DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL31761001M
Compliance #: HL31761002C

Date Concluded: May 24, 2022

Name, Address, and County of Licensee Investigated:
Lino Lakes Gracewood
675 Market Place Drive
Lino Lakes, MN 55014
Anoka County

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

Evaluator's Name: Stacia Hansen, RN
Special Investigator

Finding: Substantiated, facility and individual responsibility

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

Allegation(s):
It is alleged: The alleged perpetrators, (AP) 1 and AP 2, neglected resident 1 when they failed to perform scheduled safety checks every two hours during an overnight shift and a day shift.

Investigative Findings and Conclusion:
Neglect was substantiated. The facility and AP 2 were responsible for the maltreatment of resident 1. Resident 1 became symptomatic of COVID-19 with coughing and unsteady gait five days prior to his death. The day before resident 1, the facility was aware of a low oxygen saturation of 79% and failed to provide the resident with any respiratory intervention. That night shift, AP 2 was scheduled to work and slept during her shift. AP 2 failed to provide scheduling toileting services and safety checks to the residents, including resident 1. Resident 1 was found dead by the morning by an infusion therapy personnel. In addition, AP 2 also was responsible for neglect of resident 2 during the night shift. Resident 2 also had COVID-19 and required every two hour monitoring. The same morning, resident 1 was found dead, resident 2

was sent to the hospital for low oxygen saturation of 85%. Resident 2 later died that same evening at the hospital of COVID-19.

Neglect was not substantiated for AP 1's responsibility. While AP 1 failed to administer resident 1's scheduled 8:00 a.m. medications, the medical examiner indicated resident 1 had died approximately 12 hours prior to being found in the morning.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. In addition, the investigator contacted law enforcement and the physician. The investigation included review of resident records including service plans, personnel files, orientation/training, policies and procedures related to maltreatment of vulnerable adults, grievances, incident reports, the facility's internal investigation and a police report. Also, the investigator toured the facility and observed resident/staff interactions.

Resident 1 resided in an assisted living facility. The resident's diagnoses included anemia, chronic kidney disease, dementia, and hypertension. The resident's service plan included scheduled services such as toileting assistance, medication administration, and scheduled reassurance checks (also known as safety checks).

Resident 1's progress notes indicated resident 1 began to have symptoms of cough, unsteady gait and runny nose five days prior to death. On day two of his infection, resident 1 had a fever of 102.3 degrees Fahrenheit (F) and a decreased oxygen saturation of 91%. (The month prior to the incident, resident 1 had an oxygen saturation of 97% when not with an acute infection.) Resident 1 received physician orders for Tylenol (anti-fever medication), "ABX" treatment and a steroid. Approximately two hours later, resident 1 experienced a fall without injury but had an elevated blood pressure of 173/69 and further decreased oxygen saturation to 89% (normal is 90% and above). The nurse sent communication to resident 1's provider. On day three, resident 1 continued to have an elevated blood pressure of 176/88, an oxygen saturation of 92% and his fever had resolved. Resident 1's COVID-19 test results returned with a positive result. The facility updated resident 1's family. The facility had no progress note documentation of resident 1's condition on day four.

On day five, resident 1 had a fever of 100.7, was given Tylenol and had a critically low oxygen saturation of 79% on room air. The nurse dictated resident 1 did not have an order for inhalers or nebulizers and updated the physician through a clinic portal message. The nurse updated family and family reported monoclonal antibody infusion was scheduled for resident 1 the next day at 9:00 a.m.

Resident 1's record indicated no new orders were received to support resident 1's critically low oxygen saturation with supplement oxygen, nebulizer treatment or sending to the hospital. In addition, the record lacked evidence the family refused transfer to the hospital or education from the facility to the family about the emergent need for resident 1 to receive respiratory support.

Resident 2 resided in an assisted living facility. Resident 2's diagnoses included type II diabetes, failure to thrive, weakness and osteoporosis. Resident 2's service plan included toileting assistance, medication administration, and scheduled reassurance checks.

Resident 2's progress notes indicated she also had a positive COVID-19 test result the same day as resident 1. Resident 2 did not have a fever and oxygen saturation was still within normal at 91%. Resident 2 had orders for antibody treatment, a decongestant and a steroid.

Resident 1's service record indicated he required to have toileting assistance during the late evening, overnight and morning at 10:00 p.m., 12:00 a.m., 4:00 a.m. and 7:00 a.m. Resident 1 required safety checks at 8:00 p.m. and 2:00 a.m.

Resident 2's service record indicated she required safety checks during the overnight shift at 12:00 a.m., 2:00 a.m., 4:00 a.m. and 6:00 a.m.

During an interview, an unlicensed personnel (ULP) stated she "peeked in" on resident 1 on the evening shift at 8:30 p.m. The ULP said he was lying in bed and seemed fine, but she did not interact with him.

On the night of day five, AP 2 was scheduled to the work the night shift from 10:00 p.m. to 6:30 a.m.

The facility's internal investigation report indicated resident 1 was found deceased at approximately 9:00 a.m. The investigator from the medical examiner's office stated the resident died from COVID but had been deceased for approximately 12 hours due to rigor mortis being present on exam. Resident 1 required two hour checks between toileting and safety and lacked documentation those were completed on overnight shift by AP 2 nor on the morning shift by AP 1. AP 1 admitted she did not complete her checks and AP 2 reported on her shift everyone was "ok". AP 1 also failed to provider resident 1's 8:00 a.m. medication between 7:00 a.m. and 9:00 a.m.

Resident 2's progress notes indicated (shortly after resident 1 was found dead) staff sent resident 2 to hospital by ambulance at 9:30 a.m. with respirations of 30, heart rate of 150 beats per minute and an oxygen saturation of 85%. Resident 2 died later that afternoon at the hospital from COVID.

Resident 1's death record indicated the cause of death was acute respiratory failure and COVID-19 infection.

Resident 2's death record indicated the cause of death was complications of COVID-19 infection.

The law enforcement report indicated facility staff had found resident 1 not breathing and with no pulse. The law enforcement report indicated the officers, a paramedic and an investigator from the medical examiner's office arrived and confirmed the resident was dead on arrival. Resident 1 had no color left in his face and it was clear he was deceased according to the report. The medical examiner investigator concluded nothing was suspicious and the resident was released to the funeral home.

During an interview, the licensed assistive living director (LALD) stated she conducted an internal investigation and interviewed staff members. The LALD said she had reviewed video footage right after the incident and could see AP 2 sleeping during the overnight shift in a chair across from her office.

During an interview, the nurse stated resident 1's family member made a decision for him to receive monoclonal antibody treatment for COVID on-site at the facility. The nurse stated she contacted resident 1's physician when his oxygen saturations levels became low and they were advised to continue to monitor him on-site at the facility.

During an interview, the physician stated resident 1's family member wanted him to receive monoclonal treatment at the facility. The physician stated she could order oxygen only if resident 1 was on hospice and family member did not want resident 1 to be placed on hospice. The physician stated the last report she received was resident 1 was resting in bed with no complaints of discomfort.

During an interview, AP 1 stated she received verbal report at shift change R1 was ok. She did not check on resident 1 or give him his scheduled 8:00 a.m. meds. AP 1 said her duties were to count medications during shift change when scheduled to work as a medication passer. AP 1 stated the caregivers are responsible to do resident safety checks. AP 1 said her shift began at 6:30 a.m. She helped another resident that morning but could not say how long that took or why she failed to give resident 1 his scheduled 8:00 a.m. medications.

During an interview, AP 2 stated she could not recall when she last checked on resident 1 or resident 2's condition during her shift. AP 2 admitted to sleeping during the shift and she was not sure how long she may have slept for. AP 2 stated she usually set an alarm to wake herself up when she was scheduled to work the overnight shift.

During an interview, another ULP stated that staff members called safety checks "breath" checks. The ULP said these checks consisted of staff members checking to make sure the resident is breathing, comfortable, and not on the floor. The ULP stated she was working with AP 2 on overnight shift but was assigned to the other side (memory care unit) of the facility and assumed everything was fine because AP 2 did not ask for any help.

The facility's safety checks policy indicated that staff members will ensure that safety checks are provided every two hours on the overnight shift.

In conclusion, neglect was substantiated for resident 1 by both the facility and AP 2. Neglect was substantiated for resident 2 by AP 2.

In addition, neglect was not substantiated against AP 1.

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:
(a) 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.
(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Vulnerable Adult interviewed: No, both residents are deceased.
Family/Responsible Party interviewed: No, attempts made to contact by phone and email.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility conducted an internal investigation and filed a MAARC report. The nurse provided education on the importance of reassurance checks to staff members. Also, the facility immediately terminated AP 1 and AP 2's employment after the incident.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment. Also, 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, or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Anoka County Attorney
Lino Lakes City Attorney
Lino Lakes Police Department
Minnesota Board of Nursing
Minnesota Board of Examiners for Nursing Home Administrators
Minnesota Board of Medical Practice
Medical Examiner

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31761	A. BUILDING: _____ B. WING _____	C 03/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINO LAKES GRACEWOOD	**675 MARKET PLACE DRIVE LINO LAKES, MN 55014**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments 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. **********REVISED********** INITIAL COMMENTS: HL31761001M/HL31761002C and HL31761003M/HL31761004C On March 31, 2022, the Minnesota Department of Health conducted a complaint investigation at the above provider. At the time of the complaint investigation, there were 30 clients receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for HL31761001M/HL31761002C, tag identification 0470, 1640, 2360. No correction orders were issued for HL31761003M/HL31761004C.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	

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0 470	Continued From page 1	0 470		
0 470 SS=I	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (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 one person responsible for responding to the requests of residents for assistance with health or safety needs is awake at night. This directly affected two of two residents reviewed (R1, R2) and had the potential to affect all residents.	0 470		

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0 470	Continued From page 2 This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living with dementia care license and was licensed for a bed capacity of 35 residents, with a current census of 30 residents. R1's medical record indicated R1 admitted to the licensee on January 15, 2021, due to diagnoses that included anemia, chronic kidney disease, dementia, and hypertension. R1's service plan agreement dated, January 15, 2021, indicated the resident received services which included medication administration, quarterly nursing assessments, bathing assistance, assistance with dressing and grooming, and reassurance checks. R2's medical record indicated R2 admitted to the licensee on September 22, 2020, due to diagnoses that included type II diabetes, failure to thrive, weakness and osteoporosis. R2's service plan agreement dated, January 29, 2021, indicated the resident received services which included medication administration, quarterly nursing assessments, mobility assistance, assistance with dressing and grooming, and reassurance checks. The licensee's safety checks are referred to as	0 470		

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0 470	Continued From page 3 reassurance checks on the service checkoff list and consist of unlicensed personnel (ULP) ensuring resident safety by physically visualizing the resident. The licensee's staffing schedule for the December 9, 2021, NOC (night) shift 10:30 p.m. to 6:30 a.m. indicated ULP-I was assigned to work in AL (assisted living) rooms 1-18 and ULP-G was assigned to work in MC (memory care) rooms 19-35. An undated licensee incident report indicated on December 10, 2021, R1, who resided in room 11, should have received safety checks every two hours on overnight shift and no documentation had been completed that safety checks were done at 12:00 a.m., 2:00 a.m., 4:00 a.m., and 6:00 a.m. on December 10, 2021. The incident report indicated R1 was found deceased in his room at approximately 9:00 a.m. on December 10, 2021. The medical examiner's office stated he died from COVID (Coronavirus disease). R2 ,who resided in room 6, should have received safety checks every two hours on the overnight shift and no documentation was completed that safety checks had been done at 12:00 a.m. and 6:00 a.m. on December 10, 2021. The progress note indicated on December 10, 2021, R2 was sent to the hospital via ambulance shortly after R1 was found deceased in his room and R2 died later the same day at the hospital due to complications from COVID. During an interview on April 1, 2022, at 11:15 a.m., licensed assisting living director (LALD)-E stated she viewed the video after the incident and she could see ULP-I sleeping in a chair across from her office. LALD-E reported that ULP-I's	0 470		

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0 470	Continued From page 4 employment was terminated on December 10, 2021, due to her sleeping on her scheduled overnight shift. During a phone interview on April 8, 2022, at 1:15 p.m., ULP-I stated she usually set an alarm in case she did fall asleep during her overnight shifts. She admitted to sleeping and could not recall how long she may have slept during her shift of the reported incident on December 10, 2021. The licensee's policy titled "ALDC Physical Environment & Staffing" dated August 1, 2021, indicated an awake staff person will be physically present within the secured unit at all times. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
01640 SS=I	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. (c) The facility must implement and provide all services required by the current service plan.	01640		

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01640	Continued From page 5 (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide scheduled safety checks and document when safety checks were provided for 14 of 14 residents (R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13 and R14) with records reviewed. This had the potential to affect all 30 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, 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). The findings include: The licensee's safety checks are referred to as reassurance checks on the service checkoff list and consist of unlicensed personnel (ULP) ensuring resident safety by physically visualizing the resident. R1's medical record was reviewed. R1's diagnoses included anemia, chronic kidney disease, dementia, and hypertension. R1's service plan agreement dated January 15, 2021,	01640		

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01640	Continued From page 6 indicated the resident received services which included medication administration, quarterly nursing assessments, bathing assistance, assistance with dressing and grooming, and reassurance checks. R1's service checkoff list for December 2021, lacked documented reassurance checks at 12:00 a.m., 2:00 a.m., 4:00 a.m., and 6:00 a.m. on: -December 1, 2021 -December 2, 2021 -December 5, 2021 -December 6, 2021 -December 7, 2021 -December 8, 2021 -December 9, 2021 -December 10, 2021 An undated licensee incident report indicated ULP-I admitted to not doing R1's safety checks during her overnight shift on December 10, 2021, and R1 was found deceased in his room at approximately 9:00 a.m. on December 10, 2021. The medical examiner's office stated he died from COVID (Coronavirus disease). R2's medical record was reviewed. R2's diagnoses included type II diabetes, failure to thrive, weakness and osteoporosis. R2's service plan agreement dated January 29, 2021, indicated R2 received services which included medication administration, quarterly nursing assessments, mobility assistance, assistance with dressing and grooming, and reassurance checks. R2's service checkoff list for December 2021, lacked documented reassurance checks at 12:00 a.m., 2:00 a.m., 4:00 a.m., and 6:00 a.m. on: -December 1, 2021	01640		

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01640	Continued From page 7 -December 2, 2021 -December 5, 2021 R2's record lacked documented reassurance checks at 6:00 a.m. on: -December 6, 2021 -December 7, 2021 -December 8, 2021 -December 9, 2021 -December 10, 2021 R2's progress note indicated on December 10, 2021, R2 was sent to the hospital via ambulance shortly after R1 was found deceased in his room and died later the same day at the hospital due to complications from COVID. R3's medical record was reviewed. R3's diagnoses included Parkinson's disease and dementia. R3's service plan agreement dated February 14, 2022, indicated R3 received services which included medication administration, quarterly nursing assessments, bathing assistance, feeding assistance, mobility assistance, toileting assistance, assistance with dressing and grooming, and reassurance checks. R3's service checkoff list for December 2021, lacked documented reassurance checks at 12:00 a.m., 2:00 a.m., 4:00 a.m., and 6:00 a.m. on: -December 7, 2021 -December 8, 2021 -December 9, 2021 -December 10, 2021 -December 11, 2021 -December 12, 2021 R4's medical record was reviewed. R4's diagnoses included atrial fibrillation and congestive heart failure. R4's service plan agreement, dated January 31,	01640		

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01640	Continued From page 8 2022, indicated R4 received services which included medication administration, quarterly nursing assessments, feeding assistance, mobility assistance, toileting assistance, assistance with dressing and grooming, and reassurance checks. R4's service checkoff list for December 2021, lacked documented reassurance checks at 12:00 a.m., 2:00 a.m., 4:00 a.m., and 6:00 a.m. on December 5, 2021, and December 12, 2021. R5's medical record was reviewed. R5's diagnoses included dementia, hypertension and depression. R5's service plan agreement dated, February 1, 2022, indicated R5 received services which included medication administration, quarterly nursing assessments, bathing assistance, assistance with dressing and grooming, and reassurance checks. R5's service checkoff list for December 2021, lacked documented reassurance checks at 12:00 a.m., 2:00 a.m., 4:00 a.m., and 6:00 a.m. on: -December 5, 2021 -December 11, 2021 -December 12, 2021 -December 13, 2021 -December 18, 2021 -December 19, 2021 R6's medical record was reviewed. R6's diagnoses included Parkinson's disease, glaucoma and hypertension. R6's service plan agreement dated, December 30, 2021, indicated R6 received services which included medication administration, quarterly nursing assessments, bathing assistance, assistance with dressing and grooming, and reassurance checks.	01640		

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	31761	A. BUILDING: _____ B. WING _____	C 03/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINO LAKES GRACEWOOD	675 MARKET PLACE DRIVE LINO LAKES, MN 55014

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01640	Continued From page 9 R6's service checkoff list for December 2021 lacked documented reassurance checks at 12:00 a.m., 2:00 a.m., 4:00 a.m., and 6:00 a.m. on: -December 5, 2021 -December 7, 2021 -December 8, 2021 -December 9, 2021 -December 10, 2021 R7's medical record was reviewed. R7's diagnoses included atrial fibrillation, edema and hypertension. R7's service plan agreement dated, March 23, 2022, indicated R7 received services which included medication administration, quarterly nursing assessments, bathing assistance, assistance with dressing and grooming, and reassurance checks. R7's service checkoff list for December 2021, lacked documented reassurance checks at 12:00 a.m., 2:00 a.m., 4:00 a.m., and 6:00 a.m. on: -December 5, 2021 -December 12, 2021 -December 13, 2021 R8's medical record was reviewed. R8's diagnoses included kidney disease, depression, edema and heart failure. R8's service plan agreement dated, March 14, 2022, indicated R8 received services which included medication administration, quarterly nursing assessments, bathing assistance, assistance with dressing and grooming, and reassurance checks. R8's service checkoff list for December 2021, lacked documented reassurance checks at 12:00 a.m., 2:00 a.m., 4:00 a.m., and 6:00 a.m. on December 5, 2021. R9's medical record was reviewed. R9's	01640		

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01640	Continued From page 10 diagnoses included Alzheimer's disease, epilepsy and hypertension. R9's service plan agreement dated, March 21, 2022, indicated R9 received services which included medication administration, quarterly nursing assessments, bathing assistance, assistance with dressing and grooming, and reassurance checks. R9's service checkoff list for December 2021, lacked documented reassurance checks at 12:00 a.m., 2:00 a.m., 4:00 a.m., and 6:00 a.m. on December 5, 2021. R10's medical record was reviewed. R10's diagnoses included Alzheimer's disease, depression and weakness. R10's service plan agreement dated, March 21, 2022, indicated R10 received services which included medication administration, quarterly nursing assessments, bathing assistance, assistance with dressing and grooming, and reassurance checks. R10's service checkoff list for December 2021, lacked documented reassurance checks at 12:00 a.m., 2:00 a.m., 4:00 a.m., and 6:00 a.m. on December 5, 2021, and December 11, 2021. R11's medical record was reviewed. R11's diagnoses included anemia, chronic kidney disease and hypertension. R11's service plan agreement dated, March 21, 2022, indicated R11 received services which included medication administration, quarterly nursing assessments, bathing assistance, assistance with dressing and grooming, and reassurance checks. R11's service checkoff list for December 2021, lacked documented reassurance checks at 12:00 a.m., 2:00 a.m., 4:00 a.m., and 6:00 a.m. on: -December 5, 2021	01640		

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01640	Continued From page 11 -December 10, 2021 -December 18, 2021 -December 19, 2021 R12's medical record was reviewed. R12's diagnoses included multiple sclerosis, chronic low back pain and hypertension. R12's service plan agreement dated, February 18, 2022, indicated R12 received services which included medication administration, quarterly nursing assessments, bathing assistance, assistance with dressing and grooming, and reassurance checks. R12's service checkoff list for December 2021, lacked documented reassurance checks at 12:00 a.m., 2:00 a.m., 4:00 a.m., and 6:00 a.m. on December 5, 2021. R13's medical record was reviewed. R13's diagnoses included arthritis, chronic renal disease and type 2 diabetes. R13's service plan agreement dated, March 21, 2022, indicated R13 received services which included medication administration, quarterly nursing assessments, bathing assistance, assistance with dressing and grooming, and reassurance checks. R13's service checkoff list for December 2021, lacked documented reassurance checks at 12:00 a.m., 2:00 a.m., 4:00 a.m., and 6:00 a.m. on: -December 5, 2021 -December 11, 2021 -December 12, 2021 -December 13, 2021 R14's medical record was reviewed. R14's diagnoses included dementia, osteoporosis and peripheral vascular disease. R14's Individual Service Plan Agreement dated, February 1, 2022, indicated R14 received services which included	01640		

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01640	Continued From page 12 medication administration, quarterly nursing assessments, bathing assistance, assistance with dressing and grooming, and reassurance checks. R14's service checkoff list for March 2022, lacked documented reassurance checks at 12:00 a.m., 2:00 a.m., 4:00 a.m., and 6:00 a.m. on: -March 9, 2022 -March 13, 2022 -March 24, 2022 -March 27, 2022 -March 28, 2022 -March 31, 2022 During an interview on March 31, 2022, at 1:45 p.m., the registered nurse (RN)-D stated staff are trained to put their initials on the service check off list after they have completed their assigned task. Also, RN-D stated she started to audit staff to ensure documentation is being completed and educate staff on importance of safety checks. During an interview on April 1, 2022, at 11:15 a.m., licensed assisting living director (LALD)-E stated she viewed the video after the incident and she could see ULP-I sleeping in a chair across from her office. LALD-E reported that ULP-I's employment was terminated after the incident. The licensee's 7.48 Safety Checks policy dated November 6, 2021, indicated that in assisted living, safety checks will be provided every two hours on the overnight shift. TIME PERIOD FOR CORRECTION: Seven (7) days	01640		
02360	144G.91 Subd. 8 Freedom from maltreatment	02360		

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02360	Continued From page 13 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 two of two residents reviewed were free from maltreatment. R1 and R2 were neglected. Findings include: On May 24, 2022, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility and an individual staff person were responsible for the maltreatment of R1 and the an individual staff person was responsible for the maltreatment of R2, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	02360	No plan of correction required for tag 2360, please refer to the public maltreatment report (sent separately) for details.	