Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL307831943M
Compliance #: HL307833669C

Date Concluded: December 7, 2022

Name, Address, and County of Licensee Investigated:
Cottage Grove White Pine II
6950 East Point Douglas Road South
Cottage Grove, MN 55016
Washington County

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

Evaluator's Name: Michele R. Larson
Special Investigator

Finding: Inconclusive

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

Initial Investigation Allegation(s):
The facility neglected resident #1 and resident #2 when they failed to provide adequate supervision. Resident #1 was punched and struck in the eye and jaw by resident #2. Resident #1 sustained injuries to his face, including injury to his left eye, and a scratch on the left side of his face.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. Resident #1's record indicated he and resident #2 had physical altercations on multiple occasions and with other residents too. Although resident #1 sustained facial injuries, the injuries did not require care of a physician and he returned to his baseline health condition. Resident #2 was moved to another floor after the incident. A family member stated resident #1's physical altercations decreased after resident #2 moved to a different floor.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted resident #1's physician. The investigation included review of resident records, policies and procedures, personnel records, and staffing schedules. Also, the investigator observed staff performing cares.

Resident #1 resided in an assisted living memory care unit. Resident #1's diagnoses included dementia with behavioral disturbances, restlessness, agitation, and traumatic brain injury (TBI). Resident #1's service plan included safety checks every two hours and behavioral interventions three times per day. Resident #1's assessment indicated he was oriented to self only and had difficulty speaking and expressing words (expressive aphasia). Resident #1 was unable to report abuse or neglect and was vulnerable to being verbally and physically abusive to other residents and staff members. Resident #1 confronted other residents when agitated and interventions included increased safety checks.

Resident #1's incident report indicated two unlicensed staff members were approached by a resident who told them resident #1 and resident #2 were fighting in the hallway outside of their rooms. Resident #1 sustained a pea-sized lump underneath his left eye, and a scratch on the left side of his chin. Resident #1's left eye was blood shot. Staff applied an ice pack to resident #1's cheekbone. An outside agency hospice nurse evaluated resident #1. Resident #1's family arrived. The unlicensed staff members documented, "it's not the first situation with them" between resident #1 and resident #2."

Review of resident #1's record indicated less than two-weeks earlier, staff members heard a commotion in the communal area and found resident #1 and resident #2 rolling around on the ground attempting to choke each other. Staff members separated the residents and contacted the on-call nurse. Resident #2 sustained a small scratch on his cheek. Both families of resident #1 and resident #2 were contacted.

During an interview, resident #1's physician stated there were a lot of altercations between resident #1 and resident #2. Resident #1's physician stated, "resident #1 doesn't cross well with others."

During an interview, the nurse stated resident #1 did not like men and would become angry and go after them. The nurse stated resident #1 and resident #2 had a few altercations prior to the

incident and stated the facility did nothing to keep them apart until resident #1 sustained injuries.

During an interview, an unlicensed staff member stated resident #1 and resident #2 should have been separated before the incident. The unlicensed staff member stated it was good to move resident #2 but “it took a while.” The unlicensed staff member stated resident #1 would become aggressive with caregivers and curse.

During an interview, the family member stated resident #1 had a tough time communicating his needs because of his TBI. The family member stated staff told them they had made comments to management to move one of the residents to a different floor, but nothing was done until the incident. The family member stated resident #1’s behaviors improved after resident #2 was moved to another floor.

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.

Vulnerable Adult interviewed: No unable to interview due to cognition and expressive aphasia.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility moved resident #2 to a different floor to decrease physical altercations.

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
	30783	A. BUILDING: _____ B. WING _____	C 10/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTAGE GROVE WHITE PINE II	6950 EAST POINT DOUGLAS ROAD S COTTAGE GROVE, MN 55016

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING 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: #HL307832614C/#HL307831443M #HL3078336693C/HL307831943M On October 25, 2022, 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 34 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL307832614C/#HL307831443M tag identification 320, 620, 730, 1420, 1470, 1500, 1540, 1620, 3000. The following correction orders are issued for #HL3078336693C/#HL307831943M, tag identification 320, 1470, 1500, 1540, 1620.	0 000	Minnesota Department of Health is documenting the State Licensing 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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0 320	Continued From page 1	0 320		
0 320 SS=D	144G.30 Subdivision 1 Regulatory powers (a) The Department of Health is the exclusive state agency charged with the responsibility and duty of surveying and investigating all assisted living facilities required to be licensed under this chapter. The commissioner of health shall enforce all sections of this chapter and the rules adopted under this chapter. (b) The commissioner, upon request to the facility, must be given access to relevant information, records, incident reports, and other documents in the possession of the facility if the commissioner considers them necessary for the discharge of responsibilities. For purposes of surveys and investigations and securing information to determine compliance with licensure laws and rules, the commissioner need not present a release, waiver, or consent to the individual. The identities of residents must be kept private as defined in section 13.02, subdivision 12. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee did not provide requested necessary resident and staff records in a timely manner to determine compliance to licensure laws and rules. 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 an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	0 320		

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0 320	Continued From page 2 Findings include: On October 25, 2022, at 10:00 a.m., the Minnesota Department of Health (MDH) surveyor entered the facility. Unlicensed personnel (ULP)-L stated she was unsure who was in charge. ULP-L escorted the surveyor down to a conference room where two other MDH surveyors were sitting. The MDH surveyors stated they arrived at 9:30 a.m. and were still waiting to do an entrance conference with an administrative person. Registered nurse (RN)-M walked into the conference room and stated regional director (RD)-N was at another licensee facility but would arrive in the next hour. On October 25, 2022, at 10:57 a.m., RD-N arrived at the facility. An entrance conference was initiated between RD-N and the MDH surveyors. Document requests were submitted to RD-N. On October 25, 2022, at 11:30 a.m., RD-N presented a few documents to the other MDH surveyors, stating, "I'm still waiting for the interim licensed assisted living director (LALD) to arrive. She's just pulling into the parking lot." On October 25, 2022, at 12:30 p.m., the two MDH surveyors left the facility without obtaining all of their requested documents. On October 25, 2022, at 12:30 p.m., the remaining MDH surveyor walked down the hall to RD-N's office to inquire about the documents the MDH surveyor requested during the entrance conference at 10:57 a.m. During the exit conference on October 25, 2022,	0 320		

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0 320	Continued From page 3 at 3:20 p.m., the MDH surveyor instructed RD-M and LALD to submit the remaining documents to the MDH surveyor's work email address. On November 14, 2022, at 9:19 a.m., the MDH surveyor emailed RD-N to request an agency licensed practical nurse (LPN)-O's employee file, including her training record. On November 15, 2022, at 9:26 a.m., the MDH surveyor emailed RD-N with a second request for LPN-O's employee file. The MDH surveyor inquired when the requested documents would be sent. On November 15, 2022, at 12:48 p.m., the MDH surveyor called the facility to speak to RD-N. A receptionist stated RD-N was at another licensee building. The receptionist gave the surveyor the phone number to the new LALD for the facility. On November 15, 2022, at 12:50 p.m., the MDH surveyor called LALD-P. LALD-P stated she had only worked at the facility for two weeks. LALD-P stated RD-N forwarded her the MDH surveyor's previous emails. LALD-P stated she would provided the requested documents by the end of the day. On November 15, 2022, at 4:36 p.m., LALD-P emailed the requested documents except for LPN-O's employee file. LALD-P stated she was still putting together LPN-O's employee file. On November 16, 2022, at 10:46 a.m., the MDH surveyor emailed LALD-P requesting LALD-P to send LPN-O's employee file by 2:00 p.m. The surveyor requested LALD-P to send whatever documents the facility had for LPN-O.	0 320		

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0 320	Continued From page 4 On November 16, 2022, at 5:03 p.m., the MDH surveyor emailed LALD-P, sending a third request for LPN-O's file. On Novmeber 17, 2022, at 9:00 a.m., the facility never produced LPN-O's employee file or training record. TIME PERIOD TO CORRECT: Seven (7) days.	0 320		
0 620 SS=D	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma 144G.42 Subd. 6. Compliance with requirements for reporting maltreatment of vulnerable adults; abuse prevention plan. (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to comply with the requirements for reporting suspected maltreatment within 24 hours for one of seven residents (R1) with records reviewed. R1 admitted to the hospital after staff found him with critically low oxygen levels. Staff were unable to administer R1's oxygen due to his oxygen tanks were empty. The facility failed to reported the incident to the Minnesota Adult Abuse Reporting Agency (MAARC). 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	0 620		

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0 620	Continued From page 5 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 R1's medical record was reviewed. R1 admitted to the facility on September 14, 2021. R1's diagnoses included dementia without behavioral disturbances and hemiplegia and hemiparesis following a stroke. R1's signed service agreement dated June 21, 2022, indicated R1 received assistance with personal cares, catheter cares, toileting, meals, medication management, daily behavioral interventions, transfer assistance of two staff, daily escort assistance of one staff using a gait belt and wheeled walker, and safety checks every two hours. R1 transferred using a gait belt, and wheeled walker. R1 used a wheelchair for mobility. R1's record indicated on April 8, 2022 through April 13, 2022, R1 was hospitalized for low oxygenation (hypoxia) and fluid in his lungs (pleural effusion). R1's hospital record indicated on April 13, 2022, at 11:37 a.m., R1 was discharged back to the facility requiring four liters per minute (lpm) continuous oxygen per nasal cannula. R1's nurse progress note dated May 10, 2022, at 7:09 p.m., indicated a home health nurse found R1 pale and discolored when they arrived to change R1's catheter. Staff took R1's vital signs and discovered R1's oxygen saturation was intially 58% room air but dropped to 46% room air	0 620		

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0 620	Continued From page 6 (normal: 90-100% room air). The nurse documented, "as needed (PRN) oxygen was unable to be given because tanks were empty." Emergency medical services (EMS) arrived and administered four lpm oxygen via nasal cannula to R1. R1 was transferred to a local hospital. On May 10, 2022, at 8:01 p.m., R1's hospital record indicated R1 was breathing abnormally when he arrived at the hospital. R1 was unable to be weaned off four lpm oxygen due to his oxygen saturation levels falling below 90% when staff attempted to discontinue his oxygen. R1 was diagnosed with acute respiratory failure with hypoxia (low oxygen). On May 16, 2022, at 3:28 p.m., R1 returned to the facility requiring two lpms oxygen per nasal cannula. R1's record lacked evidence the facility filed a MAARC report regarding this incident. On November 14, 2022, at 4:47 p.m., registered nurse (RN)-E stated the licensed assisted living director (LALD) and the RN in the facility were responsible for completing MAARC reports. RN-E stated MAARC reports should be completed within 24 hours. A vulnerable adult policy was requested but was not provided. TIME PERIOD TO CORRECT: Seven (7) days.	0 620		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident:	0 730		

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0 730	Continued From page 7 (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service	0 730		

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0 730	Continued From page 8 termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure unlicensed personnel (ULP) accurately documented and provided scheduled services for four of seven residents (R1, R5, R6, R7) with records reviewed. ULP inaccurately documented they performed R1 and R7's scheduled services during the time they were hospitalized, and inaccurately documented scheduled services were provided for R5 and R6 after they were deceased. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings Include: R1 R1's medical record was reviewed. R1 admitted to the facility on September 14, 2021. R1's diagnoses included dementia without behavioral disturbances and hemiplegia and hemiparesis following a stroke. R1's hospital record indicated on April 8, 2022 through April 13, 2022, R1 was hospitalized with	0 730		

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0 730	Continued From page 9 hypoxia (low oxygen levels), and fluid in his lungs (plural effusion). R1's hospital record indicated R1 arrived to the hospital in respiratory distress. R1's hospital record dated April 13, 2022, at 9:00 a.m., indicated R1 was discharged back to the facility. R1 required 4 liters per minute (lpm) continuous oxygen per nasal cannula to keep his oxygen saturation level greater than or equal to 90%. R1's hospital record indicated on May 10, 2022, at 8:01 p.m., R1 arrived at the hospital. R1 was diagnosed with acute respiratory failure. On May 16, 2022, at 3:28 p.m., R1 returned to the facility on 2 lpm of oxygen via nasal cannula. R1's service delivery record dated May 2022, indicated between May 10, 2022, at 8:00 p.m., through May 12, 2022, unlicensed personnel (ULP) falsely documented they provided the following services to R1 while he was hospitalized: personal cares, catheter cares, toileting, meals, daily behavioral interventions, transfer assistance of two staff, daily escort assistance of one staff using a gait belt and wheeled walker, and safety checks every two hours. In addition, R1's May 2022 through June 6 service delivery records did not include R1's oxygen as a scheduled service. R1 nurse progress note dated June 6, 2022, at 12:10 p.m., indicated R1's oxygen was discontinued. R5 R5's medical record was reviewed. R5 admitted to the facility at an unknown date. R5's diagnoses included cognitive impairment.	0 730		

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0 730	Continued From page 10 R5's service plan (unknown date), indicated he had a mechanical soft, honey thickened diet. R5's assessment dated June 20, 2022, indicated R5 was oriented to person only. R5 received two-hour safety checks and continuous redirection from facility staff. R5 received full assistance with personal cares, medication management, housekeeping, toileting, transfers, and eating. R5 had a history of wandering and pacing. R5 used a Hoyer lift with the assist of two staff persons and a wheelchair for mobility. R5's death certificate indicated R5 died on June 25, 2022, at 8:50 a.m. R5's service delivery record dated June 25, 2022 through June 27, 2022, indicated ULP falsely documented they provided the following services to R5 after he died: Two-hour safety checks, housekeeping, behavioral interventions, glasses, group socialization, laundry, meals, mobility assistance, oral care, toileting, transfers, bathing, fingernail/toenail cares, dressing and grooming. R6 R6's medical record was reviewed. R6 admitted to the facility on May 6, 2022. R6's diagnoses included Alzheimer's disease. R6's signed service agreement dated May 6, 2022, indicated R6 received assistance with personal cares, group socialization, behavioral interventions, meals, two-hour safety checks, escorts, transfer assistance, staff interventions, toileting, laundry, and housekeeping. R6's nurse progress note dated June 10, 2022, at 9:06 a.m., indicated R6 died peacefully. RN-B indicated R6 was given a bed bath and	0 730		

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0 730	Continued From page 11 repositioned prior to passing. R6's service delivery record dated June 2022, indicated ULP falsely documented they provided services to R6 after he died on the following dates and times: *June 10, 2022: Overnight (NOC) shift: Toileting and transfer assistance. *June 11, 2022: (All day): Group socialization, meals, oral care, toileting and transfer assistance, two-hour safety checks. June 14, 2022: (All day): Group socialization, meals, oral care toileting and transfer assistance, two-hour safety checks. *June 18, 2022: (All day): Group socialization, meals, oral care, toileting and transfer assistance, two-hour safety checks. *June 23, 2022: (all day): Group socialization, oral care, meals, toileting and transfer assistance, two-hour safety checks. R7 R7's medical record was reviewed. R7 admitted to the facility on February 17, 2022. R7's diagnoses included dementia. R7's service plan dated October 26, 2022, indicated received daily assistance with personal cares, meals, blood sugar checks, medication management, escorts, transfers, toileting, and 2 lpm continuous oxygen via nasal cannula. R7 received weekly diabetic foot care nail trims performed by a nurse, and safety checks every two hours. Staff were to visualize R7 every two hours to ensure his safety. R7 used a four-wheeled walker for mobility. R7's nurse progress note dated August 5, 2022, at 1:45 p.m., indicated R7 was admitted to the	0 730		

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0 730	Continued From page 12 hospital intensive care unit (ICU) due to a hemoglobin level of 5.0 (normal-13.0-15.0). R7's international normalized ratio (INR) was 7 (normal-1.0 for person not on anticoagulation therapy). R7 was diagnosed with a stomach bleed. R7's nurse progress note dated August 12, 2022, at 12:29 p.m., indicated R7 was discharged from the hopsital back to the facility. The RN documented R7, "appears at baseline." R7's service delivery record dated August 2022, indicated between August 5, 2022 through August 12, 2022, ULP falsely documented they provided the following services to R7 while he was hospitalized: bathing and toileting assistance, dressing and grooming, escorts, meals, medication administration, oral care, transfer assistance, blood glucose monitoring, and two-hour safety checks. On November 14, 2022, at 4:47 p.m., RN-B stated ULP were able to see the services residents required on their service check-off sheet. RN-B stated ULP signed the service check-off sheet at the end of their shift, indicating services were provided to the residents. The licensee policy titled Bill of Rights, dated August 1, 2021, indicated staff would be trained on the concepts/rights contained in the Assisted Living Bill of Rights. TIME PERIOD TO CORRECT: Seven (7) days.	0 730		
01420 SS=G	144G.62 Subd. 2 Delegation of assisted living services	01420		

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01420	Continued From page 13 (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If an unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. This MN Requirement is not met as evidenced by: Based on record review and interviews, the licensee failed to ensure unlicensed personnel (ULP) were competently trained on how to refill oxygen tanks for four of five ULP (ULP-P, ULP-Q, ULP-R, ULP-S) employee files reviewed. R1's oxygen tanks were not filled, and unable to go be used when R1 was found with critically low 02 levels of 46% (normal 90-100%). 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). The findings include:	01420		

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01420	Continued From page 14 R1's medical record was reviewed. R1 admitted to the facility on September 14, 2021. R1's diagnoses included dementia without behavioral disturbances and hemiplegia and hemiparesis following a stroke. R1's record indicated on April 8, 2022 through April 13, 2022, R1 was hospitalized for low oxygenation (hypoxia) and fluid in his lungs (plural effusion). R1's hospital record dated April 13, 2022, at 9:00 a.m., indicated R1 was discharged back to the facility. R1 required 4 liters per minute (LPM) continuous oxygen via nasal cannula to keep his oxygen saturation level above 90%. R1's record indicated on April 13, 2022, at 3:15 p.m., a medical supply company delivered an oxygen compressor, oxygen concentrator, and oxygen tanks to the facility for R1 to use after his discharge from the hospital. R1's nurse progress note dated May 10, 2022, at 7:09 p.m., indicated a home health nurse found R1 pale and discolored when they arrived to change R1's catheter. Staff took R1's vital signs and R1's oxygen was 43% on room air (normal: 90-100% room air). The nurse wrote, "as needed (PRN) oxygen was unable to be given because tanks were empty." Emergency medical services (EMS) arrived and administered R1 4 LPM continuous oxygen via nasal cannula. R1 transferred to a local hospital. R1's hospital record indicated on May 10, 2022, at 8:01 p.m., R1 was diagnosed with acute respiratory failure. On May 16, 2022, at 3:28 p.m., R1 returned to the facility on 2 LPM continous oxygen via nasal cannula.	01420		

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01420	Continued From page 15 R1's physician orders dated May 24, 2022, included "supplemental oxygen, 1-2 LPM, to keep oxygen saturations above 90%." R1's nurse progress note dated May 24, 2022, at 9:47 a.m., indicated registered nurse (RN)-B spoke to R1's family about staff not filling R1's oxygen tanks. A clarification order for R1's oxygen was sent to R1's physician. Review of the medical supply company document note dated May 24, 2022, at 10:48 a.m., indicated RN-B contacted the company to have a representative come to the facility to train staff on how to refill R1's oxygen tanks. Review of the medical supply document note dated May 25, 2022, at 12:01 p.m., indicated the medical supply representative arrived at the facility but found no oxygen in R1's room. The note indicated the medical supply representative spoke with a facility nurse who indicated R1's oxygen was "picked up a couple of weeks ago." Review of the medical supply document note dated May 25, 2022, at 1:04 p.m., indicated RN-B called the medical supply company stating a representative never arrived to refill R1's oxygen tanks and instruct staff members on use. RN-B verified R1's oxygen homefill equipment delivery ticket matched R1's oxygen April delivery ticket. R1's nurse progress note dated May 26, 2022, at 12:35 p.m., indicated R1 was to continue supplemental oxygen per physician orders. ULP-P ULP-P's hire date was August 15, 2018. On August 21, 2018, ULP-P's record lacked evidence	01420		

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01420	Continued From page 16 he demonstrated competency on oxygen condenser use, portable oxygen tanks, oxygen refill, and oxygen humidity. ULP-Q ULP-Q's hire date was August 10, 2021. ULP-Q's record lacked evidence he demonstrated competency on oxygen condenser use, portable oxygen tanks, oxygen refill, and oxygen humidity. ULP-R ULP-R's hire date was November 5, 2021. ULP-R's record lacked eveidence she received any training on oxygen. ULP-S ULP-S's hire date was October 12, 2018. On October 16, 2022, ULP-S's record lacked evidence he demonstrated competency on oxygen condenser use, portable oxygen tanks, oxygen refill, and oxygen humidity. On November 14, 2022, at 4:47 p.m., RN-E stated ULP were responsible for monitoring resident's oxygen tanks to ensure they were full. On November 16, 2022, at 2:06 p.m., RN-B stated ULP should have been trained on how to refill R1's 02 tanks and stated ULP were responsible for ensuring the oxygen tanks were full and alerting the nurses. RN-B stated some ULP had no idea how to refill the tanks. RN-B stated she contacted the medical company to have them come to the facility to do a demonstration for staff on how to refill the tanks. On November 23, 2022, at 9:48 a.m., family member (FM)-H stated the hospital always discharged R1 back to the facility on oxygen because of his oxygen levels fell below 90% on	01420		

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01420	Continued From page 17 room air. The licensee policy titled Bill of Rights, dated August 1, 2021, indicated staff would be trained on the concepts/rights contained in the Assisted Living Bill of Rights. TIME PERIOD TO CORRECT: Seven (7) days.	01420		
01470 SS=E	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care	01470		

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01470	Continued From page 18 Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure two of eight direct care staff, registered nurse (RN)-M and unlicensed personnel (ULP)-R, with records reviewed, received orientation to include all required content as specified in Minnesota Statute 144G.63, Subd. 1, 2. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01470		

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01470	Continued From page 19 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 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). The findings include: RN-M RN-M was hired on September 19, 2022, to provide direct care services to the licensee's residents. RN-M's employee record lacked evidence of up-to-date orientation training to include the following: *Introduction and review of facility's policies and procedures related to the provision of assisted living services by the individual staff person; *Compliance with reporting of maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); *Handling of residents' complaints, reporting complaints, where to report complaints, including information on the office of Health Facility Complaints (OHFC). *Consumer advocacy services of the Office of Ombudsman for Long-Term Care (OOLTC) ULP-R ULP-R was hired November 5, 2021, to provide direct care services to the licensee's residents.	01470		

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01470	Continued From page 20 ULP-R's employee record lacked evidence of up-to-date orientation training to include the following: *Introduction and review of facility's policies and procedures related to the provision of assisted living services by the individual staff person; *Principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; *Handling of residents' complaints, reporting complaints, where to report complaints, including information on the office of Health Facility Complaints (OHFC). *Compliance with reporting of maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); *Consumer advocacy services of the Office of Ombudsman for Long-Term Care (OOLTC), office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services (DHS), county-managed care advocates, or other relevant advocacy services. On November 10, 2021, at 12:30 p.m., ULP-J stated newly hired ULP received one day of on the floor training before they were signed off to work alone. The licensee policy titled Orientation of Staff and Supervisors & Content, dated August 1, 2021, indicated all staff of the licensee's facility must complete an orientation to assisted living facility	01470		

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01470	Continued From page 21 licensing requirements and regulations before providing assisted living services to residents. TIME PERIOD TO CORRECT: Twenty-One (21) days.	01470		
01500 SS=E	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and	01500		

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01500	Continued From page 22 procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure direct care staff received at least eight hours of annul training for each 12 months of employment for three of eight employees, unlicensed personnel (ULP)-J, ULP-S, ULP-T, with records 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	01500		

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01500	Continued From page 23 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). The findings include: ULP-J ULP-J's hire date was March 22, 2012. ULP-J's employee record lacked evidence of up-to-date annual training to include: *Reporting of maltreatment of vulnerable adults under section 626.557 *Review of the assisted living (AL) bill of rights (BOR) *Review of infection control techniques *Effective approaches to use to problem solve when working with a resident's challenging behaviors *Review of the facility's policies and procedures *Principles of person-centered planning and service delivery ULP-T ULP-T's hire date was August 15, 2018. ULP-T's employee record lacked evidence of up-to-date annual training to include: *Reporting of maltreatment of vulnerable adults under section 626.557 *Review of the assisted living (AL) bill of rights (BOR) *Review of infection control techniques *Effective approaches to use to problem solve when working with a resident's challenging behaviors *Review of the facility's policies and procedures *Principles of person-centered planning and	01500		

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	30783	A. BUILDING: _____ B. WING _____	C 10/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTAGE GROVE WHITE PINE II	6950 EAST POINT DOUGLAS ROAD S COTTAGE GROVE, MN 55016

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01500	Continued From page 24 service delivery ULP-S ULP-S's hire date was October 12, 2018. ULP-S's employee record lacked evidence of up-to-date annual training to include: *Reporting of maltreatment of vulnerable adults under section 626.557 *Review of the assisted living (AL) bill of rights (BOR) *Review of infection control techniques *Effective approaches to use to problem solve when working with a resident's challenging behaviors *Review of the facility's policies and procedures *Principles of person-centered planning and service delivery On November 10, 2022, at 12:30 p.m., ULP-J stated newly hired ULP were trained by ULP who already worked at the facility. ULP-J stated training consisted of one day on the floor. ULP-J stated the facility had quite a few temporary staff who were not trained and "thrown" on the medication cart. On November 15, 2022, at 9:26 a.m., the MDH surveyor emailed regional director (RD)-N to request a phone interview to discuss compliance issues including employee training. RD-N never responded to the MDH request for an interview. A licensee policy was requested but not provided. TIME PERIOD TO CORRECT: Twenty-one (21) days.	01500		

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01540	Continued From page 25	01540		
01540 SS=E	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 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, interview and record review, the licensee failed to ensure three of eight direct care staff unlicensed personnel (ULP)-J, ULP-Q, ULP-S, ULP-T) with records reviewed, completed at least two hours of training on topics related to dementia care for each 12 months of employment thereafter as required. In addition, the licensee failed to ensure ULP-R with records reviewed, completed the required initial eight hours of dementia care training within 80 hours of employment start date. 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	01540		

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01540	Continued From page 26 cause serious injury, impairment, or death) 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). The findings include: TWO HOURS ANNUAL DEMENTIA TRAINING ULP-J ULP-J's hire date was March 22, 2012. ULP-J's employee record lacked evidence ULP-J completed two hours of annual dementia training, specified under Minnesota (MN) Statute 144G.64, Subd. 3. ULP-T ULP-P's hire date was August 15, 2018. ULP-T's employee record lacked evidence ULP-T completed two hours of annual dementia training, specified under MN Statute 144G.64, Subd. 3. ULP-S ULP-S's hire date was October 12, 2018. ULP-S's employee record lacked evidence ULP-S completed two hours of annual dementia training, specified under MN Statute 144G.64, Subd. 3. EIGHT HOURS INITIAL DEMENTIA TRAINING ULP-R ULP-R's hire date was November 5, 2021. ULP-R's employee record lacked evidence ULP-R completed the required initial eight hours of dementia care, specified under Minnesota Statute 144G.64, Subd. 3. The facility's staff schedule dated May 2022 and	01540		

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01540	Continued From page 27 July 2022, indicated ULP-R worked 12-hour shifts on the following dates: May 2022: 4, 5, 9, 10, 12, 14, 15, 18, 19, 24, 28, 29. Total hours worked for May 2022-144 hours. July 2022: 4, 5, 14, 15, 18, 23, 28, 29. Total hours worked for July 2022-96 hours. On November 16, 2022, at 2:06 p.m., registered nurse (RN)-B, stated she was in charge of trainng direct care staff. The licensee policy titled Dementia Training, dated August 1, 2021, indicated all staff were required to complete dementia training at the time of hire and annually. Direct care employees would complete eight hours of initial training within 160 hours of employment start date. All staff would complete two hours of additional training for each 12 months of employment. TIME PERIOD TO CORRECT: Seven (7) days.	01540		
01620 SS=G	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	01620		

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01620	Continued From page 28 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 ensure a registered nurse (RN) performed reassessments for three of seven residents (R2, R3, R7) with records reviewed. R2 and R3 were involved in physical altercations and were not assessed after the altercation. R7 upon return from the hospital visits and a change in vitals. 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). The findings include: R7 R7's medical record was reviewed. R7 admitted to the facility on February 17, 2022. R7's diagnoses included dementia. R7's service plan dated October 26, 2022,	01620		

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01620	Continued From page 29 indicated received daily assistance with personal cares, meals, blood sugar checks, medication management, escorts, transfers, toileting, and 2 liters per minute (LPM) continuous oxygen via nasal cannula. R7 received weekly diabetic foot care nail trims performed by a nurse, and safety checks every two hours. Staff were to visualize R7 every two hours to ensure his safety. R7 used a four-wheeled walker for mobility. R7's nurse progress note dated August 5, 2022, at 1:45 p.m., indicated R7 was admitted to the hospital intensive care unit (ICU) due to a hemoglobin (Hgb) 5.0 (Normal-13.0-15.0). R7's international normalized ratio (INR) was 7 (normal-1.0 for person not on anticoagulation therapy). R7 was diagnosed with a stomach bleed. R7's nurse progress note dated August 11, 2022, at 5:23 p.m., indicated R7 would be discharged back to the facility August 12, 2022. R7's progress note indicated R7 was prescribed 4 LPM continuous oxygen via nasal cannula. R7's nurse progress note dated August 12, 2022, at 12:29 p.m., indicated R7 was discharged from the hopsital back to the facility. The RN documented R7, "appears at baseline." R7's record lacked evidence an RN assessed him after his discharge from the hospital. R7's nurse progress note dated August 17, 2022, at 11:53 a.m., indicated R7 was transported to the emergency department (ER). R7's oxygen saturation was 83% on 3 LPM of oxygen. R7's pulse was 160. R7 extremities were pale. R7 was instructed to take deep breaths.	01620		

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01620	Continued From page 30 R7's nurse progress note dated August 17, 2022, at 2:02 p.m., indicated R7 was discharged from the ER back to the facility. R7's hemoglobin (hgB) was 8.8. The nurse documented, "no changes." R7's record lacked evidence an RN assessed him after his discharge from the ER. R7's nurse progress note dated August 19, 2022, at 5:44 p.m., indicated staff called a licensed practical nurse (LPN) after they found him with an oxygen reading of 84% while on 3 LPM of oxygen. R7 denied any difficulty breathing. The LPN instructed staff to have R7 take deep breaths. R7's blood pressure was 93/58, but dropped to 92/52 (normal blood pressure is 120/80). The LPN advised staff to recheck R7 in one hour after encouraging fluids and deep breathing. R7's record lacked evidence an RN assessed R7 after R7 experienced a decrease in oxygen saturation and blood pressure. R2 R2's medical record was reviewed. R2 admitted to the facility on November 11, 2019. R2's diagnoses included dementia with behavioral disturbances and agitation. R2's signed service agreement dated January 23, 2020, indicated R2 received assistance with personal cares, meals, medication management, daily group socialization, daily as needed (PRN) escorts, and PRN toileting assistance. R2's 90-day assessment dated August 3, 2022, indicated R2 was oriented to person only. R2 was to receive safety checks every two hours and continuous redirection from facility staff PRN due	01620		

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01620	Continued From page 31 to R2's behaviors and high risk for elopement. R2's service plan dated October 26, 2022, indicated R2 received daily assistance with personal cares, behaviors, meals, medication management, escorts, and safety checks every two hours including overnights. R1 was incontinent of bowel and bladder and required total assistance with transfers to and from the bathroom. R2 walked independently. R2's nurse progress note dated July 4, 2022, at 11:49 a.m., indicated staff found R2 and R3 laying on the hallway floor choking each other. R3 received a scratch on his cheek. R2's nurse progress note dated July 7, 2022, at 1:52 p.m., indicated R2 had a new bruise on his left upper arm. Nursing staff documented, "guessing it was from the altercation that took place over the weekend with another resident." R2's record lacked documentation a RN assessed R2 for further injuries or to address behaviors. R2's incident report dated July 16, 2022, at an unknown time, indcated two unlicensed personnel (ULP) were in another resident's room assisting them with cares when a resident walked up to them and told them R2 and R3 were fighting. R2 sustained a pea-sized lump underneath his left eye, and a scratch on the left side of his chin. R2's left eye was blood shot. The two ULP applied an ice pack to R2's cheekbone. An outside agency hospice nurse evaluated R2. R2's family arrived. The ULP documented, it's not the first situation with them, R3 and R2. R2's nurse progress note dated July 18, 2022, at	01620		

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01620	Continued From page 32 9:14 a.m., indicated R2 was punched and hit in the eye and jaw by R3. R2 had blood and a bruise above and below his eye. R2 reported pain in his jaw but was unable to state a pain level. R2's record lacked documention a facility RN assessed R2 after the incident with R3. R3 R3's medical record was reviewed. R3 admitted to the facility on November 11, 2019. R3's diagnosis included Alzheimer's disease. R3's service plan dated October 26, 2022, indicated R3 received daily assistance with personal cares, behaviors, meals, medication management, escorts, as needed transfer assistance of one staff person, and two-hour toileting assistance and safety checks. Staff were to visualize R3 every two hours to ensure his safety. R3 walked independently. R3's record failed to include documentation a RN assessed R3 after an altercation with R2 on July 4, 2022. R3's nurse progress note dated July 16, 2022, at 12:44 p.m., indicated R3 was involved in a physical altercation with R2. The RN documented R3, "does not appear to have any injuries noted." R3 was administered an antipsychotic. R3's 90-day assessment dated August 17, 2022, indicated R3 was able to make his needs known. R3 had a history of physical aggression, hostility, angry outbursts, and wandering. R3 was an elopement risk. On November 14, 2022, at 4:47 p.m., RN-E stated she oversaw the licensee's 11 buildings. RN-E stated the RN's conducted 14-day, 90-day,	01620		

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01620	Continued From page 33 and change in condition assessments. The licensee policy titled Assessments, Reviews, and Monitoring, dated August 11, 2022, indicated ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and could not exceed 90 calendar days from the last date of the assessment. TIME PERIOD TO CORRECT: Seven (7) days.	01620		
03000 SS=D	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter	03000		

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03000	Continued From page 34 knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to comply with the requirements for reporting suspected maltreatment within 24 hours for one of seven residents (R1) with records reviewed. R1 admitted to the hospital after staff found him with critically low oxygen levels. Staff were unable to administer R1's oxygen due to his oxygen tanks were empty. The facility failed to reported the incident to the Minnesota Adult Abuse Reporting Agency (MAARC). 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	03000		

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03000	Continued From page 35 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 R1's medical record was reviewed. R1 admitted to the facility on September 14, 2021. R1's diagnoses included dementia without behavioral disturbances and hemiplegia and hemiparesis following a stroke. R1's signed service agreement dated June 21, 2022, indicated R1 received assistance with personal cares, catheter cares, toileting, meals, medication management, daily behavioral interventions, transfer assistance of two staff, daily escort assistance of one staff using a gait belt and wheeled walker, and safety checks every two hours. R1 transferred using a gait belt, and wheeled walker. R1 used a wheelchair for mobility. R1's record indicated on April 8, 2022 through April 13, 2022, R1 was hospitalized for low oxygenation (hypoxia) and fluid in his lungs (pleural effusion). R1's hospital record indicated on April 13, 2022, at 11:37 a.m., R1 was discharged back to the facility requiring four liters per minute (lpm) continuous oxygen per nasal cannula. R1's nurse progress note dated May 10, 2022, at 7:09 p.m., indicated a home health nurse found R1 pale and discolored when they arrived to change R1's catheter. Staff took R1's vital signs and discovered R1's oxygen saturation was intially 58% room air but dropped to 46% room air	03000		

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COTTAGE GROVE WHITE PINE II	6950 EAST POINT DOUGLAS ROAD S COTTAGE GROVE, MN 55016

(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
03000	Continued From page 36 (normal: 90-100% room air). The nurse documented, "as needed (PRN) oxygen was unable to be given because tanks were empty." Emergency medical services (EMS) arrived and administered four lpm oxygen via nasal cannula to R1. R1 was transferred to a local hospital. On May 10, 2022, at 8:01 p.m., R1's hospital record indicated R1 was breathing abnormally when he arrived at the hospital. R1 was unable to be weaned off four lpm oxygen due to his oxygen saturation levels falling below 90% when staff attempted to discontinue his oxygen. R1 was diagnosed with acute respiratory failure with hypoxia (low oxygen). On May 16, 2022, at 3:28 p.m., R1 returned to the facility requiring two lpms oxygen per nasal cannula. R1's record lacked evidence the facility filed a MAARC report regarding this incident. On November 14, 2022, at 4:47 p.m., registered nurse (RN)-E stated the licensed assisted living director (LALD) and the RN in the facility were responsible for completing MAARC reports. RN-E stated MAARC reports should be completed within 24 hours. A vulnerable adult policy was requested but was not provided. TIME PERIOD TO CORRECT: Seven (7) days.	03000		