Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL313372910M
Compliance #: HL313375003C

Date Concluded: August 29, 2023

Name, Address, and County of Licensee Investigated:
Highland GW LLC
1925 Graham Avenue
Saint Paul, MN 55116
Ramsey County

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

Evaluator's Name: Erin Johnson-Crosby, RN, Special Investigator

Finding: Substantiated, facility responsibility

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

Initial Investigation Allegation(s):
The facility neglected the resident when staff failed to provide care as directed by the resident's service plan, failed to respond to the resident's requests for assistance and follow up on call light system concerns, failed to follow-up on incidents and injuries, and failed to assess and monitor the resident with a change in condition.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. Facility staff failed to follow the plan of care and failed to provide services in accordance with the resident's service plan causing bruising, severe pain, and immobility. Facility staff also failed to respond to the resident's requests for assistance and despite awareness of ongoing concerns related to their call light response system, no system changes were made to ensure availability for residents to request assistance or ensure resident

needs were met. In addition, facility staff failed to monitor and assess the resident following a change in condition and the resident was admitted to the intensive care unit (ICU) for septic shock related to norovirus.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted the resident's case manager and other outside agency staff who participated in the resident's care. The investigation included review the resident's facility and hospital records. During the onsite visit, the investigator made observations of staff providing resident care and the facility's call light system.

The resident resided in an assisted living facility. The resident's diagnoses included rheumatoid arthritis and chronic pain. The resident's service plan identified the resident received assistance with medication administration and required the assistance of two staff for dressing, transfers, and use of the bed pan. The resident's record indicated the resident received assistance from an outside agency for bathing. The resident's service plan also indicated for staff to complete every two-hour checks on the resident and to wake the resident if sleeping at the time of the check. The resident's assessment identified the resident as alert and oriented, able to verbally communicate her needs, and able to independently activate her call light.

A review of facility grievances identified multiple concerns with staff not following the resident's plan of care, not providing prompt toileting assistance, extended call light response times, and the call light being silenced without checking on the resident.

Months after the grievances were filed, the resident's medical record included documentation of incidents such as the resident being dropped during a transfer with a mechanical lift resulting in injury, significant pain and injury sustained while being assisted off the bed pan, and bruises of unknown origin. Despite documentation of staff's awareness of these incidents and injuries, nursing staff failed to re-assess the resident, failed to document and monitor the areas of injury, failed to initiate further investigation into the root cause of the incidents, failed to follow up with staff involved in the incidents, and failed to implement interventions to prevent further occurrence.

An incident report and progress note identified the resident called 911 herself and was sent to the hospital. The incident report identified the resident "wasn't feeling well, her breathing was not normal, her color was off." The resident was admitted to the ICU due to sepsis (a life-threatening condition related to the body's response to infection) related to norovirus (very contagious virus that causes vomiting and diarrhea.)

The resident's medical record included no additional documentation or indication of vomiting, diarrhea, the resident's condition, or change in condition, prior to the note and incident report of the resident contacting 911.

Hospital records indicated the resident reportedly experienced nausea, vomiting, and diarrhea for the last three days. Hospital records included upon the resident's presentation to the emergency room, hospital staff were unable to contact the facility for further information about the resident. The resident received intravenous (IV) fluids and antibiotics and was hospitalized for 14 days before she returned to the facility.

During the onsite visit, the investigator observed staff reset resident call lights from the hallway without entering the resident room. When the alarm was silenced in the hallway, it did not reset the switch in the resident's room, leaving the resident unable to re-activate their call light to continue to request assistance. The investigator also observed an incident of the service plan not followed by staff during the transfer of a resident.

Investigative interviews with current and former facility staff identified and acknowledged concerns with the facility's call light response system. Staff interviewed indicated call lights could be reset and cleared by facility staff from outside of the resident's room, with no record of the light being activated. Staff reported they had witnessed other ULP's shut off call lights from the hallway without checking on residents. Staff interviews also reported concerns with staffing and not having the adequate number of staff scheduled to provide the required amount of assistance for resident cares. Staff indicated they had reported these concerns to facility management but received no response.

Facility nursing and administrative staff who worked at the time the incidents occurred were no longer employed at the facility and declined to be interviewed.

During an interview, nursing and administrative staff indicated there had been a recent change in management, but the facility was aware of staff shutting off call lights from outside of the resident rooms. Nursing and administrative staff stated it's been a long term and repetitive problem and they were looking into solutions on how to resolve this issue.

During an interview, the resident's case manager stated there were many issues at this facility including the call light system. The case manager indicated call lights could be reset in the hallway and staff would not need to go into the resident's room. The case manager stated the resident was left on the bed pan for several hours on a few different occasions. The case manager recalled one incident where only one staff member was available and when assisting the resident, a popping sound was heard, and the resident was "bed ridden for a while." The case manager stated she had reported these concerns to multiple management staff and "the facility dropped the ball on several occasions."

During interview with outside agency staff who provided bathing services to the resident during her stay at the facility, recalled a time the resident contacted their agency staff and requested them to come to the facility earlier than scheduled, as it was past noon and facility staff had not yet came in to assist her out of bed. The outside agency staff member responded to the

resident’s request and recalled the resident was still in bed when they arrived and the resident’s call light had been activated.

During an interview, the resident’s family member (FM) had numerous concerns regarding the resident’s care. The FM stated the resident was able to direct her own care, but staff, at times, would not listen to her and would transfer and reposition the resident incorrectly. The FM recalled one time when facility staff transferred the resident by themselves, and the resident sustained compression fractures and was on bed rest for four weeks. The FM felt facility staff did not check on the resident every two hours as indicated in her care plan. The FM also shared multiple concerns regarding the call light system. The FM stated the resident would put on her call light and staff would not reset or clear the call light so the resident would not be able to call for further assistance. The FM stated there was a substantiated maltreatment investigation in 2018 when the resident was left on the commode for four hours. The FM was also concerned the resident had to call 911 herself and facility staff did not notice a change in condition prior to the resident’s 14-day hospital stay.

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

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

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
“Neglect” means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: No; Deceased
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
No action taken.

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
Ramsey County Attorney
Saint Paul City Attorney
Saint Paul Police Department
The Board of Executives for Long Term Services and Supports

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31337	A. BUILDING: _____ B. WING _____	C 08/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND GW LLC	1925 GRAHAM AVENUE SAINT PAUL, MN 55116

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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: #HL313375003C/#HL313372910M, #HL313371503C/#HL313372722M, #HL313374438C/#HL313372546M, #HL313373760C/#HL313377305M. On June 27, 2023 to August 7, 2023, 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 31 residents receiving services under the provider's Assisted Living with Dementia Care license. The following immediate correction order is issued. Correction orders with a period to correct that are not immediate may be issued at a later date during the investigation. The following immediate correction order is issued for #HL313375003C/#HL313372910M, #HL313371503C/#HL313372722M, #HL313374438C/#HL313372546M, tag	0 000	The Minnesota Department of Health documents 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the Surveyors and/or Investigators ' findings is the Time Period for Correction. Per Minnesota Statute §144G.30, Subd. 5 (c), the assisted living facilities must document any action taken to comply with the state correction order. A copy of the provider ' s records documenting those actions may be requested for follow-up surveys and/or complaint investigations. 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.	

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0 000	Continued From page 1 identification 2310 was issued on June 27, 2023. The immediate order for #HL313375003C/#HL313372910M, #HL313371503C/#HL313372722M, #HL313374438C/#HL313372546M, tag identification 2310 was removed on June 28, 2023, at 12:00 p.m. however non-compliance remains at a scope and level of a G. On August 7, 2023, at 3:00 p.m. the following immediate correction order is issued for HL313375003C/#HL313372910M/ HL313373760C/#HL313377305M tag identification _0460. Immediacy remains. The following correction orders are issued for #HL313375003C/#HL313372910M, #HL313371503C/#HL313372722M, #HL313374438C/#HL313372546M, #HL313373760C/#HL313377305M, tag identification 0250, 0470, 0530, 0540, 0620, 2360, 2370, 2560, and 3000. The following correction order is issued for #HL313373760C/#HL313377305M, tag identification 1640. The following correction order is issued for #HL313371503C/#HL313372722M, tag identification 1760. The following correction orders are issued for #HL313375003C/#HL313372910M, #HL313372910M/ HL313373760C/#HL313377305M, tag identification 2480.	0 000	THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPY AND LEVEL ISSUED PURSUANT TO THE MINN. STAT. § 144G.31, SUBDIVISION 2 and 3.	

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0 250	Continued From page 2	0 250		
0 250 SS=F	144G.20 Subdivision 1 Conditions (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; (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;	0 250		

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0 250	Continued From page 3 (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 (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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is 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).	0 250	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH	

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0 250	Continued From page 4 The findings include: A complaint investigation was initiated on June 27, 2023, and an entrance conference was conducted with the licensed assisted living director (LALD)-A. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the	0 250	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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0 250	Continued From page 5 Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons, all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a l icense. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract.	0 250		

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0 250	Continued From page 6 - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page five was electronically signed by an authorized agent on December 16, 2022. The licensee had an assisted living license renewal issued on March 21, 2023, with an expiration date of February 29, 2024. The licensee failed to ensure the following policies and procedures were developed and/or implemented: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (4) handling complaints regarding staff or services provided by staff; (5) conducting initial evaluations of residents' needs and the providers' ability to provide those services;	0 250		

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0 250	Continued From page 7 (6) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (7) orientation to and implementation of the assisted living bill of rights; (12) medication and treatment management; (13) delegation of tasks by registered nurses or licensed health professionals; (14) supervision of registered nurses and licensed health professionals; and (15) supervision of unlicensed personnel performing delegated tasks. On December 16, 2022, an application for license renewal was signed by the licensee and confirmed the licensee provided Assisted Living with Dementia Care services but failed to implement corresponding policies and procedures, as required. As a result of this survey, the following orders were issued : 0250, 0460, 0470, 0530, 0540, 0620, 1640, 1760, 2310, 2370, 2480, 2560, 3000, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 250		

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0 250	Continued From page 8 (21) days	0 250		
0 460 SS=I	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the call light system was fully functional and maintained to meet the scheduled and unscheduled needs of each resident and respond to requests for assistance of health or safety 24 hours a day, seven days a week as required. This had the potential to affect all 31 residents. 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,	0 460		

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0 460	Continued From page 9 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). This resulted in an immediate correction order on August 7, 2023, at 3:30 p.m., as of the date this the immediacy of the order has not been removed. The findings include: A complaint investigation was initiated on June 27, 2023, and an entrance conference was conducted with the licensed assisted living director (LALD)-A. The licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) dated March 11, 2023, indicated the staffing level for the day and evening shift would include four or more staff members, and at night two or more staff members (depending on the census and level of acuity). The UDALSA also identified the licensee had a pull cord system for emergency and non-emergency situations. A copy of the licensee's staffing plan was requested but not provided by the facility. The licensee's grievances were reviewed, however, most handwritten grievances were illegible. A typed grievance report filed on October 6, 2022, identified concerns regarding R1's call light. The resident was not able to call for assistance, causing R1 to be left on the bed pan for hours resulting in the resident experiencing an increase in pain. The grievance also indicated	0 460		

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	31337	A. BUILDING: _____ B. WING _____	C 08/07/2023

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0 460	Continued From page 10 caregivers silenced the call light system in the hallway without entering R1's room. The grievence further identified these same concerns had been discussed previously with multiple staff members and were told a new system was going to be installed. The grievance included information that there had been concerns with the facility's call light system since R1's admission in 2017. On June 27, 2023, at 10:45 a.m., the investigator observed the licensee's pull cord system. Two to three pull cords were located in each resident room (including one light in the bathroom). There was a string attached to the call light. The light was activated when the string was pulled down. When activated, the call light would light up and a loud beeping sound was audible in the hallway. Alerts of the call light activation were located in three places; one at a box hanging near a common area and one at each end of the hallway. The beeping would sound until the alarm was silenced or the call light was physically reset by staff within the resident's room. It was only able to be shut off/silenced from the hallway otherwise needed to be reset manually from within the resident room. On June 27, 2023, at 11:15 a.m., the investigator observed, unlicensed personnel (ULP)-D silence the call light in the hallway. ULP-D did not enter the resident room or alert other staff of the call light. At 11:25 a.m., ULP-D stated if the resident pulled the call light and it was not reset (pulled back up) in the room, the resident would not be able to further call for assistance. On June 27, 2023, at 2:00 p.m., ULP-E stated when a call light goes off she will stop the alarming in the hallway and then will enter the	0 460		

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0 460	Continued From page 11 resident's room. ULP-E stated, "we try not to cancel the call light until a staff member can get to the resident, but it can't always be done that way." On June 28, 2023, at 7:50 a.m., registered nurse (RN)-F stated staff were not supposed to turn off the call light before going in to the resident's room. RN-F also stated facility staff completed call light audits but the call light audits did not include the time the call light audits where completed. RN-F stated they would change that right away to include the time. RN-F did not know if audits had been completed from 7:00 a.m. to 9:00 a.m., or during the night. RN-F was also not aware of the staffing plan requirement identified in assisted living licensure statutes. R1 R1's diagnoses included rheumatoid arthritis and chronic pain. R1's assessment dated June 27, 2022, indicated R1 was alert and oriented. R1's service plan dated March 4, 2022, indicated the resident required assistance with dressing, grooming, and two assist of staff with transferring, toileting, and bed mobility. The service plan indicated R1 was on every two hour checks and directed staff to wake R1 if R1 was sleeping at the time of the check. On July 25, 2023, at 9:30 a.m., an outside agency staff member involved in R1's care, stated on September 19, 2022, R1 called a home health aide from the outside agency to come in early since R1 had not been assisted out of bed all day and had not been able to use the bathroom. The home health aide arrived at the facility around 1:00 p.m., and found R1 was still in bed. The home health aide noticed R1's pull cord had been	0 460		

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0 460	Continued From page 12 activated prior to her arrival and remained in the activated setting (so the resident could not request for further assistance) and R1 informed her staff were purposely not helping her. On July 25, 2023, at 10:00 a.m., R1's county case manager (CM) indicated there had been a lot of issues with the call light system. The CM stated the alarm system could be reset in the hallway and then staff would not need to go and check on the residents. The CM stated management was aware and "dropped the ball on several occasions." R5 R5's diagnoses included Amyotropic Lateral Sclerosis (nervous system disease that affected nerve cells in the brain and spinal cord), and expressive aphasia (loss of ability to speak). R5's undated service plan indicated R5 required assistance with bathing, meals, medication administration, two staff assistance for toileting, transfers, bed mobility, and reassurance checks to be completed every two hours. R5's assessment dated June 16, 2023, indicated R5 was non-verbal and utilized her Ipad (electronic device) and hand signals for communication. The report indicated R5 was alert and oriented and indicated the resident worried at night as she was concerned she would need to wait for assistance for a long period of time. On June 27, 2023, at 11:50 p.m., R5's family member (FM)-B stated staff never used the call light system like they were supposed to. FM-B stated staff silenced the call light alarm in the hallway and would not enter the resident's room to provide or inquire about their request for assistance. FM-B recalled two occasions where	0 460		

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0 460	Continued From page 13 he had stayed overnight with R5. FM-B pressed the call light and did not get assistance for over two hours and had to locate staff to notify them of the need for assistance. FM-B stated he wanted to make sure R5 would be able to get assistance if needed when he was not at the facility. On June 28, 2023, at 8:50 a.m., RN-B stated he was aware of R5's concerns regarding the call light system and long call light wait times. RN-B stated FM-B thought the overnight staff were sleeping. RN-B stated he talked to staff about this and re-educated them. On August 1, 2023, FM-B stated on July 4, 2023, R5 pressed the call light early in the morning and staff did not respond. When FM-B arrived at the facility they found R5 in distress and screaming. R5 informed FM-B that she had summoned for assistance over two hours ago. FM-B then went and found staff to assist R5. This concern was reported to management staff. On August 3, 2023, RN-B stated he was aware of the long call light wait times. RN-B stated if an alarm is silenced in the hallway, the staff may get busy and forget about that resident, resulting in unanswered call lights. RN-B stated sometimes the alarms are silenced if the staff are busy with another resident. RN-B stated we try and educate the staff on not silencing the alarms. On August 7, 2023, at 11:45 a.m., FM-B reported that on Friday evening R5 pressed her call light. FM-B indicated it was very hot that day (around 95 degrees) and R5 did not have an air conditioner in her room. FM-B stated no one came to assist R5 and later the facility noticed that another pull cord in R5's room had not been reset, causing the other call light pull cords in	0 460		

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0 460	Continued From page 14 R5's room to be inactive. On August 8, 2023, at 3:00 p.m., LALD-A stated there had not been a concern raised regarding call lights since prior to the complaint investigation visit initiated on June 27, 2023. LALD-A stated staff were re-educated regarding the resetting of the pull light and not silencing the alarm. LALD-A stated she did not interview additional residents to inquire if they had any concerns regarding the call light system. LALD-A stated she reached out to corporate staff today and was going to request another meeting soon if she didn't hear anything to ensure staff were not able to silence the alarm. During the interview, LALD-A later acknowledged awareness of FM-B's concern with R5's call light not being answered over the weekend. A call light policy was request but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	0 460		
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	0 470		

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0 470	Continued From page 15 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 (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the required staffing plan was developed, implemented, and evaluated for appropriateness of staffing levels as required, potentially affecting all of the current residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is 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). The findings include: On June 27, 2023, at 10:37 a.m., the licensee's	0 470		

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0 470	Continued From page 16 staff plan was requested. On June 27, 2023, at 1:00 p.m., the licensee emailed a document titled, Critical Functions Long-term Care Contingency Staffing plan. The investigator again requested the licensee's staffing plan. On June 28, 2023, at 7:50 a.m., registered nurse (RN)-F and RN-B stated they were not aware of the staffing plan requirement identified in the assisted living licensure statutes. The licensee's Staffing and Scheduling policy dated September 22, 2022, indicated the Assisted Living Director, in conjunction with the RN, will develop and implement a written staffing plan that provides an adequate number of qualified direct-care staff to meet the residents' needs 24 hours a day, seven days a week. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 530 SS=C	144G.41 Subd. 5 Resident councils The facility must provide a resident council with space and privacy for meetings, where doing so is reasonably achievable. Staff, visitors, and other guests may attend a resident council meeting only at the council's invitation. The facility must designate a staff person who is approved by the resident council to be responsible for providing assistance and responding to written requests that result from meetings. The facility must consider the views of the resident council and must respond promptly to the grievances and	0 530		

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0 530	Continued From page 17 recommendations of the council, but a facility is not required to implement as recommended every request of the council. The facility shall, with the approval of the resident council, take reasonably achievable steps to make residents aware of upcoming meetings in a timely manner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a resident council, and develop a process to consider resident council recommendations and grievances. This had the potential to affect all 31 residents. This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On June 28, 2023, at 8:21 a.m., the investigator requested resident council minutes for the last six months. On June 28, 2023, at 8:45 a.m., registered nurse (RN)-B did not know what resident council was. On June 28, 2023, at 8:50 a.m., RN-F stated the facility did not have resident or family council but should have. The licensee's Resident and Family Council policy, dated August 1, 2021, indicated the facility must designate a staff person who is approved by	0 530		

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0 530	Continued From page 18 the resident council to be responsible for providing assistance and responding to written requests that result from the meetings. The facility must consider the view of the resident council and must respond promptly to the grievances and recommendation of the council. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days	0 530		
0 540 SS=C	144G.41 Subd. 6 Family councils The facility must provide a family council with space and privacy for meetings, where doing so is reasonably achievable. The facility must designate a staff person who is approved by the family council to be responsible for providing assistance and responding to written requests that result from meetings. The facility must consider the views of the family council and must respond promptly to the grievances and recommendations of the council, but a facility is not required to implement as recommended every request of the council. The facility shall, with the approval of the family council, take reasonably achievable steps to make residents and family members aware of upcoming meetings in a timely manner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to designate a staff person who is approved by the family council to be responsible for providing assistance and responding to written requests that result from the resident council meetings. This had the potential to affect all 31	0 540		

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0 540	Continued From page 19 residents and their families. This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On June 28, 2023, at 8:21 a.m., the investigator requested family council minutes for the last six months. On June 28, 2023, at 8:45 a.m., registered nurse (RN)-B did not know what family council was. On June 28, 2023, at 8:50 a.m., RN-F stated the facility did not have a family council but should have. The licensee's Resident and Family Council policy, dated August 1, 2021, indicated the facility must designate a staff person who is approved by the family council to be responsible for providing assistance and responding to written requests that result form meeting. The facility must consider views of the family council and must respond promptly to the grievances and recommendation of the council but is not required to implement as recommended. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days	0 540		

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0 620	Continued From page 20	0 620		
0 620 SS=F	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma (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 licensee failed to report suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC) for three of four residents (R1, R2, and R5) regarding suspected neglect. 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). The findings include: A complaint investigation was initiated on June 27, 2023, and an entrance conference was conducted with the licensed assisted living director (LALD)-A. The licensee's grievances were reviewed, however, most handwritten grievances were illegible. A typed grievance report filed on October 6, 2022, identified concerns regarding R1's call	0 620		

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0 620	Continued From page 21 light. The resident was not able to call for assistance, causing R1 to be left on the bed pan for hours resulting in the resident experiencing an increase in pain. The grievance also indicated caregivers silenced the call light system in the hallway without entering R1's room. The grievance further identified these same concerns had been discussed previously with multiple staff members and were told a new system was going to be installed. The grievance included information that there had been concerns with the facility's call light system since R1's admission in 2017. No MAARC reports were filed in relation to the grievances filed. R1 R1's diagnoses included rheumatoid arthritis and chronic pain. R1's assessment dated June 27, 2022, indicated R1 was alert and oriented. R1's service plan dated March 4, 2022, indicated the resident required assistance with dressing, grooming, and two assist of staff with transferring, toileting, and bed mobility. The service plan indicated R1 was on every two hour checks and directed staff to wake R1 if R1 was sleeping at the time of the check. A grievance filed January 26, 2023, indicated staff transferred R1 with one staff and R1 required two assistance for transfers. The incident report indicated after this incident R1 complained of back pain and current pain medications were not sufficient. No MAARC report was filed related to the grievance filed January 26, 2023.	0 620		

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0 620	Continued From page 22 R1's progress notes and incident report dated February 27, 2023 at 9:30 p.m., indicated R1 reported to staff she called 911 since she was breathing weird and her color was off and not feeling well. R1 was admitted to the intensive care unit (ICU). R1's hospital records dated Februaray 27, 2023, indicated R1 was admitted to the ICU with septic shock from norovirus. the records indicated R1 had nausea, vomitting and diarrhea for three days and other residents at the facility were also ill. R1 was in the hospital for 14 days. There was no follow up related to the February 27, 2023, incident and no MAARC report was filed with the state agency. On July 25, 2023, at 9:30 a.m., an outside agency staff member involved in R1's care, stated on September 19, 2022, R1 called a home health aide to come in early since R1 had not been assisted out of bed all day and had not been able to use the bathroom. The home health aide arrived at the facility around 1:00 p.m., and R1 was in bed. The home health aide noticed R1's pull cord had been activated prior to her arrival and remained in the activated setting (so the resident could not request for further assistance) and R1 informed her staff were purposely not helping her. On July 25, 2023, at 10:00 a.m., R1's county case manager (CM) indicated there had been a lot of issues with the call light system. The CM stated the alarm system could be reset in the hallway and then staff would not need to go and check on the residents. The CM stated management was aware and "dropped the ball on several occasions."	0 620		

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0 620	Continued From page 23 R5 R5's diagnoses included Amyotropic Lateral Sclerosis (nervous system disease that affected nerve cells in the brain and spinal cord), and expressive aphasia (loss of ability to speak). R5's undated service plan indicated R5 required assistance with bathing, meals, medication administration, two staff assistance for toileting, transfers, bed mobility, and reassurance checks to be completed every two hours. R5's assessment dated June 16, 2023, indicated R5 was non-verbal and utilized her Ipad (electronic device) and hand signals for communication. The report indicated R5 was alert and oriented and indicated the resident worried at night as she was concerned she would need to wait for assistance for a long period of time. On June 27, 2023, at 11:50 p.m., R5's family member (FM)-B stated staff never used the call light system like they were supposed to. FM-B stated staff silenced the call light alarm in the hallway and would not enter the resident's room to provide or inquire about their request for assistance. FM-B recalled two occasions where he had stayed overnight with R5. FM-B pressed the call light and did not get assistance for over two hours and had to locate staff to notify them of the need for assistance. FM-B stated he wanted to make sure R5 would be able to get assistance if needed when he was not at the facility. On June 28, 2023, at 8:50 a.m., RN-B stated he was aware of R5's concerns regarding the call light system and long call light wait times. RN-B stated FM-B thought the overnight staff were	0 620		

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0 620	Continued From page 24 sleeping. RN-B stated he talked to staff about this and re-educated them. Despite RN-B's awareness of these concerns and incidents with R5, no MAARC reports were filed with the state agency. On August 1, 2023, FM-B stated on July 4, 2023, R5 pressed the call light early in the morning and staff did not respond. When FM-B arrived at the facility they found R5 in distress and screaming. R5 informed FM-B that she had summoned for assistance over two hours ago. FM-B then went and found staff to assist R5. This concern was reported to management staff, however no MAARC report was filed related to this incident. On August 3, 2023, RN-B stated he was aware of the long call light wait times. RN-B stated if an alarm is silenced in the hallway, the staff may get busy and forget about that resident, resulting in unanswered call lights. RN-B stated sometimes the alarms are silenced if the staff are busy with another resident. RN-B stated we try and educate the staff on not silencing the alarms. RN-B did not know why these complaints were not reported as suspected maltreatment. On August 7, 2023, at 11:45 a.m., FM-B reported that on Friday evening R5 pressed her call light. FM-B indicated it was very hot that day (around 95 degrees) and R5 did not have an air conditioner in her room. FM-B stated no one came to assist R5 and later the facility noticed that another pull cord in R5's room had not been reset, causing the other call light pull cords in R5's room to be inactive. On August 8, 2023, at 3:00 p.m., LALD-A stated she did not know why the prior complaints or suspected maltreatment were not reported to the	0 620		

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0 620	Continued From page 25 state agency. LALD-A stated any suspected abuse or neglect should be reported within 24 hours. The licensee's Vulnerable Adult Maltreatment-Prevention and Reporting, dated August 1, 2021, indicated licensee staff who suspect maltreatment of a resident should report to Minnesota Adult Abuse Reporting Center (MAARC) no later than 24 hours the maltreatment was suspected. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) days.	0 620		
01640 SS=G	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable.	01640		

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01640	Continued From page 26 (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure service plans were implemented per the resident's assessments for two of two residents (R1, R6) with records reviewed. 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). Findings Include: R5 R5's diagnoses included Amyotropic Lateral Sclerosis (nervous system disease that affected nerve cells in the brain and spinal cord), and expressive aphasia (loss of ability to speak). R5's service plan effective June 4, 2023 indicated R5 required assistance with bathing, meals, medication administration, toileting, reassurance checks every two hours, bed mobility and a hoyer lift (mechanical lift) with two staff for transfers. R5's admission progress note dated June 2, 2023, indicated R5 required assist of two people with most of her care including a hoyer lift for transfers.	01640		

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01640	Continued From page 27 R5's assessment dated June 16, 2023, indicated R5 was non-verbal and utilized her Ipad (electronic device) and hand signals for communication. R5's assessment indicated R5 required two staff with gait belt and hoyer lift. On June 27, 2023, at 11:25 a.m., the investigator observed two licensee staff transfer R5 with a gait belt to the bathroom. There was a hoyer lift observed in R5's room but not utilized during the transfer. R6 R6's diagnoses included osteoarthritis, morbid obesity and diabetes type II. R6's undated service plan indicated R6 required assistance with bathing, meals, dressing, grooming, safety checks, medication administration, toileting, and transfered with the use of a hoyer lift and two to three staff. R6's 90 day assessment dated May 17, 2023, indicated R6 weighed 411 lbs. The assessment indicated R6 requied full assistance with the hoyer lift. The assessment did not indicate how many staff were required to provide assistance with the hoyer lift for transfers. On August 9, 2023, at 3:07 p.m., unlicensed personnel (ULP)-D stated three males or two females were needed to assist R6 with transfers. On August 9, 2023, at 3:30 p.m., registered nurse (RN)-B stated staff should follow the service plan when providing care. RN-B did not know how staff were to assess if R6 required two or three staff for transfers. The licensee's Service Plan Policy, dated August	01640		

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01640	Continued From page 28 11, 2022, indicated service plans are based on the initial and ongoing assessments, monitoring, individual review of the resident's needs and preferences. A service plan describes what services will be provided to the resident. The policy also indicated the service plan should be revised, if needed, based on the resident assessment and monitoring. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) days.	01640		
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure medications were administered as prescribed for three of three residents (R7, R8, and R9) with records reviewed.	01760		

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01760	Continued From page 29 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 is 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). The findings include: A complaint investigation was initiated on June 27, 2023, and an entrance conference was conducted with the licensed assisted living director (LALD)-A. On June 27 - June 28, 2023, the licensee's medication error reports were reviewed and included the following: -On April 25, 2022, R7 received another resident's medications including tamsulosin (urinary retention), methanamine (anti-infectives), and trazodone (antidepressant). R7 complained of dizziness and R7's blood pressure was 109/60. The licensee's action plan indicated photos of all resident along with their room number will be on located on the electronic MAR to assist new staff to give medications to the correct residents. The report did not include an internal investigation or facility wide education. -On July 30, 2022, R8 received another resident's medications including divaloproex (seizures), fluoxetine (antidepressant), haloperidol (anti-psychotic), seroquel (antipsychotic), and vitamin D3. The licensee indicated staff was using a paper MAR and gave the incorrect medications to R8. The report did not include an	01760		

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01760	Continued From page 30 internal investigation or facility wide education. -On February 27, 2023, R9 received another resident's medication including atorvastatin (medication to lower cholesterol), hydralazine (medication used to treat high blood pressure), gabapentin (anticonvulsant) , and baclofen (muscle relaxant). The report did not include an internal investigation or facility wide education. On June 28, 2023, at 7:00 a.m., the investigator observed 10 out of 14 memory care residents did not have a profile picture on their electronic MAR to assist in identifying the resident, despite this identified as an intervention following the medication error on April 25, 2022. On June 28, 2023, at 8:26 a.m., registered nurse (RN)-B stated staff had been re-educated regarding medication administration. RN-B did not know about the intervention for all resident's to have a profile picture in the electronic MAR or that it was identified as the facility's response to previous medication errors. RN-B was not aware of the previous medication errors involving staff administering another resident's medications and stated he was not employed at the facility at the time of the previous medication errors. On June 28, 2023, at 8:50 a.m., the licensee's Regional Director of Nursing (RN)-F stated all residents should have a picture in their electronic record to decrease the chance for medication errors. The licensee's Medication Error Policy dated August 2, 2021, indicated the licensee had a goal of zero medication errors. The policy indicated a medication error report would be completed and documented in the resident's record, progress	01760		

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01760	Continued From page 31 notes completed on what occurred, the date and time, who was contacted and what the actions were to correct the situation. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure appropriate care and services were provided based on the resident's needs and according to an up-to-date assessment and service plan subject to accepted health care standards when smoking assessment safety interventions were not implemented for one of one resident (R4) reviewed. This had the potential to affect all four residents that smoked at the facility. 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	02310		

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02310	Continued From page 32 situation has occurred only occasionally). This resulted in an immediate correction order on June 27, 2023. Immediacy was removed on June 28, 2023, at 12:00 p.m, however non-compliance remained at a scope and level of a G. The findings include: R4's medical record identified diagnoses of left sided weakness related to a stroke, and congestive heart failure. R4's service plan indicated R4 required assistance with bathing, dressing, range of motion to left hand and leg, safety checks every two hours, medication administration, transfers, toileting and ambulation assistance. R4's service plan did not identify R4 smoked and did not include interventions to keep R4 safe when smoking. R4's 90-day assessment dated January 31, 2023, indicated R4 did not handle lit smoking materials appropriately and R4 should wear a smoking apron. R4's 90-day assessment dated May 1, 2023, indicated R4 did not handle lit smoking material appropriately and R4 should wear a smoking apron. R4's individual abuse prevention plan (IAPP) dated May 5, 2023, indicated R4 needed to be reminded to smoke in designated smoking areas. The assessment did not include interventions regarding safe smoking.	02310		

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02310	Continued From page 33 On June 27, 2023, at 9:40 a.m., the investigator observed R4 outside smoking. No staff were observed in the smoking area and R4 was not wearing a smoking apron. R4 entered the building and the investigator noticed multiple burn holes on the resident's pants. On June 27, 2023, at 3: 31 p.m., registered nurse (RN)- B stated when assessing smoking, staff do not have to watch the resident smoke and was not aware of burn holes on R4's clothing. RN-B verified she completed R4's smoking assessment on May 1, 2023, which identified R4 did not handle lit smoking materials approprately and should use a smoking apron. However, RN-B stated she did not know what a smoking apron was. On June 27, 2023, at 4:16 p.m., RN-C stated the assessment he completed on January 31, 2023, indicated R4 could not handle lit smoking material appropriately and should use a smoking apron. RN-C stated he never asked R4 if he wanted a smoking apron because R4 was independent and smoked outside. On June 27, 2023, at 4:33 p.m., R4 stated he did not need to be supervised when smoking or use a smoking apron. R4 stated no staff have ever watched him smoke. On June 27, 2023, at 4:50 p.m., RN-B stated she will have to go look at R4's clothes as she did not know what burn holes looked like. The licensee did not have a smoking policy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	02310		

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02310	Continued From page 34 Days	02310		
02360	144G.91 Subd. 8 Freedom from maltreatment 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. This MN Requirement is not met as evidenced by: Based on observations, interviews, and document review, the facility failed to ensure four of four residents reviewed (R1, R2, R3, R5) were free from maltreatment. R1, R2, R5 were neglected and R3 was abused Findings include: The Minnesota Department of Health (MDH) issued a determination that abuse and neglect occurred, and that the facility and an individual staff person was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	02360		
02370 SS=F	144G.91 Subd. 9 Right to come and go freely Residents have the right to enter and leave the facility as they choose. This right may be restricted only as allowed by other law and consistent with a resident's service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure residents not	02370		

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02370	Continued From page 35 residing in memory care had the right to come and go freely. This had the potential to affect all 19 residents who did not reside in the dementia care unit and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an Assisted Living with Dementia Care license for a resident capacity of 36 and current capacity of 31. Per Minnesota Assisted Living: Chapter 144G, 144G.08, Subd. 62, "Secured dementia care unit" means a designated area or setting designed for individuals with dementia that is locked or secured to prevent a resident from exiting, or to limit a resident's ability to exit, the secured setting. A secured dementia care unit is not solely an individual resident's living area. On June 28, 2023, at 8:30 a.m., the investigator arrived at the facility. The entrance had a key code and was locked. There was a door bell to press for staff assistance to enter the building. The investigator waited in the entry way for staff for approximately 15 minutes. The facility had a secured/locked unit on the 2nd floor which also required a code to exit the area. On June 27, 2023, at 11:50 p.m., FM-B recalled	02370		

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02370	Continued From page 36 two occasions where he had stayed overnight with R5 and had to wait over two hours on both occasions to get help for R5 and to be able to leave the facility as he did not have the code to let himself out. On August 15, 2023, the investigator requested information regarding the locked entry way. Licensed Assisted Living Director (LALD)-A responded via email on August 15, 2023, and indicated resident's could come and go freely with the assistance of staff. LALD-A identified there was no assessment to determine which residents were allowed the code to exit and enter independently and management requested the code not be shared with residents or family members. ALD-A stated this was done because residents were coming and going at all times of the morning and night. A policy was requested but not provided. The licensee Minnesota Home Care Bill of Rights for Assisted Living Clients of Licensed Only Home Care Providers dated November, 2019. This Bill of Rights was not the Bill of Rights that aligned with the licensee's current statute requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) Days	02370		
02480 SS=F	144G.91 Subd. 20 Grievances and inquiries Residents have the right to make and receive a timely response to a complaint or inquiry, without limitation. Residents have the right to know, and	02480		

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02480	Continued From page 37 every facility must provide the name and contact information of the person representing the facility who is designated to handle and resolve complaints and inquiries. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to respond to grievances for two of two residents (R1, and R5) reviewed for grievances. R1 and R5 communicated several concerns to the licensee without resolution. 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). The findings include: On June 27, 2023, the investigator requested to review facility grievances. The licensees' grievances included the following: R1 A grievance filed July 11, 2022, indicated facility staff refused to help R1 during the day. The form indicated education was provided regarding resident rights. A grievance filed October 6, 2022 indicated the following concerns: - cares were not provided per R1's service plan regarding transfers, dressing and bed mobility. - extended call light times	02480		

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02480	Continued From page 38 - pull cord system had been an issue since 2017 regarding staff silencing the sound in the hall without entering the resident room and this had been discussed with several managers. A grievance filed January 26, 2023, indicated staff transferred R1 with one staff and R1 required two assistance for transfers. The incident report indicated after this incident R1 complained of back pain and current pain medications were not sufficient. The form indicated the education was provided. R5 R5's assessment dated June 16, 2023, indicated R5 was non-verbal and utilized her Ipad (electronic device) and hand signals for communication. The assessment indicated R5 was alert and oriented and indicated the resident worried at night as she was concerned she would need to wait for assistance for a long period of time. On June 27, 2023, at 11:50 p.m., R5's family member (FM)-B stated staff never used the call light system like they were supposed to. FM-B stated staff silenced the call light alarm in the hallway and would not enter the resident's room to provide or inquire about their request for assistance. FM-B recalled two occasions where he had stayed overnight with R5. FM-B pressed the call light and did not get assistance for two hours and had to locate staff to notify them of the need for assistance. FM-B stated he wanted to make sure R5 would be able to get assistance if needed when he was not at the facility. On June 28, 2023, at 8:50 a.m., RN-B stated he was aware of R5's concerns regarding the call light system and long call light wait times. RN-B	02480		

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02480	Continued From page 39 stated FM-B thought the overnight staff were sleeping. RN-B stated he had talked to staff about this and re-educated them. On August 1, 2023, FM-B stated on July 4, 2023, R5 pressed the call light early in the morning and staff did not respond. When FM-B arrived at the facility they found R5 in distress and screaming. R5 informed FM-B she had summoned for assistance over two hours ago. FM-B then went and found staff to assist R5. This concern was reported to management staff. On August 3, 2023, RN-B stated he was aware of the long call light wait times. RN-B stated if an alarm is silenced in the hallway, the staff may get busy and forget about that resident, resulting in an unanswered call light. RN-B stated sometimes the alarms are silenced if the staff are busy with another resident. RN-B stated we try and educate the staff on not silencing the alarms. RN-B was not aware of the grievance policy and procedure. On August 7, 2023, at 11:45 a.m., FM-B reported that on Friday evening R5 pressed her call light. FM-B indicated it was very hot that day (around 95 degrees) and R5 did not have an air conditioner in her room. FM-B stated no one came to assist R5 and later the facility noticed that another pull cord in R5's room had not been reset, causing the other call light pull cords in R5's room to be inactive. On August 8, 2023, at 3:00 p.m., the Licensed Assisted Living Director (LALD)-A stated there had not been a concern raised regarding call lights since prior to the complaint investigation visit initiated on June 27, 2023. LALD-A stated	02480		

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02480	Continued From page 40 staff were re-educated regarding the resetting of the pull light and not silencing the alarm. LALD-A stated she did not interview additional residents to inquire if they had any concerns regarding the call light system. LALD-A stated she reached out to corporate staff and was going to request another meeting soon if she didn't hear anything to ensure staff are not able to silence the alarm. During the interview, LALD-A later acknowledged awareness of FM-B's concern with R5's call light not being answered over the weekend. On August 9, 2023, RN-F and the regional LALD stated grievances should be followed up on and if the intervention implemented was not working, it should be re-assessed and changed. The licensee's Complaint/Grievance Policy dated August 1, 2021, indicated complaints that cannot be easily resolved or have not been resolved to an employee or resident satisfaction should be dealt with in the following way: 1: A facility complaint form should be filled out by the resident, resident representative, or employee and given to the supervisor or the director 2: The facility should assist to fill out a complaint form as needed 3: when possible the complaint will be resolved immediately 4: If needed, an investigation surrounding the facts of the complaint shall be initiated 5: After investigation a prompt response will be given the the concerned party verbally and if desired in writing 6: If maltreatment was identified a report to Minnesota Adult Abuse Reporting Center will be made within 24 hours. No further information was provided.	02480		

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02480	Continued From page 41 TIME PERIOD FOR CORRECTION: Twenty-One (21) Days	02480		
02560 SS=D	144G.92 Subdivision 1. Retaliation prohibited A facility or agent of a facility may not retaliate against a resident or employee if the resident, employee, or any person acting on behalf of the resident: (1) files a good faith complaint or grievance, makes a good faith inquiry, or asserts any right; (2) indicates a good faith intention to file a complaint or grievance, make an inquiry, or assert any right; (3) files, in good faith, or indicates an intention to file a maltreatment report, whether mandatory or voluntary, under section 626.557; (4) seeks assistance from or reports a reasonable suspicion of a crime or systemic problems or concerns to the director or manager of the facility, the Office of Ombudsman for Long-Term Care, the Office of Ombudsman for Mental Health and Developmental Disabilities, a regulatory or other government agency, or a legal or advocacy organization; (5) advocates or seeks advocacy assistance for necessary or improved care or services or enforcement of rights under this section or other law; (6) takes or indicates an intention to take civil action; (7) participates or indicates an intention to participate in any investigation or administrative or judicial proceeding; (8) contracts or indicates an intention to contract to receive services from a service provider of the resident's choice other than the facility; or (9) places or indicates an intention to place a camera or electronic monitoring device in the	02560		

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02560	Continued From page 42 resident's private space as provided under section 144.6502. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of one unlicensed personal (ULP)-K did not experience retaliation after ULP-K shared concerns regarding staff sleeping while working, and service plans not being followed. Upon sharing these concerns ULP-K was taken off of the schedule without notice. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: Minnesota (MN) Statute 144G.92, subdivision 1, clause (1-3), Retaliation Prohibited. A facility or agent of a facility may not retaliate against a resident or an employee if the resident, employee, or any person acting on behalf of the resident: (1) files a good faith complaint or grievance, makes a good faith inquiry, or asserts any right; (2) indicates a good faith intention to file a complaint or grievance, make an inquiry, or assert any right; (3) files, in good faith, or indicates an intention to file a maltreatment report, whether mandatory or voluntary, under section 626.557.	02560		

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02560	Continued From page 43 ULP-K's employee file included a note written by ULP-K on July 20, 2023, indicated beginning August 18, 2023, she was going to start working every other weekend. ULP-K's 90 day review, completed on August 15, 2023, by Licensed Assisted Living Director (LALD)-A indicated ULP-K's overall performance exhibited quality performance most of the time. This was signed by LALD-A, but was not dated and was not signed by ULP-K. On August 23, 2023, at 2:30 p.m., ULP-K stated she was taken off of the schedule without cause and was retaliated against because she brought up concerns regarding staff sleeping while working, and resident service plans not being followed. ULP-K stated the licensee approved her request to work every other weekend and her next scheduled shift was the weekend of August 25 and 26, 2023. ULP-K stated she never told LALD-A she wanted to quit, but was taken off of the schedule. ULP-K was not aware she was taken off of the schedule until she spoke with registered nurse (RN)-B. ULP-K stated if she would have quit she would have written a resignation letter. ULP-K stated an employee review was not completed with LALD-A. The licensee's schedule sent by ULP-K indicated ULP-K was scheduled to work 2:30 p.m., to 10:30 p.m., on August 25 and 26, 2023. On August 23, 2023, at 6:44 p.m., registered nurse (RN)-B stated ULP-K was a good worker and had no concerns. RN-B stated management informed him ULP-K quit, but when he called ULP-K, she stated she did not quit and wondered why she was taken off the schedule. RN-B stated there must have been a personal issue with	02560		

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02560	Continued From page 44 ULP-K and management. On August 19, 2023, at 11:03 p.m., a text message sent to ULP-K from LALD-A indicated, "I hope wherever else you go they can put up with (you) because your attitude and behavior is very nasty. I'm glad God got you out of our way instead of my firing you. Good luck and good night." On August 25, 2023, at 9:15 a.m., LALD-A stated ULP-K called her on August 17th, 2023, and quit. LALD-A stated she did not have ULP-K write up a resignation letter. LALD-A also denied receiving any complaints from ULP-K regarding staff sleeping or services not being provided. LALD-A stated she sent the text to ULP-K and verified that sending this text was not appropriate. The licensee's Complaint/Grievance policy dated August 1, 2023, did not include information regarding retaliation. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) Days	02560		
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	03000		

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03000	Continued From page 45 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 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.	03000		

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03000	Continued From page 46 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to report suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC) for three of four residents (R1, R2, and R5) regarding suspected neglect. 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). The findings include: A complaint investigation was initiated on June 27, 2023, and an entrance conference was conducted with the licensed assisted living director (LALD)-A. The licensee's grievances were reviewed, however, most handwritten grievances were illegible. A typed grievance report filed on October 6, 2022, identified concerns regarding R1's call light. The resident was not able to call for assistance, causing R1 to be left on the bed pan for hours resulting in the resident experiencing an increase in pain. The grievance also indicated caregivers silenced the call light system in the hallway without entering R1's room. The grievance further identified these same concerns had been discussed previously with multiple staff members and were told a new system was going to be installed. The grievance included information that there had been concerns with the	03000		

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03000	Continued From page 47 facility's call light system since R1's admission in 2017. No MAARC reports were filed in relation to the grievances filed. R1 R1's diagnoses included rheumatoid arthritis and chronic pain. R1's assessment dated June 27, 2022, indicated R1 was alert and oriented. R1's service plan dated March 4, 2022, indicated the resident required assistance with dressing, grooming, and two assist of staff with transferring, toileting, and bed mobility. The service plan indicated R1 was on every two hour checks and directed staff to wake R1 if R1 was sleeping at the time of the check. A grievance filed January 26, 2023, indicated staff transferred R1 with one staff and R1 required two assistance for transfers. The incident report indicated after this incident R1 complained of back pain and current pain medications were not sufficient. No MAARC report was filed related to the grievance filed January 26, 2023. R1's progress notes and incident report dated February 27, 2023 at 9:30 p.m., indicated R1 reported to staff she called 911 since she was breathing weird and her color was off and not feeling well. R1 was admitted to the intensive care unit (ICU). R1's hospital records dated Februaray 27, 2023, indicated R1 was admitted to the ICU with septic shock from norovirus. the records indicated R1 had nausea, vomitting and diarrhea for three days	03000		

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03000	Continued From page 48 and other residents at the facility were also ill. R1 was in the hospital for 14 days. There was no follow up related to the February 27, 2023, incident and no MAARC report was filed with the state agency. On July 25, 2023, at 9:30 a.m., an outside agency staff member involved in R1's care, stated on September 19, 2022, R1 called a home health aide to come in early since R1 had not been assisted out of bed all day and had not been able to use the bathroom. The home health aide arrived at the facility around 1:00 p.m., and R1 was in bed. The home health aide noticed R1's pull cord had been activated prior to her arrival and remained in the activated setting (so the resident could not request for further assistance) and R1 informed her staff were purposely not helping her. On July 25, 2023, at 10:00 a.m., R1's county case manager (CM) indicated there had been a lot of issues with the call light system. The CM stated the alarm system could be reset in the hallway and then staff would not need to go and check on the residents. The CM stated management was aware and "dropped the ball on several occasions." R5 R5's diagnoses included Amyotropic Lateral Sclerosis (nervous system disease that affected nerve cells in the brain and spinal cord), and expressive aphasia (loss of ability to speak). R5's undated service plan indicated R5 required assistance with bathing, meals, medication administration, two staff assistance for toileting,	03000		

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03000	Continued From page 49 transfers, bed mobility, and reassurance checks to be completed every two hours. R5's assessment dated June 16, 2023, indicated R5 was non-verbal and utilized her Ipad (electronic device) and hand signals for communication. The report indicated R5 was alert and oriented and indicated the resident worried at night as she was concerned she would need to wait for assistance for a long period of time. On June 27, 2023, at 11:50 p.m., R5's family member (FM)-B stated staff never used the call light system like they were supposed to. FM-B stated staff silenced the call light alarm in the hallway and would not enter the resident's room to provide or inquire about their request for assistance. FM-B recalled two occasions where he had stayed overnight with R5. FM-B pressed the call light and did not get assistance for over two hours and had to locate staff to notify them of the need for assistance. FM-B stated he wanted to make sure R5 would be able to get assistance if needed when he was not at the facility. On June 28, 2023, at 8:50 a.m., RN-B stated he was aware of R5's concerns regarding the call light system and long call light wait times. RN-B stated FM-B thought the overnight staff were sleeping. RN-B stated he talked to staff about this and re-educated them. Despite RN-B's awareness of these concerns and incidents with R5, no MAARC reports were filed with the state agency. On August 1, 2023, FM-B stated on July 4, 2023, R5 pressed the call light early in the morning and staff did not respond. When FM-B arrived at the facility they found R5 in distress and screaming. R5 informed FM-B that she had summoned for	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31337	A. BUILDING: _____ B. WING _____	C 08/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND GW LLC	1925 GRAHAM AVENUE SAINT PAUL, MN 55116

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03000	Continued From page 50 assistance over two hours ago. FM-B then went and found staff to assist R5. This concern was reported to management staff, however no MAARC report was filed related to this incident. On August 3, 2023, RN-B stated he was aware of the long call light wait times. RN-B stated if an alarm is silenced in the hallway, the staff may get busy and forget about that resident, resulting in unanswered call lights. RN-B stated sometimes the alarms are silenced if the staff are busy with another resident. RN-B stated we try and educate the staff on not silencing the alarms. RN-B did not know why these complaints were not reported as suspected maltreatment. On August 7, 2023, at 11:45 a.m., FM-B reported that on Friday evening R5 pressed her call light. FM-B indicated it was very hot that day (around 95 degrees) and R5 did not have an air conditioner in her room. FM-B stated no one came to assist R5 and later the facility noticed that another pull cord in R5's room had not been reset, causing the other call light pull cords in R5's room to be inactive. On August 8, 2023, at 3:00 p.m., LALD-A stated she did not know why the prior complaints or suspected maltreatment were not reported to the state agency. LALD-A stated any suspected abuse or neglect should be reported within 24 hours. The licensee's Vulnerable Adult Maltreatment-Prevention and Reporting, dated August 1, 2021, indicated licensee staff who suspect maltreatment of a resident should report to Minnesota Adult Abuse Reporting Center (MAARC) no later than 24 hours the maltreatment was suspected.	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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03000	Continued From page 51 No further information was provided. TIME PERIOD TO CORRECT: Seven (7) days.	03000		