Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL348752600M
Compliance #: HL348751804C

Date Concluded: May 20, 2024

Name, Address, and County of Licensee Investigated:
Talamore Senior Living
215 37th Avenue North
St. Cloud, MN 56303
Sherburne County

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

Evaluator's Name: Brandon Martfeld, RN BSN
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 identify the resident's change in condition. That failure led to facility staff providing inappropriate care and services for the resident including oral cares, bathing, and repositioning, The resident developed a coccyx (tailbone) wound. In addition, the resident experienced 17 falls in one year.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to identify a sudden decline in the resident's condition that required increased staff assistance to complete the resident's care. The resident experienced poor hygiene, oral hygiene, and lacked a repositioning schedule to maintain the resident's skin integrity. The resident developed a coccyx wound.

The Minnesota Department of Health determined neglect related to the resident's frequent falls was not substantiated. In the seven months the resident resided in the memory care unit, the resident had three unrelated falls without injury.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator interviewed a hospice nurse and a family member. The investigation included review of the resident records, death record, hospice records, facility incident reports, staff schedules, related facility policy and procedures. Also, the investigator observed staff and residents at the facility.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Parkinson's disease, Lewy body dementia, blindness, anxiety, and depression. The resident required a wheelchair for mobility.

Early one month, an assessment indicated the resident had impaired cognition, had no wounds, no difficulty with swallowing, and required a regular diet with thin liquids. The resident had no change in appetite or weight loss in the previous three months. The resident used a bedrail to assist with bed mobility and required one staff and a mechanical stand lift for transfers. The resident required assist of one staff for bathing one time a week, denture, and oral care, and staff assistance to and from meals three times a day. Staff administered the resident's medications four times a day. The assessment did not indicate the resident required assistance with repositioning either in bed or in the wheelchair. The resident's individual abuse prevention plan indicated no vulnerabilities or abuse concerns.

Five days after the assessment, the resident's record indicated the resident had a fall while trying to transfer out of bed with assistance of a family member.

Twelve days after the assessment, the resident's record indicated the facility requested a physician's order for thicken liquids and a referral to hospice.

Two days later, staff reported the resident had a "large" open area on his coccyx, measuring approximately two inches and bleeding. Staff cleansed and covered the wound with a dressing. The facility record lacked evidence of a plan of care for on-going dressing changes and lacked a repositioning schedule for the resident.

In the two weeks following the assessment, the resident had a fall, a change in diet, a referral to hospice, and developed a coccyx wound. The resident's record lacked interventions to care for the resident with the change in condition.

Sixteen days after the facility's assessment, the contracted hospice admission assessment indicated the resident was non-weight bearing, required a mechanical sling lift for transfers, required staff assistance to reposition every two hours, and was incontinent of bowel and bladder. The resident required assistance with bathing, grooming, dressing, eating, and had

poor nutrition. In a nine-month period prior to the hospice admission the resident had a 44-pound weight loss. The resident was disorientated and lethargic. A family member reported to hospice the resident had not been bathed in weeks.

The resident's record indicated facility staff failed to provide the resident assistance with bathing for 16 days.

The facility failed to update the resident's care needs until after the hospice assessment that identified an increase in the resident's needs.

The resident's death record indicated the resident died two days after admitting to hospice services. The resident cause of death was Parkinson's disease with other significant conditions contributing to the resident's death included malnutrition and Lewy-body dementia.

During an interview a contracted hospice nurse stated the day of the resident's admission to hospice, the resident was resting in bed, his eyes crusted shut with oral pills partially disintegrated in the resident's mouth. The resident's clothes and face were soiled with leftover food. In addition, the resident was unkempt and appeared that he had not been bathed for some time. The hospice nurse indicated she completed oral cares with multiple oral swabs, a partial bed bath, and changed the resident clothes. The hospice nurse stated she arranged for a mechanical sling lift and a pressure reducing mattress to be delivered to the facility for the resident.

During an interview, a facility nurse stated the facility completed an assessment for every resident during admission, every 90 days, and with a change in condition. The facility nurse stated a change in condition assessment should be completed when a resident returned from the hospital or required more staff assistance. Determining a change in condition is assessed either by the nurse or what staff are reporting to the nurse. The facility nurse stated she did not assess the resident for a change in condition until notified by hospice of the resident's change in condition.

During an interview, nursing leadership stated a different nurse completed all the assessments including a change in condition assessment. The resident had refused bathing on his scheduled day, however, the resident's record lacked documentation of staff reattempting or rescheduling the resident's bath. Nursing leadership stated the resident's delivery record indicated the resident did not receive a bath for two weeks prior to him passing away. Nursing leadership stated another nurse looked at the resident's wound. The facility failed to provide an interventions and an assessment of the resident coccyx wound.

During an interview, a family member stated they requested hospice services for the resident, not facility staff. The family member stated staff were to complete all the resident's cares, which included dressing, bathing, oral hygiene, and toileting. The family member stated hygiene and clipping the resident's fingernails was not completed. The resident did not appear very

clean. The family member was told the resident often refused bathing and cares however, the resident did not have the cognitive ability to refuse and if he did refuse, the facility did not return to offer the care at a later time. The resident spent most of his time in bed and did not use the restroom.

Another concern investigated included the resident experiencing several falls within one year. Review of the resident record indicated in the seven months the resident resided in the memory care unit, the resident experienced three falls; one when the resident attempted to self-transfer, another during seizure like activity, and one when a family member attempted to transfer the resident. The facility provided safety checks for the resident and reminded the family member to request staff assistance with transfers.

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. The resident was deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility cleansed and applied a dressing to the resident’s wound. After hospice services were initiated, the facility completed an assessment on the resident.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

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

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Sherburne County Attorney
St. Cloud City Attorney
St. Cloud Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34875	A. BUILDING: _____ B. WING _____	C 03/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TALAMORE SENIOR LIVING	215 37TH AVENUE NORTH SAINT CLOUD, MN 56303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER 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: #HL348752540M/#HL348751720C #HL348752620M/#HL348751920C #HL348752600M /#HL348751804C On March 26, 2024, 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 123 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order are issued for #HL348752540M/#HL348751720C, tag identification 2310 and 2360. The following correction orders are issued for #HL348752620M/#HL348751920C / #HL348752600M/#HL348751804C, tag identification 1620, 2310 and 2360.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. 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 SUBDIVISION 1-3.	

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01620	Continued From page 1	01620		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to conduct a comprehensive reassessment for one of three residents (R3) with a change of condition. This failure had the potential to effect the care and services provided for all the resident with a change in condition. 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	01620		

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01620	Continued From page 2 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: R3's record indicated the resident's diagnoses included Parkinson's disease, Lewy body dementia, anxiety, and depression. R3's 90-day assessment dated January 3, 2024, indicated R3 had impaired cognition, had no wounds, no difficulty with swallowing, and required a regular diet with thin liquids. R3 had no change in appetite or weight loss in the previous three months. R3 used a bedrail to assist with bed mobility and required one staff and a mechanical stand lift for transfers. R3 required one staff for assistance with bathing one time a week, denture and oral care, and staff assistance to and from meals three times a day. R3's medications were administered by staff four times a day. R3's assessment lacked evidence that R3 required assistance with repositioning either in bed or in the wheelchair. R3's individual abuse prevention plan indicated R3 had no vulnerabilities or abuse concerns. R3's incident report dated January 8, 2024, indicated R3 was found on the floor after R3's family member attempted to transfer R3 out of bed. Progress notes dated January 15, 2024, indicated an order was sent to R3's physician requesting thicken liquids for R3. That same day, the progress notes indicated R3's family member	01620		

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01620	Continued From page 3 requested hospice services. Progress notes dated January 17, 2024, indicated R3 had a "large" open area on his coccyx, measuring approximately two inches and bleeding. Staff cleansed and covered the wound with a dressing. R3's medical record lacked evidence of a plan of care for on-going dressing changes and lacked a repositioning schedule for R3. R3's hospice admission assessment dated January 19, 2024, indicated R3 was non-weight bearing, required a mechanical sling lift for transfers, required staff assistance to reposition every two hours, and was incontinent of bowel and bladder. R3 required assistance with bathing, grooming, dressing, eating, and had poor nutrition. R3's hospice admission assessment further indicated R3 had a 44-pound weight loss in a nine-month period. R3 was disorientated and lethargic. On January 19, 2024, R3 had a 90-day assessment completed. R3's death record indicated R3 died January 21, 2024. R3's cause of death was Parkinson's disease. R3's death record indicated other significant conditions contributing to the R3's death included malnutrition and Lewy-body dementia. During an interview on March 27, 2024, at 8:30 a.m. the hospice nurse stated the day R3 admitted to hospice, R3 was resting in bed, his eyes crusted shut with oral pills partially disintegrated in his mouth. R3's clothes and face were soiled with leftover food. In addition, R3 was unkempt and appeared that he had not been	01620		

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01620	Continued From page 4 bathed for some time. The hospice nurse stated she completed oral cares with multiple oral swabs, a partial bed bath, and changed the resident clothes. The hospice nurse stated she arranged for a mechanical sling lift and a pressure reducing mattress to be delivered to the licensee for the resident. During an interview on March 28, 2024, at 1:32 p.m. registered nurse (RN)-F stated she completed an assessment for every resident during admission, every 90 days, and with a change in condition. RN-F stated a change in condition assessment should be completed when a resident returned from the hospital or required more staff assistance. Determining a change in condition was assessed either by the nurse or what staff are reporting to the nurse. RN-D stated a change in condition assessment was completed for R3 once she knew the resident was receiving hospice services. During an interview on March 29, 2024, at 8:26 a.m., Director of nursing (DON)-B stated RN-F completed all the assessments including change in condition assessments. R3 had refused bathing on his scheduled day, however, R3's record lacked documentation of staff reattempting or rescheduling R3's bath. DON-B stated the R3's delivery record indicated R3 did not receive a bath for two weeks prior to him passing away. DON-B stated another nurse looked at R3's coccyx wound. The facility failed to provide an assessment of the R3's coccyx wound. The licensee's Initial and On-going Nursing Assessment of Residents policy dated August 1, 2021, indicated the registered nurse (RN) would reassess the resident if the resident had a change in condition.	01620		

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01620	Continued From page 5 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01620		
02310 SS=H	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 provide the care and services according to the acceptable health care medical and nursing standards for two of three residents (R1 and R2) reviewed for refusal of care and were dependent on staff for care. 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1's diagnoses included Alzheimer's disease with late onset and inflammatory disorders of scrotum.	02310		

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02310	Continued From page 6 R1's service plan dated May 1, 2023, indicated R1 received services which included application of topical medication, safety checks, bathing, and medication management. R1's admission assessment dated May 1, 2023, indicated R1 had been hospitalized a month prior for a scrotal infection. R1's progress notes dated January 10, 2024, indicated, change adult diaper, and pants every morning. R1's individual abuse prevention plan dated January 30, 2024, indicated R1 had no vulnerabilities. R1's assessment dated January 30, 2024, indicated R1 had verbal aggression and frequently needed reassurance and redirection. R1's assessment indicated R1 required assistance with toileting and/or continence care and the care was provided by R1's family member (FM)-D. R1's assessment indicated R1 was independent with skin care needs, had no wounds, and had no skin concerns. R1's physician order dated February 29, 2024, indicated Nystatin (anti-fungal) cream apply three times a day to diaper area until rash is healed. R1's medication sheet dated February 2024, and March 2024, indicated R1 did not receive 24 doses of 28 scheduled doses of Nystatin 100,000 unit/G cream. R1's medication sheet lacked evidence of why the medication was not applied. R1's progress notes dated March 9, 2024, at 1:04 p.m. indicated licensed practical nurse (LPN)-E	02310		

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02310	Continued From page 7 received a call from staff. R1 refused to get changed and family requested a nurse attempt to change R1. LPN-E attempted to change R1. R1 refused multiple times. LPN-E told R1 he was covered in urine and R1 continued to refuse. LPN-E attempted to tell R1 he could stay laying down and R1 could be changed while laying there. R1 agreed but when LPN-E attempted to remove the soiled pants, R1 started kicking and said "no". R1 stated, "you're a bitch" and continued to refuse. LPN-E told R1 they would continue to reattempt until R1 was changed. R1's progress notes dated March 10, 2024, at 2:48 p.m. indicated the on call registered nurse was notified that R1 was resistive to cares, was complaining of flank pain (below the rib cage and above the waist) and was incontinent. The note indicated R1 was resistive to cares and R1 was still in same clothing since the previous day. R1's family requested R1 be sent to the emergency room. R1's hospital record dated March 10, 2024, indicated R1 had increased agitation and according to the family the week prior R1 had stayed in bed, refused care from staff with agitation, and did not eat unless being fed. R1 arrived at the hospital with incontinent products soaked with urine and soiled with feces. R1's scrotum was significantly red and painful. R1 was last changed by FM-D on March 8, 2024 (2 days earlier). R1 was diagnoses with scrotal cellulitis and during his hospitalization, R1's overall health declined. R1 was placed on comfort cares and died at the hospital 10 days later. R1's death report indicated R1's cause of death was Alzheimer's dementia with behavioral disturbance, severe scrotum cellulitis due to poor	02310		

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02310	Continued From page 8 hygiene, failure to thrive, and urinary retention requiring catheter placement. During an interview on March 28, 2024, at 9:10 a.m., family member (FM)-D stated she expected the licensee to provide R1 when she was gone. FM-D stated staff came to complete cares for R1 however, R1 would say "no." Staff would leave the room and document that R1 had refused and did not complete the care. During an interview on April 2, 2024, at 8:28 a.m., LPN-E stated she received a call on March 9, 2024, that R1 would not let staff assist with changing him and he kept kicking at staff. LPN-E stated she told R1 that the room smelt and that she really needed to change him. LPN-E stated family member (FM)-F asked what should be done next and what the plan was for R1. LPN-E called director of nursing (DON)-B who advised LPN-E to administer an as needed medication for anxiety. LPN-E advised staff to administer the medication and attempt to redirect R1. LPN-E stated if the as needed medication did not work staff were directed to administer the scheduled anti-anxiety and reattempt cares. LPN-E stated she assumed the cares were completed until she got a call from staff during her shift the next day on March 10, 2024, when FM-F wanted R1 sent to the hospital. LPN-E stated FM-F reported he he assisted R1 to get up, R1 started to scream and was in pain. LPN-E called the on call registered nurse and it was agreed to send R1 to the emergency room. LPN-E stated she was not aware R1 had a groin rash. LPN-E stated the licensee had no plan in place for R1's refusals. During an interview on March 27, 2024, at 3:00 p.m., DON-B stated when FM-D would be out of town the facility staff would take over R1's	02310		

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02310	Continued From page 9 dressing/grooming, bathing, toileting, and incontinent care. DON-B stated a better plan should have been in place for R1's refusals knowing that FM-D was going to be gone. R2 R2's diagnoses included unspecified lump in the right breast, overlapping quadrants and unspecified dementia. R2's service plan dated May 1, 2023, indicated R2 received services which included bathing assistance, dressing/ grooming assistance, dining escort and medication management. R2's assessment dated February 28, 2024, indicated R2 was orientated to self and had short and long term memory loss. During an observation on March 26, 2024, at 12:18 p.m. the investigator knocked on R2's door and R2 did not answer. While walking in the hallway the investigator asked ULP-G why the door was locked. ULP-G stated usually slept until after lunch. ULP-G stated R2 liked to stay up late and play cards with other residents. The investigator had unlicensed personnel (ULP)-G open R2's door. When the investigator entered the room there was a strong smell of urine. R2 was laying in her bed with her eyes closed in a nightgown. Unopened boost (protein drink) sitting on the night stand. No observation of lunch or beverage in R2's apartment. During an interview on March 26, 2024, at 12:18 p.m. R2 stated the staff do not check on her often. R2 stated she had not been offered lunch at the time of the investigator interview.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34875	A. BUILDING: _____ B. WING _____	C 03/26/2024

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02310	Continued From page 10 R2's service check off list dated March, 2024, indicated R2 received: 7 :00 a.m. dressing: cueing/standby 13 times out of 31 times scheduled. 7:00 a.m. grooming: cueing/standby 13 times out of 31 times scheduled. 7:00 a.m. oral care: cueing/standby 15 times out of the 31 times scheduled. 7:30 a.m. dining: escort 14 times out of the 31 times scheduled. R2's service check off indicated R2 ate breakfast 4 times out of 31 days. 11:30 a.m. dining: escort: 17 times out of 31 times scheduled. R2's service check off indicated R2 ate lunch 8 times out of 31 days. 3:00 p.m. bathing: physical assist 1: 1 time out of 5 times scheduled. R2's medical record lacked evidence the licensee had a plan in place for R2's refusals of care. During an interview on March 27, 2024, at 1:00 p.m., registered nurse (RN)-D stated R2 had a history of chronically refusing cares however, with redirection she was usually compliant. RN-D stated licensee staff have reported to her that they just let R2 do her own thing and don't attempt to help anymore. During an interview on March 27, 2024, at 12:38 p.m., family member (FM)-C stated R2 refused cares once in a while and the licensee just lets it go. R2 doesn't really get bathed or showered like she should. During an interview on March 27,2024, at 3:15 p.m., DON-B stated staff are educated to reapproach, ask a coworker to attempt if a resident refuses care or medications. If refusals continue, they are to reach out to a nurse and get direction from the nurse.	02310		

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02310	Continued From page 11 During an interview on March 28, 2024, at 11:00 a.m. licensed assisted living director (LALD)-A stated the expectation for staff was to report any concerns or changes with the residents to the nurses. When necessary, the nurses completed an assessment for the resident and update the residents' provider when needed. The licensee's uniform disclosure of assisted living services and amenities (UDALSA) undated indicated the licensee was prepared to manage challenging behaviors based on the registered nurse assessment. The licensee's behavioral symptoms and interventions in ALDC dated November 2, 2021, indicated the licensee would evaluate each resident for any behavioral symptoms that may be disturbing to the resident and to determine individual intervention plans. Each resident would be evaluated for a history or demonstration of behavioral symptoms as part of the assessment conducted by the registered nurse. Evident behaviors would be evaluated in attempt to determine a root cause, triggers, or patterns of behaviors, as well as approaches that would comfort the individual to minimize or eliminate the behavior. Staff and family would be consulted for interventions that are effective that could be shared with other staff. Each direct care staff person would be oriented to the individual resident and their needs. Consultation with the individual's physician would occur to assure appropriate diagnosis and treatment. The licensee's Initial and On-going Nursing Assessment of Residents policy dated August 1, 2021, indicated the registered nurse (RN) would reassess the resident if the resident had a	02310		

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02310	Continued From page 12 change in condition. No further information was provided. TIME FOR CORRECTION: Seven (7) 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: The facility failed to ensure two of three residents reviewed (R1 and R3) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No plan of correction is required for this tag.	