Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL307456024M
Compliance #: HL307451340C

Date Concluded: June 20, 2023

Name, Address, and County of Licensee Investigated:
Lino Lakes Assisted Living
725 Town Center Parkway
Lino Lakes, MN 55014
Anoka County

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

Evaluator's Name:
Lisa Coil, RN Special Investigator

Finding: Substantiated, individual responsibility

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

Initial Investigation Allegation(s):
The alleged perpetrator (AP) neglected the resident when the AP failed to complete every two-hour safety check for approximately eight hours. The resident fell, crawled around the room, and was unable to get off the floor. When staff members entered the room, approximately four hours after the resident fell, the resident had no clothing on and had stool smeared on herself and all over the carpet. The resident was taken to the hospital for evaluation.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The AP was responsible for the maltreatment. The AP failed to complete safety checks on the resident every two hours as indicated on the resident's care plan.

The investigator conducted interviews with facility staff members, including administrative staff, and unlicensed staff. The investigator contacted the resident's family member and law

enforcement. The investigation included review of the resident's facility record, hospital record, and video footage. Also, the investigator observed interactions with the resident and staff.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia. The residents care plan indicated she was independent with walking but a fall risk and on safety checks every two hours. The care plan also indicated she had severe memory loss, was unable to make her needs known, and had a deficit in judgment related to safety.

The resident's accident/fall and investigation report indicated she fell outside of her bathroom door early one morning and was seated in an odd position, with her legs in a "w" position, blood on her right calve, and was complaining of pain in her right arm and right leg. The report indicated she every hour in one section of the form but in a different section of the form it listed every two hours. The form indicated the resident was left unattended and did not receive safety checks three times through the night shift.

The residents progress note indicated the resident was found on the floor in her room shaking uncontrollably, pale, clammy skin, staff called 911, and she was transported to the emergency room (ER) for evaluation.

A review of resident's medical record did not identify documentation of the resident's safety checks for the night of the incident.

The resident's hospital record indicated she was brought to the emergency room by emergency medical services (EMS) and evaluated following an unwitnessed fall. The record indicated staff were doing rounds when they found her on the floor, propped up on her knees, in a wet brief and dried stool. The resident had a bruise over her left eyebrow and complained of right knee soreness. The same documents indicated the resident required two-person-assistance to walk and admitted to the hospital for further evaluation and treatment.

The video footage indicated the AP assisted the resident with bedtime cares, assisted the resident to bed, and exited the resident's room at 8:15 p.m., closing the door behind her. By 8:18 p.m., the resident got out of bed, got undressed, and for the next four hours she paced around her bed straightening her blankets, wandered around the room, in and out of the bathroom, opened and closed the bathroom and closet doors, crawled in and out of bed, and folded clothing. At 12:15 a.m. as the resident was walking from her closed bedroom door to the living area, she lost her balance and fell to the floor. For the next 38 minutes, the resident scooted herself around the floor, and attempted to use furniture around the room to get up from the floor multiple times with no success. The next time the video footage recorded was at 4:41 a.m. when staff members, including the AP, entered the room and found the resident on the floor in the bathroom doorway.

During an interview, the unlicensed caregiver stated she worked the night of the incident but was not assigned to the hall the resident resided on, so was not assigned to do the resident's

safety checks. However, the unlicensed caregiver stated she and the AP were doing morning rounds together and entered the resident's room around 4:40 a.m. and found the resident on the floor. The unlicensed caregiver stated they attempted to get the resident up from the floor but were unable to, so called 911 to transport her to the ER. The unlicensed caregiver stated the resident was able to open and close her bedroom door by herself, staff do not lock her bedroom door, she did not think the resident could lock/unlock her bedroom door by herself and believed the bedroom door was unlocked all night. The unlicensed caregiver stated the AP told her she had checked on the resident through the night. The unlicensed caregiver also stated she did not recall seeing the AP do safety checks that night and the AP did not ask the unlicensed caregiver to do any safety checks for her.

During an interview, the resident's family member stated a staff member from the facility called and notified them the resident had fallen and was being transferred to the hospital by ambulance. The family member later learned from the video footage and the resident fell and was on the floor for four (4) hours and 26 minutes before staff found her. The family member also stated the camera was activated by movement and figured the resident may have fallen asleep for just under four (4) hours until staff members found her early in the morning. The family member stated the resident spent a few days in the hospital to work on walking and then went back to the facility.

During an interview, the nurse stated the AP told her she checked on the resident at 12:45 a.m., did not do the 2:00 a.m. safety check, and went into the resident's room about 4:45 a.m. for the 4:00 a.m. safety check. The nurse stated the AP was suspended during and then later terminated while another staff member working that night shift was educated on safety checks.

During an interview, the AP stated she worked a double shift that evening into night, from 2:00 p.m. to 5:30 a.m. the next morning. The AP stated she had access to the resident's care plan and knew it indicated the resident was on every two (2) hour safety checks during the night shift, which started at 10:00 p.m. The AP stated she did not do a 10:00 p.m. safety check on the resident but did not remember why. The AP stated she was kicked by another resident during 12:00 a.m. rounds, was feeling nauseated, went to the bathroom, and rested for a brief time. The AP stated after resting for a bit, she started doing laundry, got sidetracked, and forgot to do the residents 12:00 a.m. and 2:00 a.m. safety checks. The AP stated she did not ask her co-worker to do the residents safety check while she was not feeling well. The AP stated she and her co-worker were doing 4:00 a.m. rounds together and got to the resident's room around 4:45 a.m. and found her on the floor. They initially tried to assist the resident to get up but were unsuccessful, so they called the shift lead, the on-call nurse, and 911.

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

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

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
Neglect means 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.

(5) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult that results in injury or harm, which reasonably requires the care of a physician, and:
(i) the necessary care is provided in a timely fashion as dictated by the condition of the vulnerable adult;
(ii) if after receiving care, the health status of the vulnerable adult can be reasonably expected, as determined by the attending physician, to be restored to the vulnerable adult's preexisting condition;
(iii) the error is not part of a pattern of errors by the individual;
(iv) if in a facility, the error is immediately reported as required under section 626.557, and recorded internally in the facility;
(v) if in a facility, the facility identifies and takes corrective action and implements measures designed to reduce the risk of further occurrence of this error and similar errors; and
(vi) if in a facility, the actions required under items (iv) and (v) are sufficiently documented for review and evaluation by the facility and any applicable licensing, certification, and ombudsman agency.

Vulnerable Adult interviewed: No, due to cognitive loss
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility investigated the incident and sent the resident to the hospital.

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.

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

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 Disabilities
Lino Lakes County Attorney
Lino Lakes City Attorney
Lino Lakes Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30745	A. BUILDING: _____ B. WING _____	04/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINO LAKES ASSISTED LIVING	725 TOWN CENTER PARKWAY LINO LAKES, MN 55014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** HOME CARE PROVIDER/ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482/144G.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: #SL30745016 #HL307451080C/#HL307455804M #HL307451340C/#HL307456024M On April 24, 2023 through April 27, 2023, the Minnesota Department of Health initiated a change in ownership (CHOW) survey along with complaint investigation(s) at the above provider, and the following correction orders are issued. At the time of the survey and complaint investigation, there were 97 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued The following correction orders are issued specifically for #HL307451080C/#HL307455804M, tag	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 License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	

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0 000	Continued From page 1 identification 1620 and 1640. The following correction order is issued specifically for #HL307451340C/#HL307456024, tag identification 2360.	0 000		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared according to the Minnesota Food Code. This had the potential to affect all 97 residents residing in the facility. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the clients). The findings include: Please refer to the additional documentation included in the Food and Beverage Establishment Inspection Reports, dated April 24, 2023.	0 480		

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0 480	Continued From page 2 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on record review, observation, and interview, the licensee failed to ensure infection control procedures were followed for six of six residents (R6, unidentified resident (UR)1, UR2, UR3, UR4, UR5)) during mealtime. This had the potential to affect all residents in the dining room at communal mealtimes. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 510		

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0 510	Continued From page 3 The findings include: During observation on April 24, 2023, at 5:12 p.m., R6 was touching food on the plate of unidentified resident #1 (UR1) sitting next to her. R6 then pulled UR1's plate over to her and started eating the food off it with her fingers. When staff observed R6 doing this, they took the plate away from R6 and gave it back to UR1, staff did not provide UR1 with a new plate of food. During observation on April 25, 2023, at 8:20 a.m., R6 was touching UR2's silverware and UR2 began to yell at R6. Staff removed R6 from the situation and placed her at another table. Staff failed to give UR2 clean silverware following R6 handling it. During observation on April 25, 2023, at 8:32 a.m., unidentified staff #1 (US1) was observed serving plates to residents with a pair of blue gloves on, touching a chair to pull up next to the table, touching silverware for UR3 and UR4, assisting UR3 and UR4 with eating, touched a lanyard with keys attached, and then had UR3 spit out scrambled eggs into her hand and place them back on her plate. These tasks were completed with the same blue gloves worn throughout the observation. During observation on April 27, 2023, at 8:29 a.m., R6 stood up from her chair, pulled UR5 plate across the table, and started eating UR5's leftovers with her fingers. The surveyor alerted unlicensed personnel (ULP)-G, who was sitting at the same table assisting UR3 and UR4 with eating, to what R6 was doing. ULP-G took the plates and as she stood by the table, R6 reached down and grabbed scrambled eggs off UR3's plate with her fingers and ate them.	0 510		

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0 510	Continued From page 4 During an interview on April 27, 2023, at 10:12 a.m., ULP-G stated she had never seen R6 eat off another resident's plate before and was not aware of any decline with R6 that may be causing this change in behavior. During an interview on April 27, 2023, at 2:06 p.m., RN-B, also the Director of Nursing, stated her expectation were for staff to follow infection control practices and these observations were not good infection control practices. The licensee's 8.09 Hand Washing policy, dated August 1, 2021, indicated hand washing techniques should be used to protect the spread of infection. The policy indicated hand washing would be performed by all employees between tasks and procedures, and after bathroom use, to prevent cross-contaminations. The Center for Disease and Control (CDC's) Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings | Infection Control | CDC, dated November 29, 2022, indicated standard precautions are the basic practices that apply to all patient care and included hand hygiene. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 510		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality	0 580		

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0 580	Continued From page 5 management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation of quality management activities. This had the potential to affect all ninety-seven (97) residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On April 24, 2023, at 2:00 p.m., during the entrance conference, the licensee's quality management documentation was requested for review of any quality management activity. On April 25, 2023, at approximately 1 p.m., the Quality management documentation was again requested from the licensee.	0 580		

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0 580	Continued From page 6 On April 26, 2023 at approximately 10 a.m. the quality management documentation was again requested from the licensee. On April 27, 2023, the regional director registered nurse (RDRN)-I confirmed there was no current documentation of quality management activity and no quality management activity had occurred by the licensee. The licensee's policy titled 2.31 Quality management program states "To ensure that a healthy, safe, sanitary and respectful environment is provided for residents, employees and other and to assure that resident care is delivered in a safe and efficient manner, this community has developed and implemented a quality management program." TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations;	0 650		

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0 650	Continued From page 7 (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation and record review, the licensee failed to ensure employee records contained the required content for four of four staff (unlicensed personnel (ULP)-D-, (ULP)-E, (ULP)-J and registered nurse (RN)-B) with employee records reviewed. This had the potential to affect all residents in the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-D ULP-D was hired on November 14, 2022. ULP-D provides services to the residents including medication administration.	0 650		

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0 650	Continued From page 8 During an observation on April 25, 2023, at 8:31 a.m., ULP-D provided transfer assistance using a Hoyer lift for R3. ULP-D returned to the medication cart and proceeded to set up medications for distribution. ULP-D's employee record lacked a dated and signed job description. ULP-E ULP-E was hired on January 24, 2023. ULP-E provides services to the residents including medication administration. During observation on April 25, 2023, at 8:30 a.m., ULP-E was providing medication administration to residents in the memory care unit. During an interview on April 25, 2023 at 09:00 a.m. with ULP-E, she stated she was a lead ULP and trained other ULP's. ULP-E's employee record lacked a dated and signed job description. ULP-J ULP-J was hired on June 1, 2022. ULP-J was terminated on April 11, 2023. ULP-J employee record lacked a document containing her address, no background study, no signed job description, and no training records. RN-B RN-B was hired on October 18, 2022.	0 650		

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0 650	Continued From page 9 RN-B's employee record lacked a dated and signed job description. The licensee's Employee Records 4.05 Policy, not dated, indicated employee records will include a completed employee application, documentation of a completed background study, current signed job description and required training and competency testing records as required. TIME PERIOD TO CORRECT: Twenty-One (21) Days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB)	0 660		

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0 660	Continued From page 10 prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The licensee failed to ensure history and symptoms screenings and screening for active TB (either a two-step tuberculin skin test (TST) or blood test) were completed and documented for one of one unlicensed personnel (ULP-E) with employee records reviewed. This had the potential to effect resident, staff members, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-E was hired January 24, 2023, to provide assisted living services for the licensee. ULP-E employee records review showed evidence of a completed tuberculosis (TB) history and symptoms screening and screening for active TB (either a two-step tuberculin skin test (TST) or blood test) on March 3, 2023. On April 25, 2023, at 8:30 a.m., ULP-E stated she has been working as a lead medication passer since late January. Licensee's Infection Control policy, effective date August 1, states the licensee would screen all employees and volunteers for tuberculosis infection and all employees would receive a	0 660		

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0 660	Continued From page 11 two-step Mantoux prior to staff being exposed to residents. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and document review, the	0 680		

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0 680	Continued From page 12 licensee failed to develop a written emergency disaster plan (EP) with all the required content. This had the potential to affect all residents, staff, and visitors. 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 include: On April 27, 2023, at 7:33 a.m., the EP policy was reviewed with director of maintenance (DM)-F who also serves as person in charge of the licensee's EP policy. The licensee's plan, not dated, lacked the following required content: - a description of the facilities approach to meeting the health/safety/security needs of the staff and residents; - process for EP cooperation with state and local EP officials/organizations. - a thoroughly completed risk assessment; - conduct exercises at least twice a year including an annual full-scale exercise that is community based or individual based functional exercise or if facility experiences an actual emergency; and an additional annual exercise that may include a full-scale exercise or mock disaster drill or table-top exercise; - a description of the population served by the licensee; -procedures for tracking of staff and residents; -policies for sheltering in place;	0 680		

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0 680	Continued From page 13 -policies to address resident information, protect confidentiality, and secure/maintain records; -method for sharing information and medical documentation for residents in the event of an evacuation; -method for sharing information with residents and their families/representatives. -role of the facility under a waiver declared by the Secretary in accordance with section 1135 of the ACT; - collaboration process with local, tribal, regional, State and Federal EPP to maintain integrated response. During an interview on April 27, 2023, at 7:33 a.m., the director of maintenance (DM)-F confirmed the provided emergency guide did not contain all the required information. DM-F stated the binder had been updated when new ownership took over June 1, 2022 but did not know the exact date the plan was reviewed. DM-F stated anything pertaining to medical was nursing's responsibility. During an interview on April 27, 2023, at 10:00 a.m., registered nurse (RN)-B stated a separate emergency binder included resident face sheets and medication records in the event of an emergency. RN-B stated she was not part of the emergency disaster plan process. During an interview on April 27, 2023, at 10:57 a.m., executive director (ED)-A stated DM-F and her had not worked on the EP plan together but had a future date set up. The licensee's Disaster and Emergency Manual, not dated, indicated the purpose of the manual is to prepare and guide the staff and residents in the event of an emergency or disaster.	0 680		

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0 680	Continued From page 14 TIME PERIOD FOR CORRECTION: Twenty-One (21) Days	0 680		
0 780 SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that are interconnected so that actuation of one alarm causes all alarms in the dwelling unit to actuate.	0 780		

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0 780	Continued From page 15 This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a 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: On April 26, 2023, at approximately 10:00 a.m., survey staff toured the facility with the Director of Maintenance (DM)-F. During the facility tour, survey staff observed the following items: In resident rooms 11 and 10 in the memory care wing, it was observed that the sleeping rooms that were equipped with smoke alarms were not interconnected with the other smoke alarms in the dwelling unit, so the actuation of one alarm would cause all alarms to operate. This deficient condition was visually verified by DM-F accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of	0 800		

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0 800	Continued From page 16 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. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain 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. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On April 26, 2023, at approximately 10:00 a.m., survey staff toured the facility with the Director of Maintenance (DM)-F. During the facility tour, survey staff observed the following items: In resident unit 129, it was observed that wallpaper was peeled off from the wall at the ceiling and wall transition. In resident unit 128, it was observed that excess material and equipment were stored in the unit.	0 800		

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0 800	Continued From page 17 The room was filled with excess tools, equipment, boxes, household supplies, and building material. The unit was not in good repair in regard to resident health and safety in accordance with maintenance and repair program. In the dining room on the first floor, it was observed that the fire-rated door was heavily damaged, and the core framings were exposed. During the interview, DM-F stated that the facility is planning to replace doors in the entire building. In resident unit 204, it was observed that excess material and personal items were stored in the unit. The room was filled with excess clothes, equipment, boxes, and household supplies. The unit was not in good repair in regard to resident health and safety in accordance with the maintenance and repair program. In the corridor on the second floor, it was observed that the wood handrail return piece was missing, and the handrail corner edge was exposed with a sharp edge. Throughout the building, in many locations, it was observed that the fire extinguisher cabinet door was not latch shut when pushed. The door was twisted and exposing sharp metal edges. DM-F visually verified these deficient findings at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment	0 810		

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0 810	Continued From page 18 (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on record review, observation, and interview, the licensee failed to provide required employee training on fire safety and evacuation and failed to complete required employee	0 810		

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0 810	Continued From page 19 evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: An interview and record review of the available documentation were conducted on April 26, 2023, at approximately 11:00 a.m., with the Community Director (ED)-A and the Director of Maintenance (DM)-F on the fire safety and evacuation plan, fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. Record review indicated that employees did not receive training twice per year after initial hire. During the interview, ED-A stated that the licensee provided annual training to employees, but not twice per year after the initial hire on the fire safety and evacuation plan, as required by statute. A policy was requested on employee training, and one was provided indicating that the licensee only provides annual training. Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute. Provided documentation indicated that the drills were conducted on 4/25/23 at 8:40 a.m., 3/9/23 at 8:00 a.m. and 11/22/23 at 7:10 a.m. with no	0 810		

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0 810	Continued From page 20 further drills being documented. DM-F verified that there were no further documented drills for the facility and verified this deficient condition. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01460 SS=D	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on observation and record review, licensee failed to ensure employees received orientation training to the assisted living licensing requirements and regulations for one of six employees (registered nurse [RN]-C) with records reviewed before providing direct care. 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).	01460		

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01460	Continued From page 21 The findings include: Unlicensed personal (ULP-E) was hired on January 24, 2023, to provide direct care services to the licensee's residents. On April 25, 2023 at 7:30 a.m., ULP-E was observed providing direct care services for residents in the memory care unit. ULP-E employee records did contain documentation ULP-E completed orientation to the assisted living facility licensing requirements and regulations on April 14, 2023. This was not before providing assisted living services to residents. A policy titled 1.01 Assisted Living statures and rules overview acknowledges the rules and requirements for this training according to the statues in 144G. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01460		
01540 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the	01540		

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01540	Continued From page 22 requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation and record review, the licensee failed to ensure employees received the required amount of dementia care training in the required period for one of one employee unlicensed personal (ULP-E) records reviewed. This practice resulted in a level two violation (a violation that did not harm a client'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: The licensee had a current assisted living facility with dementia care license. ULP-E was hired on January 24, 2023, to provide direct care services to the licensee's residents. On April 25, 2023, at 7:35 a.m., ULP-E was observed providing direct care services for residents in the memory care unit. During record review, ULP-E employee record did not contain documentation of the required eight	01540		

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01540	Continued From page 23 (8) hours of training on the specific dementia care topics within 80 working hours of ULP-E's hire date. The licensee's 5.03 Dementia Training policy dated August 31, 2021, noted direct care employees of assisted living with dementia care licensed facilities would complete eight hours of initial training within 80 hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	01540		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (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	01620		

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	30745	A. BUILDING: _____ B. WING _____	04/27/2023

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01620	Continued From page 24 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 ensure the required comprehensive nursing assessment was completed by a registered nurse (RN) for two of three residents (R5, R9). 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). Findings include: R5 R5 admitted to the facility on June 1, 2022, with a diagnosis of multiple sclerosis, type I Diabetes Mellitus, anxiety, and depression, R5's service plan, reviewed March 29, 2023, indicated R5 received services for showering assistance one time a week, housekeeping, laundry, meals, daily resident checks, and medication administration and management. Review of R5's most recent 90-day comprehensive assessment dated March 28, 2023, indicated the assessment was completed	01620		

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01620	Continued From page 25 by the licensed practice nurse (LPN). R9 R9 was admitted to the facility on June 1, 2022, with diagnoses which included major depressive disorder and panic disorder. R9's medical record lacked evidence any assessments were completed. During interviews on April 27, 2023, at 10:00 a.m. and 1:30 p.m., registered nurse (RN)-B, also the director of nursing, stated only an RN can conduct resident assessments. RN-B stated she was unaware the LPN had completed R5's assessment and did not have an explanation why. RN-B also verified R9 did not have any completed assessment in her record. Policy titled 6.01 Assessments, Reviews & Monitoring, dated August 1, 2021, indicated assessments will be conducted by an RN. This same policy indicated the registered nurse who conducted the assessment will date and sign the assessment.	01620		
01640 SS=D	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	01640		

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01640	Continued From page 26 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 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 record review and interview, the licensee failed to complete a service plan within 14 days of admission for one of one residents (R9). 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 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). R9 admitted to the facility on June 1, 2022, with diagnoses which included major depressive disorder and panic disorder. R9's medical record lacked evidence of a service plan. During an interview on April 27, 2023, at 1:30 p.m., registered nurse (RN)-B, also the Director of Nursing, verified R9's record did not include a	01640		

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01640	Continued From page 27 service plan. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
02170 SS=D	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities;	02170		

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02170	Continued From page 28 (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on record review, and interview, the licensee failed to have a written individual activity plan which reflected the resident's activity preferences and needs and included structured and non-structured activities for one of one resident (R6). 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 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: R6's diagnoses included dementia. R6's service plan, dated February 5, 2023, indicated R6 would participate in activities of choice in the community and needed assistance/escort to and from activities. R6's intervention flowsheet for March 2023, indicated R6 had spontaneous activities scheduled for every hour from 8:00 a.m. through 8:00 p.m. each day and included one additional spot for as needed (PRN) signature. Of the 403 scheduled spontaneous activity signature spots, 121 were signed off as being completed. The flowsheet did not indicate what type of spontaneous activities R6 completed on those	02170		

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02170	Continued From page 29 121 occasions. R6's assessment, dated April 10, 2023, indicated R6 wandered around the unit throughout the day. R6's activity capabilities were best with one-to-one visits due to her stage of dementia, simple commands and conversations which included yes/no answers. The assessment also indicated R6 was at a risk to be abused by other and should be kept in communal areas with staff, safety checks every two hours, and redirected when wandering near other residents as she did not understand the personal space of others. R6's moments that matter form, completed by her husband, dated April 14, 2023, provided the facility with detailed information regarding R6's background, family life, and personal data. The form is used for memory care specific residents by the facility's activity department to create wonderful moments for the resident and allow the resident to feel they are contributing to their community. The form also allows gathers information for staff to understand the important things in R6's life along with things that may trigger both good, bad, and anxious moods or behaviors. During an interview on April 26, 2023, at 11:25 a.m., life enrichment director (LED)-M, stated the Moments That Matter document is used to determine what activities R6 would be interested in participating in. LED-M stated R6 sit with her for short periods while she is working at her desk, sit by her when she is calling out BINGO numbers, walks with her to make copies, and spends one-to-one time with her when LED-M sees her wandering all over the place. LED-M stated other residents will yell at R6 when she gets in their personal space and R6 will yell back	02170		

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02170	Continued From page 30 so staff members take R6 and walk away with her. During an interview on April 27, 2023, at 1:30 p.m., registered nurse (RN)-B, also the Director of Nursing, stated the Moments That Matter document should be referenced in the service plan, but they also will be using the electronic medical record (EMAR) for data collection, which is a newer system. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02170		