

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL273899725M
Compliance #: HL273897682C

Date Concluded: January 19, 2024

Name, Address, and County of Licensee

Investigated:

Beacon Home of Rosemount
12591 Shannon Parkway
Rosemount, MN 55068
Dakota County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Peggy Boeck, RN
Special Investigator

Finding: Substantiated, facility responsibility

Nature of Visit:

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

Initial Investigation Allegation(s):

The facility neglected a resident when they failed to follow-up and implement recommendations to heal the residents pressure ulcers. The facility failed to complete consistent skin checks, did not complete cares as assessed, and failed to address the residents' individual needs. The resident acquired a pressure ulcer.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to have a system in place to ensure recommendations to promote healing and prevent further pressure ulcers were followed up on and implemented. The resident developed a pressure ulcer.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of medical records, facility incidents, consultant reports/recommendations, policies, and procedures related to resident bill

of rights, plan of care, maltreatment of vulnerable adults. Also, the investigator observed staff/resident interactions.

The resident lived in an assisted living facility. The resident's diagnoses included multiple sclerosis. The resident's service plan included assistance with bathing, toileting, repositioning, and transfers. The resident's assessment indicated the resident was confined to his bed and/or wheelchair and was dependent on staff for all transfers.

The resident was admitted to the facility with a pressure ulcer. The facility obtained outside skilled nursing to provide the residents wound care. The facility nurse also requested orders for a pressure relieving mattress, a catheter, and a urology appointment.

An internal investigation document indicated the nurse reached out multiple times for the mattress, catheter, and urology appointment until the resident's pressure ulcer healed. The nurse left employment at the facility and there was no system in place for follow up on the recommended mattress, catheter, or urology appointment. The investigation indicated about two and a half months later, a second nurse observed a pressure ulcer on the resident's bottom.

During an interview the second nurse stated she was not aware the resident did not want to reposition or transfer out of his bed. The nurse stated there were no interventions written into the service plan for staff to address non-compliance, so staff documented the resident refused assistance or write nothing at all. The nurse stated she covered six additional facility's and did not review service completion or monitor wounds as part of her job duties.

During investigative interviews, multiple staff members stated the resident was very pleasant about his refusals and would tell staff he did not want to trouble staff with having to change his wet linens or use a lift to transfer him out of bed.

During an interview, the resident stated the pressure ulcer was in the same spot as the original pressure ulcer and reopened. The resident stated a facility nurse tried to place a catheter, but it was too uncomfortable, so they took it out. The resident stated the facility wanted him to go to a urologist to place the catheter, but he would have to rent a handicapped transportation vehicle. The resident stated the facility did not follow through and get him a different mattress. The resident stated he made sure to get out of bed at least every other day. The resident stated there was a lot of staff turnover, and they did not know how to work with him until they got to know him. The resident stated some staff were good, but he was moving to another facility.

In conclusion, neglect is 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.

Vulnerable Adult interviewed: Yes

Family/Responsible Party interviewed: No, per resident.

Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:

The facility started weekly skin checks for all residents.

The facility started having the nurse assess/document any skin concerns for all residents.

The facility put behavior interventions in the service plan for resident refusal of cares.

The facility began using a wound rounding form and checklist.

The facility began documenting/reviewing all pending referrals, appointments, and equipment needs for all seven facilities in morning stand-up meeting with administration.

Action taken by the Minnesota Department of Health:

The responsible party will be notified of their right to appeal the maltreatment finding.

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

Dakota County Attorney

Rosemount City Attorney

Rosemount Police Department

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 27389	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 01/09/2024
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NAME OF PROVIDER OR SUPPLIER BEACON HOME OF ROSEMOUNT	STREET ADDRESS, CITY, STATE, ZIP CODE 12591 SHANNON PARKWAY ROSEMOUNT, MN 55068
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{0 000}	<p>Initial Comments</p> <p>On January 9, 2023, the Minnesota Department of Health conducted a licensing order follow-up related to correction orders issued for complaint #HL273895311C/ #HL273898147M and #HL273892279C/ #HL273896564M.</p> <p>The following correction orders are re-issued for #HL273895311C/ #HL273898147M and #HL273892279C/ #HL273896564M, tag identification 0250, 0470, 1290, and 2310.</p> <p>Complaint investigation: #HL273897682C/#HL273899725M</p> <p>On January 9, 2023, the Minnesota Department of Health also conducted a complaint investigation #HL273897682C/#HL273899725M, at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were 6 residents receiving services under the provider's Assisted Living license.</p> <p>The following correction order is issued for #HL273897682C/#HL273899725M, tag identification 2310 and 2360.</p>	{0 000}		
{0 250} SS=I	<p>144G.20 Subdivision 1 Conditions</p> <p>(a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules;</p>	{0 250}		

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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{0 250}	Continued From page 1 (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or	{0 250}		

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{0 250}	<p>Continued From page 2</p> <p>(15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to meet the requirements of licensure when the licensee violated requirements, failed to develop policies, and failed to implement polices for six of six residents (R1, R2, R3, R4, R5, R6) reviewed. The licensee failed to provide staff adequate in numbers, training, and qualifications for the assessed needs of the residents' scheduled and reasonably foreseeable unscheduled needs as required by the residents' assessments and service plans on a 24-hour per day basis ensuring prompt, effective response to emergencies. The licensee failed to ensure clearance of a background study of an employee who worked at more than one location. The licensee failed to provide appropriate care and services to residents per their service plans. The licensee failed to follow the consulting company's recommendations for compliance to correct investigation deficiencies.</p> <p>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at 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).</p> <p>Findings include</p>	{0 250}	<p>Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction.</p> <p>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND</p>	

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{0 250}	Continued From page 3 See tag 0470- Minimum Requirement 144G.41 Subdivision 1. See tag 1290- Background Studies Required- 144G.60 Subdivision 1. See tag 2310- Appropriate Care and Services-144G.91 Subdivision 4 (a)	{0 250}	REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
{0 470} SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and	{0 470}		

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{0 470}	<p>Continued From page 4</p> <p>(v) capable of following directions;</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the licensee failed to ensure staff in appropriate numbers and qualifications were available to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis ensuring prompt, effective response to emergencies for six of six residents (R1, R2, R3, R4, R5, R6) reviewed.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).</p> <p>Findings include:</p> <p>R1 admitted March 22, 2022, due to diagnoses that included traumatic brain injury, dementia, and epilepsy.</p> <p>R1's Service Agreement dated November 21, 2023, indicated R1 received services including bathing twice weekly, frequent redirection, orientation for severe confusion, medications, bed mobility, transfers, behavior management, and toileting every two hours.</p> <p>R1's Medication Administration Record dated January 2024 indicated R1 received medications</p>	{0 470}	<p>Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction.</p> <p>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.</p>	

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{0 470}	<p>Continued From page 5</p> <p>at 8:00 a.m., 11:00 a.m., 12:00 p.m., 2:00 p.m., 5:00 p.m., 8:00 p.m. (which included two topical medications for a facial rash), and as needed (PRN).</p> <p>R2 admitted March 1, 2014, due to a stroke with right side weakness, cognitive impairment, and impaired vision (left eye sewn shut).</p> <p>R2's Service Checkoff List dated January 3, 2024, indicated R2 received services including the following: Safety checks every two hours, behavior management, right foot and right arm brace assistance (on in morning and off at bedtime), medication administration four times daily, toileting, and transfers with a total body lift (ceiling lift).</p> <p>R3 admitted November 22, 2022, due to diagnoses that included weakness, history of falls, and acute respiratory failure.</p> <p>R3's Service Checkoff List dated January 3, 2024, indicated R3 received services including medication administration at 8:00 a.m., 8:00 p.m. and PRN.</p> <p>R4 admitted on June 29, 2020, due to diagnoses that included Spinocerebellar degeneration (a neurological disease that created difficulty with walking, eating, dressing, bathing, etc), dysphagia, and impaired coordination.</p> <p>R4's Service Agreement dated February 15, 2023, indicated R4 required a sit-to-stand or total body lift (ceiling lift) for transfers. The service Agreement indicated R4 required assist of two staff for evacuation.</p> <p>R4's Vulnerability Assessment/Abuse Prevention</p>	{0 470}		

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{0 470}	<p>Continued From page 6</p> <p>plan dated December 20, 2023, indicated R4 was non-ambulatory, wheelchair dependent, and required a ceiling lift for transfers.</p> <p>R4's Service Checkoff List dated January 3, 2024, indicated R4 received services including the following: toileting every two hours, repositioning, behavior management, assistance with left and right leg braces (on in morning and off at bedtime), dressing and undressing, peri care (morning and bedtime), medication administration at 8:00 a.m., 12:00 p.m., 2:00 p.m., 4:00 p.m., and 8:00 p.m., transfer with total body lift, and toileting every two hours.</p> <p>R4's Service Agreement dated January 10, 2024, indicated R4 required assist of one staff for evacuation.</p> <p>R5 admitted on June 18, 2019, due to diagnoses that included dementia, bilateral hearing loss, stroke, and cortical blindness.</p> <p>R5's Service Checkoff dated January 3, 2024, indicated R5 received services that included turn and reposition every two hours, behavior management, assistance with left leg brace (on in morning and off at bedtime), medication administration at 8:00 a.m., 2:00 p.m., 8:00 p.m., and PRN.</p> <p>R6 admitted on May 9, 2023, due to diagnoses that included multiple sclerosis, pressure ulcer of sacral region, and sleep disorder.</p> <p>R6's Vulnerability Assessment/Abuse Prevention Plan dated December 18, 2023, indicated R6 could lift only his left arm and was bed/wheelchair bound.</p>	{0 470}		
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{0 470}	<p>Continued From page 7</p> <p>R6's service plan dated January 9, 2024, indicated R6 received services including meal monitoring in room, dressing and undressing, wound care, medication administration at 9:30 a.m., 10:00 a.m., 8:00 p.m., and PRN, turning/repositioning every two hours, and transfers with a ceiling lift.</p> <p>During an observation on January 9, 2024, at 10:22 a.m. the Minnesota Department of Health investigator observed unlicensed personnel (ULP)-B and ULP-C use a ceiling lift for R6. ULP-B and ULP-C placed a sling under R6. ULP-B worked the lift controls (located on the device attached to the ceiling and the resident). ULP-B moved R6 up off the bed and the device battery alarmed and stopped working. ULP-B stated, "That means the battery is dead, so we have to get a new one". The emergency lowering system on the device allowed ULP-B to lower R6 back down to the bed. The investigator observed ULP-C removed the ceiling lift, went to a storage area, unplugged a new device, and brought it into the room. ULP-B raised R6 over and next to right side of the bed. ULP-B changed R6's linens while ULP-C stood next to R6 who was hanging in the air. The new device's alarm sounded, and ULP-B stated "The battery on this one is about to die. They [the devices] do not hold a charge." ULP-B quickly finished with changing the linens and used the device to move R6 back over, and using the emergency lowering system, back onto the bed.</p> <p>During an interview on January 9, 2024, at 10:25 a.m., unlicensed personnel (ULP)-B stated the ceiling lift no longer had a remote control, so staff had to use the controls on the device, which raised up as the resident was raised up, and being a shorter person, she needed a second person to assist her with R6's transfers. ULP-B</p>	{0 470}		
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{0 470}	<p>Continued From page 8</p> <p>stated the facility did not have a mechanical lift in the building and was not sure how they would transfer R6 with both device batteries dead. ULP-B stated R6 needed two staff for transfers. ULP-B stated although administrative staff were on the schedule, they "don't actually work the floor." ULP-B relayed a recent incident where an administrative staff came into R6's room while ULP-B and another staff were completing cares using the ceiling lift and asked if one of them would go answer a call light. ULP-B stated the administrative staff did not assist with R6's cares or answer the call light.</p> <p>During an interview on January 9, 2024, at 1:45 p.m., registered nurse (RN)-A stated she had no system in place to audit/review completion of services, such as how many times staff turn/reposition a resident.</p> <p>During an interview on January 9, 2024, at 3:31 p.m., assisted living director (ALD)-D stated the staff were to charge the ceiling lift devices, and any staff reports that the devices don't hold a charge was not truthful. ALD-D stated the staffing level was adequate with two staff from 7:00 a.m. to 8:00 p.m. and one staff from 8:00 p.m. to 7:00 a.m. ALD-D stated "not much happens after 8:00 p.m".</p> <p>The Conditional Licensure Report from Zellner Consulting dated November 10, 2023, indicated the consultant recommended the licensee use a staffing tool reflective of acuity level of residents, and a revised policy for scheduling and staffing. The report indicated a review of previous three weeks of facility staff schedule found gaps in the schedule with 17 days with only one staff scheduled from 8:00 p.m. to 11:00 p.m.</p>	{0 470}		

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{0 470}	<p>Continued From page 9</p> <p>The Conditional Licensure Report from Zellner Consulting dated December 1, 2023, indicated the consultant recommended development of a tool to assist with acuity levels and provided a resource.</p> <p>The Conditional Licensure Report from Zellner Consulting dated December 15, 2023, indicated the consultant reviewed scheduling and staffing and discovered gaps in staffing on 11 days. The nurse consultant observed the leadership team was not monitoring staffing daily and the nurse consultant expressed concerns to leadership of their baseline knowledge of Minnesota regulations and statutes.</p> <p>The Conditional Licensure Report from Zellner Consulting dated December 22, 2023, indicated the consultant reviewed scheduling and staffing. The report noted the current staffing system in place did not appear to manage needed daily coverage. The report indicated eight days where the schedule did not match the reports of punch in/out (so it could not be determined how many staff were actually on site) and/or only one staff was scheduled.</p> <p>The Conditional Licensure Report from Zellner Consulting dated January 12, 2024, indicated the nurse consultant observed a ULP passing medications. The ULP reported to the nurse consultant that medications were late because it was a busy morning and the ULP was the only staff providing services until after 8:00 a.m. The report indicated multiple gaps in the facility schedule.</p> <p>The Staffing Plan document dated September 5, 2023, indicated the facility plan was two staff on AM shift, PM shift, and one staff on nights. The</p>	{0 470}		
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{0 470}	Continued From page 10 plan also indicated minimum staffing of one staff on AM shift, one staff on PM shift, and one staff on night shift. The document did not include any of the recommendations from the consultant. The Safe Patient Handling Policy dated December 17, 2023, indicated a mechanical lift was the appropriate mode of transfer for a resident unable to bear weight, unable to participate in the transfer process. The policy indicated a mechanical lift was only used if the ceiling lift was not functioning properly. The policy indicated that in the event of a fall staff may use a ceiling lift depending on location and that staff were to contact 911 for lift assistance only after the nurse on call has given approval.	{0 470}		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and document review, the	01290	Minnesota Department of Health is	

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01290	<p>Continued From page 11</p> <p>licensee failed to complete a background study for one of one staff (unlicensed personnel) ULP-D reviewed for background studies. ULP-D provided direct services to residents. This had the potential to affect all residents.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).</p> <p>Findings include:</p> <p>On January 9, 2024, the Minnesota Department of Health (MDH) investigator conducted a licensing order follow-up on correction orders issued to the provider on September 20, 2023.</p> <p>A roster search of the Minnesota Department of Human Services background study web site (https://netstudy2.dhs.state.mn.us/Live/Employees/SearchRoster) conducted on January 8, 2024, indicated the employee roster affiliation for the licensee (HFID #27389) did not include ULP-D.</p> <p>A document provided by the registered nurse (RN)-A on January 9, 2024, at 10:45 a.m. with names and contact phone numbers of staff who worked at the facility (HFID#27389) included ULP-D.</p> <p>Facility schedules provided to the MDH investigator on January 9, 2024, indicated ULP-D worked the following dates: December 24, 25, 26, 27,29, 30, 31, 2023, January 1, and 5, 2024.</p>	01290	<p>documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction.</p> <p>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.</p>	

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01290	<p>Continued From page 12</p> <p>A person search of the Minnesota Department of Human services background study web site (https://netstudy2.dhs.state.mn.us/Live/PersonSearch) conducted on January 10, 2024, indicated ULP-D was affiliated with another of the licensees facilities (HFID #28204).</p> <p>In an e-mail communication from assisted living director, (ALD)- C indicated the New Hire Packet process policy indicated employees would have a background studies clearance letter for all locations.</p> <p>The Hiring Practice policy dated December 18, 2023, indicated the human resources department submit a criminal history background check and would not hire an applicant if they had a substantiated finding of maltreatment. The policy did not contain information on affiliation of a company employee who worked at another of the company's facilities.</p>	01290		
{02310} SS=G	<p>144G.91 Subd. 4 (a) Appropriate care and services</p> <p>(a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to provide appropriate care and services per the service plan for four of four residents (R1, R2, R4, R6) reviewed for maltreatment. The licensee failed to follow up on requests for a catheter, pressure relieving</p>	{02310}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far	

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{02310}	<p>Continued From page 13</p> <p>mattress, and urologist appointment for R6. Harm occurred when R6 developed a pressure ulcer. The licensee failed to ensure skin checks were completed for R1, R2, and R4.</p> <p>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>R1 admitted March 22, 2022, due to diagnoses that included traumatic brain injury, dementia, and epilepsy.</p> <p>R1's Service Agreement dated November 21, 2023, indicated R1 received services including bathing twice weekly, skin condition monitoring weekly, frequent redirection, orientation for severe confusion, medications, bed mobility, transfers, behavior management, and toileting every two hours.</p> <p>R2 admitted March 1, 2014, due to a stroke with right side weakness, cognitive impairment, and impaired vision (left eye sewn shut).</p> <p>R2's Service Checkoff List dated January 3, 2024, indicated R2 received services including the following: safety checks every two hours, bathing twice weekly, skin condition monitoring weekly, behavior management, right foot and right arm brace assistance (on in morning and off at bedtime), medication administration four times</p>	{02310}	<p>left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction.</p> <p>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.</p>	
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{02310}	<p>Continued From page 14</p> <p>daily, toileting, and transfers with a total body lift (ceiling lift).</p> <p>R4 admitted on June 29, 2020, due to diagnoses that included Spinocerebellar degeneration (a neurological disease that created difficulty with walking, eating, dressing, bathing, etc), dysphagia, and impaired coordination.</p> <p>R4's Service Checkoff List dated January 3, 2024, indicated R4 received services including the following: toileting every two hours, repositioning, bathing once weekly, skin condition monitoring weekly, behavior management, assistance with left and right leg braces (on in morning and off at bedtime), dressing and undressing, peri care (morning and bedtime), medication administration at 8:00 a.m., 12:00 p.m., 2:00 p.m., 4:00 p.m., and 8:00 p.m., transfer with total body lift, and toileting every two hours.</p> <p>R6 admitted on May 9, 2023, due to diagnoses that included multiple sclerosis, pressure ulcer of sacral region, and sleep disorder.</p> <p>R6's service plan dated May 9, 2023, indicated R6 received services from the licensee that included physical assist of one staff for activities, skin condition monitoring weekly, assist of staff for turning/repositioning in bed every two hours, escorts to meals (with a note indicating R6 eats all meals in his room), assist of staff for dressing/grooming/nailcare/shaving/toileting, transfers with a total body (ceiling) lift, physical assist of one staff for toileting/incontinence care, and behavior management.</p> <p>R6's Communication Notes from Interim Home Care dated June 1, 5, 8, 13, 15, 20, 23, 26, and</p>	{02310}		

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{02310}	<p>Continued From page 15</p> <p>July 13, 2023, indicated R6 received skilled nursing care for a pressure injury to the buttocks.</p> <p>R6's Communication Note from Interim Home Care dated August 24, 2023, indicated R6's wound healed, thus was discharged from skilled nursing.</p> <p>R6's Service Delivery Record document for October 2023, indicated R6 received one bath in the month on October 14, 2023. The record indicated staff turned/repositioned R6 once during the day on October 7, 14, 23, and 31, 2023. The record indicated staff turned/repositioned R6 two times per day on October 1,2,3,8,9,10,14,16,17,21,22,24,27,29, and 30, 2023 The record indicated staff turned/repositioned R6 three times per day on October 4, 5, 6, 11,12, 15, 18, 19, 25, 26, and 28, 2023.</p> <p>R6's Service Delivery Record document for November 2023, indicated R6 received one bath in the month on November 3, 2023. The record indicated staff turned/repositioned R6 one time on November 11, and 12, 2023. The record indicated staff turned/ repositioned R6 two times on November 1,2,5,6, and 7, 2023. The record indicated staff turned/repositioned R6 three times on November 3,4,9, and 10, 2023. The record indicated staff turned/repositioned R6 four times on November 13,19,25, and 28, 2023.</p> <p>R6's progress note dated November 15, 2023, indicated RN-A assessed R6 on November 13, 2023, and found skin breakdown on R6's right buttock.</p> <p>The Conditional Licensure Report from Zellner Consulting dated November 24, 2023, indicated</p>	{02310}		
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{02310}	<p>Continued From page 16</p> <p>the consultant conducted an audit of R6's chart and discovered lack of implementation of interventions placed for a new wound on R6's buttock (i.e. urologist consult, catheter placement, behavior interventions for non-compliance, and an order for a pressure relieving mattress were not followed-up.) The report indicated the licensee lacked a Wound policy/procedure.</p> <p>A facility Internal Review document dated December 1, 2023, indicated registered nurse (RN)-A and former RN-E requested a pressure relieving air mattress for R6 on May 16, 19, 25, 31, 2023, June 7, 2023, July 11, 21, 2023, and August 2, 2023. No further requests were made until a consulting nurse reviewed R6's chart on November 21, 2023. The review indicated requests for a catheter for R6 were sent on May 12, 16, 25, 31, 2023, June 6, 19, 22, 23, 2023, July 5, and 14, 2023. No further requests were made until a consulting nurse reviewed R6's chart on November 21, 2023. The review indicated a request for a urology appointment for R6 were made on June 22, 2023, and August 2, 2023. No further requests were made until a consulting nurse reviewed R6's chart on November 21, 2023. The internal review indicated a policy was being generated for resident care ans timely follow-up.</p> <p>The Conditional Licensure Report from Zellner Consulting dated January 12, 2023, indicated recommended weekly skin checks were not completed for three residents (R1's last skin check was November 27, 2023, R2's last skin check was November 22, 2023, and R4's last skin check was December 14, 2023).</p> <p>The Service Plan policy dated August 1, 2021,</p>	{02310}		
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{02310}	<p>Continued From page 17</p> <p>indicated all residents receiving assisted living services would have a service plan in place, based on outcomes of assessments, monitoring, and review of resident's needs.</p> <p>The Minnesota Bill of Rights for Assisted Living Residents indicated residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards.</p> <p>At the time of the investigation the licensee did not have a Wound policy/procedure, or a policy/procedure for Resident Cares and Timely Follow-up (as noted in the Internal Review document).</p>	{02310}		
{02360}	<p>144G.91 Subd. 8 Freedom from maltreatment</p> <p>Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act.</p> <p>This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R6) was free from maltreatment.</p> <p>Findings include:</p> <p>The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility.</p> <p>Please refer to the public maltreatment report for</p>	{02360}	No plan of correction is required for this tag.	

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{02360}	Continued From page 18 details.	{02360}		