of safety checks and failed to update the service plan with safety checks when they were changed in frequency, for one of one resident (R1) reviewed. In addition, other services added to R1's service agreement failed to have documentation the services were provided. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). This had the ability to effect all residents. The findings include: R1's diagnoses included Type 2 diabetes with diabetic neuropathy, congestive heart failure, stroke, and benign enlarged prostate with lower urinary tract symptoms. R1's service plan agreement dated February 17, 2024, included services for bathing and medication administration effective January 8, 2024. Other services were included in the document, however the effective dates were later than February 17, 2024. There were no safety check services included in R1's service plan	01640		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01640	Continued From page 9 agreement. A progress note dated February 15, 2024, at 11:53 a.m., indicated R1 had an unwitnessed fall in his bathroom. A progress note on February 20, 2024, at 12:42 p.m., indicated it was a late entry for February 19, 2024, at 9:00 a.m., when R1 had an unwitnessed fall in his bathroom on February 17, 2024. R1 said he fell while pulling up his pants. Director of health services (DHS)-A wrote family notified, R1 complained of hip pain, 911 called and transported him to the hospital. A progress note dated March 26, 2024, at 3:53 p.m., indicated R1 returned from his hospital admission after a fall resulting in a displaced fracture of base of neck of right femur and rehabilitation. An incident report dated March 27, 2024, indicated R1 fell attempting to use the bathroom. Nursing to monitor need for additional services if resident continues not to use pendant. During an interview on September 11, 2024, at 2:2 p.m., unlicensed personnel (ULP)-D said R1 fell, was gone and when he returned [from March hospitalization] he was weaker. The nurse said R1 needed more cares, like toileting and increased safety checks to hourly instead of every two hours. ULP-D said safety checks showed up as rounding checks, but she did not recall recording it in POC (point of care, an electronic medical record). There was no service plan agreement update to include changes in R1's safety checks and his previous service plan agreement failed to include	01640		

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	30689	A. BUILDING: _____ B. WING _____	C 09/11/2024

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01640	Continued From page 10 safety checks every two hours as reported by ULP-D. R1's service plan agreement updated March 5, 2024, did not include any new services added in March. The documented included services from April 2024 and later. Services added in April 2024 included: -Toileting and incontinence assistance services effective April 4, 2024 - Monthly vital signs effective April 18, 2024 - Wound management effective April 18, 2024 - Skin care effective April 4, 2024 and April 18, 2024 - Escort assistance effective April 18, 2024 - Grooming/physical assist effective April 18, 2024 - Turning and repositioning effective April 18, 2024 - Meal assist/set up effective April 18, 2024 - Nail care effective April 18, 2024 - Dressing physical assist of one effective April 18, 2024 - Transfer assist of one effective April 18, 2024. R1's service plan did not include safety checks. An incident report dated May 8, 2024, at 2:17 p.m., indicated R1 had an unwitnessed fall in his bedroom with no physical injuries or bruises noted. R1's Service Received dated May 9-11, 2024 indicated no service documentation for safety checks. It also failed to include documentation for added services in April 2024: toileting and incontinence assistance, wound management, skin care, escort assistance, grooming/physical assist, meal assist, nail care, control drug count,	01640		

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01640	Continued From page 11 housekeeping, dressing/physical assist of one, and transfer assist of one. The only service include for staff to document as provided was turning/repositioning. An incident report dated May 17, 2024, indicated R1 had an unwitnessed fall that morning. The incident report indicated the RN who advised staff to call 911 due to a low blood pressure of 82/35, a pulse of 91 and diaphoretic (sweaty). Family and PCP notified. A progress note dated May 22, 2024, at 3:56 p.m., indicated R1 was admitted to the hospital for dehydration and rectal colitis. A progress note dated May 25, 2024, at 4:29 p.m., indicated R1 was discharged from the hospital and readmitted to the licensee with medications and discharge orders. R1's service plan updated May 30, 2024, indicated R1's transfer assistance increased to an assist of two effective May 28, 2024. Services included on the service plan added after May 30, 2024, included: - Homemaking/bedmaking effective June 11, 2024 - Housekeeping effective June 11, 2024 - Control drug count effective June 11, 2024 During an interview on September 11, 2024, at 11:48 a.m., DHS-A said safety checks were not separate services, they were folded into other services. They were built into routinely seeing a resident for something like toileting. R1 had no safety checks on his service plan because they were part of other tasks. For overnight safety checks, some residents did not want to be	01640		

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01640	Continued From page 12 awakened but staff still need to check on them. She was not sure how safety checks alone, with no other services, would be documented. During an interview on September 11, 2024, at 1:35 p.m., DHS-A said most of the residents needed at least 1 daily check, like a welfare check. DHS-A said she sees the safety checks were done when point of care services are provided but they are not called safety checks. A policy titled Service Plan, revised date September 2023, indicated the purpose was to ensure clear documentation of requested services, frequency of cares provided, type of staff providing each service, frequency of supervision and fees. All services provided to clients will be delivered after an assessment by an RN is completed, and an up-to-date Service Plan is signed by an RN and the client or the client's designated representative. The licensee did not have a policy on resident safety checks. TIME PERIOD TO CORRECT: Seven (7) Days	01640		
01650 SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident;	01650		

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01650	Continued From page 13 (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to ensure the service plan included all required components for one of one (R1) resident reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1's diagnoses included Type 2 diabetes with	01650		

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01650	Continued From page 14 diabetic neuropathy, congestive heart failure, stroke, and benign enlarged prostate with lower urinary tract symptoms. R1's service plan agreement dated February 17, 2024 and updated March 5, 2024, lacked signatures from R1 or R1's representative for authentication of services. The service plan also lacked the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; During an interview on September 11, 2024 at 9:30 a.m., executive director (ED)-B, said the licensee's previous owners took all the paper records so there was no "original" signed service plan agreement for R1, but the new management did new paperwork and electronic records for the residents in January. A policy titled Service Plan, revised date September 2023, indicated an up-to-date Service Plan is signed by a registered nurse and the client or the client's designated representative. TIME PERIOD TO CORRECT: Seven (7) Days	01650		