

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL307454361M
Compliance #: HL307455340C

Date Concluded: September 24, 2024

Name, Address, and County of Licensee

Investigated:

Lino Lakes Assisted Living
725 Town Center Pkwy
Lino Lakes, MN 55014
Anoka County

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

Evaluator's Name: Brooke Anderson, RN
Special Investigator

Finding: Not Substantiated

Nature of Investigation:

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

Initial Investigation Allegation(s):

The facility neglected the resident when the resident was found on the side of her bed. The resident reported she hit her head, began throwing up, and was sent to the hospital.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was not substantiated. Although the resident fell and went to the hospital, there was not a preponderance of evidence to support that the fall was caused by the failure of facility staff to provide necessary care or services. The resident returned to the facility following discharge from the hospital.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record, hospital records, facility incident reports, personnel files, staff schedules, and related facility policies and procedures. Also, the investigator observed interactions between staff and residents.

The resident resided in an assisted living memory care unit with a diagnosis of dementia. The resident's service plan included assistance with transfers, toileting, and safety checks. The resident's assessment indicated the resident was able to use her call light to request assistance and staff were directed to complete safety checks on the resident.

A facility report indicated the resident pulled her call light requesting assistance and when staff responded they found the resident on the floor in her bedroom. The resident complained of hip and head pain and began throwing up. Facility staff called 911 and the resident was sent to the hospital for evaluation.

Hospital records indicated the resident was trying to get out of bed, slipped and landed on her tailbone. The resident was evaluated, no injuries were found, and the resident was discharged back to the facility.

During an interview, the facility nurse stated the facility staff responded to the resident's call light and when she had complaints of hip pain and reported she hit her head, 911 was called.

During an interview, a family member stated she was not told about the fall until after the resident was sent to the hospital.

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

"Not Substantiated" means:

An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17

"Neglect" means neglect by a caregiver or self-neglect.

(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and

(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: No. Resident not available.

Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:

Facility staff responded to the resident's call light, contacted 911 and sent the resident to the hospital for evaluation.

Action taken by the Minnesota Department of Health:

No further action taken at this time.

cc:

The Office of Ombudsman for Long Term Care

The Office of Ombudsman for Mental Health and Developmental Disabilities

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30745	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/14/2024
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NAME OF PROVIDER OR SUPPLIER LINO LAKES ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 725 TOWN CENTER PARKWAY LINO LAKES, MN 55014
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0 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.</p> <p>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.</p> <p>INITIAL COMMENTS: #HL307454393C/#HL307453901M #HL307455340C/#HL307454361M #HL307456117C/#HL307454782M</p> <p>On August 14, 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 83 residents receiving services under the provider's Assisted Living license.</p> <p>No correction orders were issued for HL307455340C/#HL307454361M.</p> <p>The following correction orders are issued for #HL307454393C/#HL307453901M, tag identification 2360, #HL307456117C/#HL307454782M, tag identification 0630, 0800, 1620, and 2360.</p>	0 000	<p>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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>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.</p>	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Minnesota Department of Health

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0 630	Continued From page 1	0 630		
0 630 SS=D	<p>144G.42 Subd. 6 (b) Compliance with requirements for reporting ma</p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to complete an individualized review and assessment of the resident'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 following observed changes in behavior and injuries of unknown origin for one of one resident (R3) reviewed. R3's individualized abuse prevention plan (IAPP) was not updated following multiple incidents of wandering and involving aggressive behavior towards staff and other residents and injuries of unknown origin.</p> <p>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</p>	0 630		

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0 630	<p>Continued From page 2</p> <p>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).</p> <p>The findings include:</p> <p>R3 admitted to the facility on March 19, 2024, due to diagnoses that included Alzheimer's disease and chronic kidney disease.</p> <p>R3's service plan undated indicated R1 required assistance with safety checks two times a day, medication management, and behavioral management.</p> <p>R3's IAPP assessment dated April 15, 2024, indicated R3 had a self-care deficit related to cognitive decline, physical limitations, and frustration over loss of independence. R3 was at risk for elopement and wandering. IAPP interventions included for staff to provide diversion or distraction.</p> <p>R3's progress notes dated May 4, 2024, indicated R3 was found on the floor during safety checks. R3 did not know what happened. R3's room was very cold, and staff turned up the heat. BP was 153/94 and O2 was 76% when R3 was up in the chair his O2 increased to 91%. Staff were instructed to continue safety checks and call triage with any changes. R3's progress not lacked evidence follow up was completed.</p> <p>R3's medical record included no evidence that R3 was assessed following the fall, R3's provider was not updated, and no interventions were put in place to prevent further occurrences. R3 was not monitored for additional injuries following the fall.</p>	0 630		

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0 630	<p>Continued From page 3</p> <p>R3's incident report dated May 8, 2024, indicated R3 was threatening staff, combative, and kicked staff in the abdomen and upper thigh. Redirection was attempted but R3 continued to follow staff.</p> <p>R3's medical record lacked evidence that R3 was assessed or that follow up of the incident was completed and no changes were made to R3's Individual Abuse Prevention Plan (IAPP) to address the change in behavior.</p> <p>R3's incident report dated May 9, 2024, indicated R3 was in another resident's room 4 times. R3 was redirected and became aggressive. R3 was redirected again and R3 told staff to shut your damn mouth.</p> <p>R3's medical record lacked evidence that R3 was assessed following the incident and R3's IAPP was not updated to reflect the change in R3's behavior. No additional interventions were implemented to mitigate further incidents or protect R3 or other residents' safety.</p> <p>R3's incident report dated May 20, 2024, indicated when staff arrived to work R3 had swelling on his right check and brow. R3 stated he got into a bar fight. The facility nurse was notified.</p> <p>The May 20th 2024, incident report lacked evidence the medical provider was updated and lacked evidence action was taken to assess, monitor, or treat the injury and no interventions were implemented to prevent further injury. There was no evidence of follow-up completed related to the resident's report of getting into a fight or review of how the injuries may have occurred.</p> <p>R3's incident report dated May 27, 2024,</p>	0 630		

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0 630	<p>Continued From page 4</p> <p>indicated R3 was throwing things in another resident's room. The other resident pulled his call light and reported R3 was in his room to staff. R3 was removed from the other resident's room. Facility management was notified. The incident report lacked evidence that the medical provider or R3's family were updated on change in the resident's behaviors.</p> <p>R3's medical record lacked evidence that R3 was assessed following the incident and R3's IAPP was not updated to reflect the change in R3's behavior or interventions to prevent further incidents or protect R3 or other residents' safety.</p> <p>R3's incident report dated May 31, 2024, indicated R3 was naked in a female resident's room. Facility staff attempted to get R3 out of another resident's room. R3 became extremely aggressive while hitting the staff, tripped and hit his head against the door. R3's incident report indicated R3 was sent to the ER for a head strike. Staff called 911 to have the resident transported to the emergency room.</p> <p>Police responded to the staff's 911 call for resident transport to the hospital and the police report dated May 31, 2024, indicated R3 had a red mark on his forehead above R3's right eye. R3 had several bruises on his face, arms and body that appeared to be in various stages of healing.</p> <p>R3's medical record did not reflect documentation, assessment, or monitoring of the injuries present on R3's body that were identified in the police report.</p> <p>The licensee failed to assess and monitor R3 after an increase in aggressive behavior and</p>	0 630		

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0 630	<p>Continued From page 5</p> <p>injuries of unknown origin were noted by facility staff.</p> <p>During an interview August 11, 2024, registered nurse (RN)-E stated the facility nurse should have assessed, monitored, put interventions in place and investigated the root cause of the incidents to prevent an incident from happening again and confirmed this was not completed for R3.</p> <p>In an email dated August 28, 2024, RN-H indicated assessments should be completed every 90 days and with a change in condition. Any newly identified areas or new vulnerabilities would be followed up with a care plan review and any needed interventions added at that time would also prompt a new service plan to be reviewed and signed.</p> <p>The licensee's policy dated December 28, 2023, titled "Individual Abuse Prevention Plan" indicated the licensee will implement and update an IAPP for each resident that assesses specific measures to minimize the risk of abuse to the resident and other vulnerable adults.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	0 630		
0 800 SS=F	<p>144G.45 Subd. 2 (a) (4) Fire protection and physical environment</p> <p>(4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.</p>	0 800		

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0 800	<p>Continued From page 6</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to keep the physical environment in a continuous state of good repair with regard to the health, safety, comfort, and well-being for one of one resident (R3) when R1's room was repeatedly observed to be in an unkempt state in visibly soiled clothing, with piles of urine-soaked clothing. In addition, the carpet in the hallways were rippled creating a potential fall hazard for residents.</p> <p>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).</p> <p>Findings include:</p> <p>R3 was admitted to the facility on March 19, 2024, with diagnoses including moderate late onset Alzheimer's dementia with mood disturbances.</p> <p>R3's service plan undated indicated R3 required assistance with safety checks two times a day, medication management, and behavioral management and housekeeping weekly.</p> <p>R3's IAPP assessment dated April 15, 2024, indicated R3 had a self-care deficit related to cognitive decline, physical limitations, and</p>	0 800		

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0 800	<p>Continued From page 7</p> <p>frustration over loss of independence. R3 was at risk for elopement and wandering. IAPP interventions included for staff to provide diversion or distraction.</p> <p>A photo of R3 on his bed showed the bed did not have sheets, blanket, or pillow on his bed.</p> <p>A photo of R3's room showed soiled clothing in R3's room.</p> <p>A police report dated May 27, 2024, indicated R3 did not have a pillow on his bed. R3's room had a "very strong odor of urine." R1's bathroom had wet toilet paper on the floor with a "large" puddle of yellow liquid that appeared to be urine. A police report indicated photos were taken.</p> <p>A police report dated May 31, 2024, indicated officers noticed "several things in the facility that caused concern." Officers noted the carpet in the hallway in front of R3 was loose and creased upward which created a tripping hazard. The police report indicated a pool of liquid on the floor underneath a table and chair in the common area that created a slipping hazard. The police report indicated the floors were sticky causing their boots to stick to the ground. The general areas smelled of urine.</p> <p>During an observation August 14, 2024, at 10:58 a.m. while walking in the halls the carpet was observed by the MDH investigator to be rippling.</p> <p>On August 15, 2024, at 1:00 p.m. during an interview with R3's family member (FM)-A stated the facility did not provide hands-on care and assistance for R3 and R3 needed more assistance than the facility provided. FM-A stated R3's room was disgusting with piles of urine and</p>	0 800		

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0 800	<p>Continued From page 8</p> <p>feces-soaked clothing. FM-A stated concerns were reported to facility management on multiple occasions, and nothing was done for R3.</p> <p>On August 21, 2024, at 9:00 a.m. during an interview with a corporate registered nurse (CRN), she stated the nurse should have completed an assessment, increased services for the resident, and put interventions in place to help R3 with his increased needs and the care R3 received was unfortunate at the end.</p> <p>On August 29, 2024 at 9:04 a.m. during an email exchange registered nurse (RN)-E stated the carpet has been rippled for a long time. Requests have been made to get it fixed daily. There are contractors working to install new carpet but it could take weeks.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	0 800		
01620 SS=G	<p>144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring</p> <p>(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.</p> <p>(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</p>	01620		

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01620	<p>Continued From page 9</p> <p>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.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and document review the licensee failed to assess, monitor, and implement interventions after changes in behavior and injuries of unknown origin were observed for one of one resident (R3).</p> <p>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 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).</p> <p>The findings include:</p> <p>R3 admitted to the facility on March 19, 2024, due to diagnoses that included Alzheimer's disease and chronic kidney disease.</p> <p>R3's service plan undated indicated R1 required assistance with safety checks two times a day, medication management, and behavioral</p>	01620		

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01620	<p>Continued From page 10 management.</p> <p>R3's IAPP assessment dated April 15, 2024, indicated R3 had a self-care deficit related to cognitive decline, physical limitations, and frustration over loss of independence. R3 was at risk for elopement and wandering. IAPP interventions included for staff to provide diversion or distraction.</p> <p>R3's progress notes dated May 4, 2024, indicated R3 was found on the floor during safety checks. R3 did not know what happened. R3's room was very cold, and staff turned up the heat. BP was 153/94 and O2 was 76% when R3 was up in the chair his O2 increased to 91%. Staff were instructed to continue safety checks and call triage with any changes. R3's progress not lacked evidence follow up was completed.</p> <p>R3's medical record included no evidence that R3 was assessed following the fall, R3's provider was not updated, and no interventions were put in place to prevent further occurrences. R3 was not monitored for additional injuries following the fall.</p> <p>R3's incident report dated May 8, 2024, indicated R3 was threatening staff, combative, and kicked staff in the abdomen and upper thigh. Redirection was attempted but R3 continued to follow staff.</p> <p>R3's medical record lacked evidence that R3 was assessed or that follow up of the incident was completed and no changes were made to R3's Individual Abuse Prevention Plan (IAPP) to address the change in behavior.</p> <p>R3's incident report dated May 9, 2024, indicated R3 was in another resident's room 4 times. R3 was redirected and became aggressive. R3 was</p>	01620		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30745	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/14/2024
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NAME OF PROVIDER OR SUPPLIER LINO LAKES ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 725 TOWN CENTER PARKWAY LINO LAKES, MN 55014
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01620	<p>Continued From page 11</p> <p>redirected again and R3 told staff to shut your damn mouth.</p> <p>R3's medical record lacked evidence that R3 was assessed following the incident and R3's IAPP was not updated to reflect the change in R3's behavior. No additional interventions were implemented to mitigate further incidents or protect R3 or other residents' safety.</p> <p>R3's incident report dated May 20, 2024, indicated when staff arrived to work R3 had swelling on his right check and brow. R3 stated he got into a bar fight. The facility nurse was notified.</p> <p>The May 20th 2024, incident report lacked evidence the medical provider was updated and lacked evidence action was taken to assess, monitor, or treat the injury and no interventions were implemented to prevent further injury. There was no evidence of follow-up completed related to the resident's report of getting into a fight or review of how the injuries may have occurred.</p> <p>R3's incident report dated May 27, 2024, indicated R3 was throwing things in another resident's room. The other resident pulled his call light and reported R3 was in his room to staff. R3 was removed from the other resident's room. Facility management was notified. The incident report lacked evidence that the medical provider or R3's family were updated on change in the resident's behaviors.</p> <p>R3's medical record lacked evidence that R3 was assessed following the incident and R3's IAPP was not updated to reflect the change in R3's behavior or interventions to prevent further incidents or protect R3 or other residents' safety.</p>	01620		

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01620	<p>Continued From page 12</p> <p>R3's incident report dated May 31, 2024, indicated R3 was naked in a female resident's room. Facility staff attempted to get R3 out of another resident's room. R3 became extremely aggressive while hitting the staff, tripped and hit his head against the door. R3's incident report indicated R3 was sent to the ER for a head strike. Staff called 911 to have the resident transported to the emergency room.</p> <p>Police responded to the staff's 911 call for resident transport to the hospital and the police report dated May 31, 2024, indicated R3 had a red mark on his forehead above R3's right eye. R3 had several bruises on his face, arms and body that appeared to be in various stages of healing.</p> <p>R3's medical record did not reflect documentation, assessment, or monitoring of the injuries present on R3's body that were identified in the police report.</p> <p>The licensee failed to assess and monitor R3 after an increase in aggressive behavior and injuries of unknown origin were noted by facility staff.</p> <p>During an interview August 11, 2024, registered nurse (RN)-E stated the facility nurse should have assessed, monitored, put interventions in place and investigated the root cause of the incidents to prevent an incident from happening again and confirmed this was not completed for R3.</p> <p>In an email dated August 28, 2024, RN-H indicated assessments should be completed every 90 days and with a change in condition. Any newly identified areas or new vulnerabilities</p>	01620		

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01620	<p>Continued From page 13</p> <p>would be followed up with a care plan review and any needed interventions added at that time would also prompt a new service plan to be reviewed and signed.</p> <p>The licensee's policy dated August 2021 titled Nursing "Assessments, Reviews, and Monitoring" indicated resident assessment and monitoring will be conducted as needed based on changes in the needs of the resident.</p> <p>No further information provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	01620		
02360	<p>144G.91 Subd. 8 Freedom from maltreatment</p> <p>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.</p> <p>This MN Requirement is not met as evidenced by: The facility failed to ensure two of three residents reviewed R1 and R3 was free from maltreatment.</p> <p>Findings include:</p> <p>The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.</p>	02360		