

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL360213705M Date Concluded: February 23, 2023

Compliance #: HL360216087C

Name, Address, and County of Licensee Investigated:

The Preserve of Roseville 2600 Dale Street North Roseville, MN 55113 Ramsey County

Facility Type: Assisted Living Facility with Evaluator's Na

Dementia Care (ALFDC)

Evaluator's Name: Peggy Boeck, RN

Special Investigator

Finding: Substantiated, facility responsibility

Nature of Visit:

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

Initial Investigation Allegation(s):

Alleged perpetrator (AP)1 and AP2 abused a resident when they held the resident down and forced a wanderguard alarm bracelet (a device that notified staff when a resident was out of a certain area) onto the resident's wrist, leaving bruises.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined abuse was substantiated. The facility was responsible for the maltreatment. The resident clearly recalled staff restraining her to place a wanderguard alarm bracelet on her wrist, even though the resident told them no. The resident's family member stated the staff involved told her an administrative staff directed staff to hold the resident to get the wanderguard on. The resident's legal representative (who held power of attorney) stated the administrative staff verified she told staff to place the wanderguard. The nurse at the facility at the time of the incident stated the administrative staff directed staff to restrain the resident. The facility failed to provide documentation to assist in the investigation, such as contact information of the staff involved in the restraint, names of

staff involved, or other relevant documentation, so it was inconclusive as to which staff were involved in the restraint.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family and POA. The investigation included review of the resident's facility record, incident reports, personnel files, policies, and procedures related to resident belongings, wandering, elopement, and maltreatment of vulnerable adults. (Multiple documents requested for the investigation were not provided by the facility, including contact information for AP1 and the identity of AP2.) Also, the investigator observed staff/resident interaction on the locked memory care units.

The resident lived in an assisted living memory care unit. The resident's diagnoses included mild cognitive impairment, generalized anxiety, and primary insomnia. The resident's service plan included assistance with orientation, medication administration, encouragement to participate in activities, providing supplies for bathing/grooming/hygiene, meals, safety checks during the night, encouragement to use her walker, housekeeping, and laundry.

The resident's care plan indicated the resident bathed independently, groomed independently, ate independently in her apartment, toileted independently, and used her cell phone independently. The care plan indicated the resident received "24-hour supervision and visual checks in the memory care unit".

The resident's abuse prevention plan did not identify elopement or wandering as a vulnerability.

The facility failed to provide copies of the resident's nursing assessments.

Progress notes indicated the resident followed someone off the locked memory care unit twice in one day and walked down to the front desk, as she had not received her daily newspaper and wanted to know if it had been delivered. One progress note indicated the resident told a nurse that she knew the code for the locked door. The next progress note indicated the resident struck at a staff who attempted to place a wanderguard alarm on the resident's wrist. The progress note indicated the resident verbalized she did not want to wear the wanderguard, but the staff put it on her anyway. The progress note indicated the resident received a bruise during the placement of the wanderguard.

During an interview, a former nurse stated he did not authorize staff to restrain the resident to place the wanderguard alarm, it came from the regional director. The former nurse could not identify the staff involved and stated he did not see a bruise on the resident's wrist.

During an interview, a family member stated the resident called her on the day of the incident crying hysterically. The resident was upset staff had held her down to place an alarm bracelet on her wrist. The family member stated she immediately went to the facility, observed a bruise

on the resident's wrist, and took a photo. The family member stated she requested to speak with an administrative staff, but the administrative staff would not discuss the incident with her as she was not identified as the resident's POA.

During an interview, the resident's POA stated she got a call from the resident on the day of the incident. The POA stated the resident was crying and in distress. The POA stated the resident told her she felt violated by the staff who held her down. The POA stated no one from the facility called her about the wanderguard alarm. The POA stated staff told her an administrative staff directed the staff to put the wanderguard on the resident. The POA stated she called the administrative staff and told them to remove the wanderguard immediately. The POA stated the facility knew the resident had the code to get out of the memory care unit, as it was not the first time the resident used the code to leave the locked unit. The POA stated she had no concerns about the resident attempting to leave the building and overall has had a positive experience with the facility.

During an interview, the administrative staff stated the staff called her about the resident leaving the locked memory care unit and they decided to place a wanderguard on the resident for extra safety. The administrative staff stated she was aware the resident received a bruise during the incident but denied telling the staff to restrain the resident to place the wanderguard. The administrative staff was "not sure" about the resident's right to refuse the wanderguard.

The current administrative staff indicated they had no knowledge of the incident as it occurred prior to her hire date.

The current nurse indicated they were aware the resident left the memory care unit and saw the resident walk down to the front desk but was not aware of the incident with the wanderguard alarm bracelet.

In conclusion, abuse is substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.

"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.

"Abuse" means:

- (a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
- (1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
- (2) the use of drugs to injure or facilitate crime as defined in section 609.235;
- (3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and

(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.

A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.

- (b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
- (1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
- (2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening;
- (3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult.

Vulnerable Adult interviewed: Yes

Family/Responsible Party interviewed: Yes

Alleged Perpetrator interviewed: AP1-Did not respond to e-mail request for an interview and the investigator had no other contact information, AP2- Not identified by the facility.

Action taken by facility:

The facility changed the code to the exit door for the locked memory care unit.

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

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

Ramsey County Attorney

Roseville City Attorney

Roseville Police Department

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION	COMPLETED	
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	******ATTENTION** ASSISTED LIVING CORRECTION OR In accordance with to 144G.95, this compursuant to a computation of the c	PROVIDER LICENSING DER Minnesota Statutes,144G.08 rection order is issued laint investigation. nether a violation is corrected with all requirements ute number indicated below. Statute contains several apply with any of the items will of compliance. TS: HL360213705M 3, the Minnesota Department d a complaint investigation at and the following correction at the time of the complaint were 55 residents receiving provider's Assisted Living with		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal so Tag numbers have been assigned Minnesota State Statutes for Assis Living Facilities. The assigned tag number appears in the far left coluentitled "ID Prefix Tag." The state so number and the corresponding text state Statute out of compliance is the "Summary Statement of Deficicolumn. This column also includes findings which are in violation of the requirement after the statement, "Minnesota requirement is not met evidenced by." Following the evaluation findings is the Time Period for Corputate Disregard The Fourth Column Which States, "Provider's Plan of Correction." This applies the Federal Deficiencies only. Will appear on Each Page. There is no requirement to Submit a Plan of Correction." The Sapplies the Time Period Sonly. Will appear on Each Page. There is no requirement to Submit a Plan of Correction. There is no requirement as a state of the page. There is no requirement to Submit a Plan of Correction. There is no requirement as a state of the page. There is no requirement to Submit a Plan of Correction. There is no requirement as a state of the page. There is no requirement of Deficience in the page of the page	oftware. to ted mn Statute tt of the isted in encies" the e state This as ators' rection. DING OF O THIS ON FOR TATE JMN IS ES AND	
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Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Minnesota Department of Health

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Minnesota Department of Health

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	dated June 22, 202 "behaviors posing a wandering/elopement of the IAPP further in risk to self or others."	ent)", thus no interventions. dicated R1 posed no potential with "physical violence or as hitting, kicking, pushing,				
	R1's nursing assess	sments were requested but				
		ated) contained no goals, staff iff tasks related to elopement				
	dated November 1, [unnamed] staff fou memory care unit, or looking for her new indicated R1 stated the door. The progr	(identified as "late entry") 2022, at 3:51 p.m. indicated nd R1 outside of the locked downstairs at the front desk spaper. The progress note she followed someone out ess note indicated [unnamed] ack up to the locked memory				
	dated November 1, R1 again went dow about her newspap escorted her back t and "made sure the	(identified as "late entry") 2022, at 3:55 p.m. indicated nstairs to the front desk to ask er and [unnamed] staff o the locked memory care unit door to the area was gress note indicated R1 initially				

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	indicated on Novement and 12:00 p.m. R1 unit twice to go down her newspaper. The the code to the lock document indicated code and placed and R1 as a "second lay contained no inform refusing the wander received. The document of resignidelines of report the building at all time. The document indicated instructed "they were the door code and the door code	ent titled Internal Investigation aber 1, 2022, at 11:00 a.m. left the locked memory care in to the front desk looking for e document indicated R1 knew ted memory care door. The the facility changed the door wanderguard wrist bracelet on yer of security". The document nation about the resident reguard or the bruise she ment concluded "no ident and incident does not fit ing as resident was secure in the nes. No negative outcomes." cated family and POA were the no longer allowed to have that staff would need to let ory Care unit and let them out				

Minnesota Department of Health

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her to wear an alarm bracelet because she lived on a locked unit. During an interview on February 6, 2023, at 1:48 p.m. RN-B stated she was "still working on getting documents" and indicated she worked for the company for two years but did not know how to retrieve most of the information requested, so had passed the task on to the regional nurse. RN-B stated the regional nurse would not be coming into the facility during the investigation. During the same interview, ALD-A stated she was new in her position and did not know how to retrieve the documents. On February 6, 2023, at 2:52 p.m., the investigator sent an e-mail to ALD-A, RN-B, and the regional nurse with a list of the documents requested for the investigation. During an interview on February 6, 2023, at 2:08 p.m. RN-B stated she recalled the incident was actually on October 31, 2022, not on November 1, 2022, as documents indicated. RN-B stated she brought R1 up to the locked memory care unit, filled out the first part of an incident report, and left for the day. During an interview on February 7, 2023, at 10:45 a.m., family member (FM)-C stated she knew the memory care exit code and used if frequently when taking R1 on outings. FM-C stated R1 must have watched her enter the code and wrote it down. FM-C stated staff working on the day of the incident did not call her about wanting to place a wanderguard alarm bracelet on R1's wrist, and that she would have said no. FM-C stated R1 called her after they forcefully placed it on her wrist, crying hysterically and very upset. FM-C	made no sense to her why the sher to wear an alarm bracelet be on a locked unit. During an interview on February p.m. RN-B stated she was "still documents" and indicated she was company for two years but did not retrieve most of the information had passed the task on to the re RN-B stated the regional nurse coming into the facility during the During the same interview, ALD new in her position and did not ke retrieve the documents. On February 6, 2023, at 2:52 p. investigator sent an e-mail to AL the regional nurse with a list of the requested for the investigation. During an interview on February p.m. RN-B stated she recalled the actually on October 31, 2022, not 1, 2022, as documents indicated she brought R1 up to the locked unit, filled out the first part of an and left for the day. During an interview on February a.m., family member (FM)-C stamemory care exit code and used when taking R1 on outings. FM-have watched her enter the code down. FM-C stated staff working incident did not call her about we wanderguard alarm bracelet on that she would have said no. FM called her after they forcefully please.	made her for a Duri portion of the formation of the forma		er why the staff tried to force in bracelet because she lived on February 6, 2023, at 1:48 we was "still working on getting icated she worked for the ears but did not know how to information requested, so on to the regional nurse, ional nurse would not be ity during the investigation. Erview, ALD-A stated she was and did not know how to ints. B, at 2:52 p.m., the e-mail to ALD-A, RN-B, and with a list of the documents westigation. On February 6, 2023, at 2:08 we recalled the incident was 31, 2022, not on November ints indicated. RN-B stated to the locked memory care st part of an incident report, on February 7, 2023, at 10:45 or (FM)-C stated she knew the independent of the day of the inter the code and wrote it staff working on the day of the inter about wanting to place a bracelet on R1's wrist, and said no. FM-C stated R1 forcefully placed it on her				

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	earlier the same da he documented tha "small bruise" when day, except to say he director. RN-G state	e entries because it happened y. RN-G could not explain why t "one day later " R1 had a it happened on the same ne was directed by the regional ed he escorted the resident unit, but never observed R1's				

Minnesota Department of Health

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e-mail with documentation of ULP-E's vulner documentation of evaluation, documentation of evaluation any winformation/documentation/energistered nurse evaluation/documentation/documentation/energistered nurse evaluation/documentation/docume	nents, however did not include lested documents/information: illance video from the day of the elist of current staff by position mation, mentation of which staff worked mory care unit where R1 resided incident, the incident reporting at policy, the wanderguard formation, grievances filed 1, 2022 though November 6, grassessments, documentation table adult training, fulp-E's performance mentation/information of (RN)-G's performance ite-ups or coaching, mentation of which staff assisted agree the wanderguard on R1's				
p.m., former con- (CAA)-F stated s day the resident locked memory of newspaper. CAA had difficulties ge	ew on February 8, 2023, at 3:20 cierge/administrative assistant he was at the front desk on the valked herself out from the are unit down to look for her. F stated the resident frequently tting her newspaper delivered to d she escorted the resident back mory care unit.				
a.m., regional dir conducted the in meet with R1. RE	ew on February 13, 2023, at 8:15 ector (RD)-I stated she estigation remotely and did not 9-I stated the investigation file statement from ULP-E and				

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STATE, ZIP CODE	

THE PRE	SFRVF OF ROSFVILLE	E STREET N LE, MN 5511		
(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
0 330	Continued From page 8	0 330		
	any/all requested documents should be provided by the current administrative staff (ALD-A and RN-B).			
	The Vulnerable Adult Maltreatment -Prevention and Reporting policy dated August 1, 2021, indicated "the facility will work with police, OHFC investigators, or others in the investigation of suspected maltreatment".			
	TIME PERIOD FOR CORRECTION: Two (2) Days			
	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma	0 620		
	(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 document review, the licensee failed to immediately report to the state agency suspected maltreatment of one of one residents (R1) reviewed for restraints. Staff held R1 down to forcefully place a wanderguard (an alarm to notify staff when R1 left the locked memory care unit) on R1's wrist against R1's wishes. The licensee did not file a report with the state agency.			
	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			

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Minnesota Department of Health

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					С	;
		36021	B. WING		02/0	6/2023
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
THE PRE	SERVE OF ROSEVIL	l F	E STREET N LE, MN 5511			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 620	Continued From pa	ge 9	0 620			
	issued at an isolate limited number of re a limited number of	irment, or death), and was discope (when one or a esidents are affected or one or staff are involved or the red only occasionally).				
	Findings include:					
	the locked memory due to diagnoses th	ed the licensee admitted R1 to care unit on August 24, 2020, at included mild cognitive lized anxiety, and primary				
	dated June 22, 202, "behaviors posing a wandering/elopeme The IAPP further incrisk to self or others	ent)", thus no interventions. dicated R1 posed no potential with "physical violence or as hitting, kicking, pushing,				
	R1's nursing assess received.	sment was requested but not				
		ated) contained no goals, staff iff tasks related to elopement				
	dated November 1, indicated [unnamed locked memory care desk looking for her note indicated R1 stout the door. The property out the door.	(identified as "late entry") 2022, at 15:51 (3:51 p.m.) I] staff found R1 outside of the unit, downstairs at the front newspaper. The progress tated she followed someone rogress note indicated corted R1 back up to the e unit.				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE COMP	SURVEY
		7.1. 201221110.			_
	36021	B. WING)6/2023
NAME OF PROVIDER OR SUPPLIER	STREET AC	DRESS, CITY, S	TATE ZIP CODE	-	
TO THE OF THE OTHER		LE STREET N			
THE PRESERVE OF ROSEVII	1 F	LE, MN 5511			
(X4) ID SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
PRÉFIX (EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETE DATE
0 620 Continued From pa	age 10	0 620			
dated November 1 indicated R1 again about her newspapescorted her back and "made sure the secured". The prostated [to unknown someone out the loknew the code. The [unnamed] family reserved R1's progress noted dated November 1 indicated R1 "structure (ULP) attempting to R1. The progress with her forearm be a wanderguard. The ULP placed the wall and one hour later comfort. The progress later a small bruise	e (identified as "late entry") , 2022, at 15:55 (3:55 p.m.) went to the front desk to ask per and [unnamed] staff to the locked memory care unit e door to the area was gress note indicated R1 initially staff] she again followed ocked door, then indicated R1 e progress noted indicated an member gave R1 the code. e (identified as "late entry") , 2022, at 16:30 (4:30 p.m.) ock at" unlicensed personnel oc place a wrist wanderguard on note indicated R1 hit the ULP ecause R1 did not want to wear ne progress note indicated the anderguard on R1's left wrist , loosened the device for R1's ress note indicated "one day e was noted on R1's wrist" and nise was from R1 striking the				
indicated on Nover and 12:00 p.m. R1	nt titled Internal Investigation nber 1, 2022, at 11:00 a.m. left the locked memory care				
her newspaper. Th	wn to the front desk looking for le document indicated R1 knew				
	ked memory care door. The				
	d the facility changed the door wanderguard wrist bracelet on				
•	yer of security". The document				
	nation about the resident				
	erguard or the bruise she				
	ument concluded "no				
maltreatment of re	sident and incident does not fit				
guidelines of repor	ting as resident was secure in				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
		36021	B. WING		C 02/06/2023	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
THE PRE	ESERVE OF ROSEVIL	l F	E STREET NO			
	T		LE, MN 5511			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
0 620	Continued From pa	ge 11	0 620			
	the building at all times. No negative outcomes."					
	During an interview p.m., R1 stated she well. R1 stated on the not received her need the front desk to see stated no one answedownstairs to look for she followed some paper was not there back upstairs. R1 sknew, three staff here forced this alarm broshe was really scars. R1 stated she called made them removes the staff bruised here and her sister took made no sense to here.	on February 6, 2022, at 12:00 recalled the incident very he day of the incident she had wspaper, so decided to call e if it had been delivered. R1 rered the phone, so she went for her newspaper. R1 stated one out the door. R1 stated the e and someone brought her stated, the next thing she eld her down on the bed and racelet on her wrist. R1 stated ed and then was really angry. It is a larm bracelet. R1 stated it trying to put that bracelet on a picture of it. R1 stated it ner why the staff tried to force in bracelet because she lived				
	a.m., family member memory care exit contact when taking R1 on have watched her edown. FM-C stated incident did not call wanderguard alarm that she would have called her after they wrist, crying hysteric stated she came to	on February 7, 2023, at 10:45 or (FM)-C stated she knew the ode and used it frequently outings. FM-C stated R1 must enter the code and written it staff working on the day of the her about wanting to place a bracelet on R1's wrist, and e said no. FM-C stated R1 of forcefully placed it on her cally and very upset. FM-C the facility to help calm R1 tos of the bruise on R1's wrist.				
	p.m., power of attor	on February 7, 2023, at 1:00 ney (POA)-D stated she R1 about the incident.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ,	CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED		
		36021	B. WING			C 02/06/2023	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, ST	TATE, ZIP CODE			
THE PRE	ESERVE OF ROSEVIL	l F	E STREET NO LE, MN 55113				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOOL CROSS-REFERENCED TO THE APPORT OF THE APPOR	OULD BE	(X5) COMPLETE DATE	
0 620	distress. POA-D stated that way before, and violated about staff to wear the wanders the facility did not a the wanderguard art to place the wander the regional director wanderguard on R1. During an interview a.m., former registed did not file a report stated he "was not at those who were "high state agency. During an interview a.m., regional direct conducted the investment with R1. RD-I concluded there was had done anything so did not require a stated R1 did receive from the wanderguard wrist. The Vulnerable Adults.	vas screaming and in mental ated R1 had never behaved d stated R1 was afraid and felt holding her down to force her guard bracelet. POA-D stated sk her for permission to place and had no right to restrain R1 guard bracelet. POA-D stated r had directed staff to put the	0 620				
	indicated staff who resident or who has has sustained a phyreasonably explained living director. The living director confirmaltreatment, they Adult Abuse Report	suspect maltreatment of a knowledge that a resident sical injury which is not ed will contact the assisted med the suspicion of would contact the Minnesota ing Center (MAARC) no later maltreatment was first					

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		36021	B. WING		02/0	; 6/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE PRE	SERVE OF ROSEVIL	2600 DAL	E STREET N	IORTH		
	OLITAL OF ITOOLVIL	ROSEVILI	_E, MN 5511	13		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 620	O Continued From page 13		0 620			
	suspected. The policy further indicated staff had the right to report suspected maltreatment directly to MAARC.					
	TIME PERIOD FOR Days	R CORRECTION: Seven (7)				
02310 SS=G	•	a) Appropriate care and	02310			
	(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.					
	by: Based on interview licensee failed to proservice for one of ormaltreatment when independently leaving unit. The licensee faimplement an indiviplan (IAPP) and fail	and document review, the rovide appropriate care and ne resident (R1) reviewed for R1 had several incidents of ng the locked memory care ailed to reassess and dualized abuse prevention ed to assess R1's needs and date service place subject to re standards.				
	violation that harmed not including serious or a violation that has serious injury, impa- issued at an isolate limited number of re- a limited number of	ed in a level three violation (a ed a resident's health or safety, injury, impairment, or death, as the potential to lead to irment, or death), and was discope (when one or a esidents are affected or one or staff are involved or the red only occasionally).				

Minnesota Department of Health

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ,	E CONSTRUCTION	COMPLETED		
		36021	B. WING		C 02/06/2023	
	PROVIDER OR SUPPLIER	2600 DAL	DRESS, CITY, S E STREET N LE, MN 5511			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
02310	the locked memory due to diagnoses the impairment, general insomnia. R1's individual abust dated June 22, 202 "behaviors posing a wandering/elopeme The IAPP further in risk to self or others potential harm such biting, or grabbing." R1's nursing assess not received. R1's care plan (und interventions, or stator wandering. R1's progress note dated November 1, indicated [unnamed locked memory cardesk looking for her note indicated R1 sout the door. The plant plant indicated R1 sout the door. The plant indicated R1 sout the door indicated R1 again desk to ask about his staff escorted her best indicated R1 again desk to ask about his staff escorted her best indicated R1 again desk to ask about his staff escorted her best indicated R1 again desk to ask about his staff escorted her best indicated R1 again desk to ask about his staff escorted her best indicated R1 again desk to ask about his staff escorted her best indicated R1 again desk to ask about his staff escorted her best indicated R1 again.	ed the licensee admitted R1 to care unit on August 24, 2020, nat included mild cognitive dized anxiety, and primary see prevention plan (IAPP) 2, indicated R1 had no a risk to self (e.g., ent)", thus no interventions. dicated R1 posed no potential with "physical violence or as hitting, kicking, pushing, esments were requested but lated) contained no goals, staff aff tasks related to elopement (identified as "late entry") 2022, at 15:51 (3:51 p.m.) all staff found R1 outside of the e unit, downstairs at the front rewspaper. The progress tated she followed someone rogress note indicated corted R1 back up to the	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			B WINC		С	
		36021	B. WING		02/0	6/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
THF PR	ESERVE OF ROSEVIL	2600 DAL	E STREET N	ORTH		
	LOCKVE OF ROOLVIE	ROSEVIL	LE, MN 5511	3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
02310	Continued From pa	ge 15	02310			
	initially stated [to un followed someone of indicated R1 knew t	progress note indicated R1 known staff] she again out the locked door, then the code. The progress noted ned] family member gave R1				
	R1's progress note (identified as "late entry") dated November 1, 2022, at 16:30 (4:30 p.m.) indicated R1 "struck at" unlicensed personnel (ULP) attempting to place a wrist wanderguard on R1. The progress note indicated R1 hit the ULP with her forearm because R1 did not want to wear a wanderguard. The progress note indicated the ULP placed the wanderguard on R1's left wrist and one hour later, loosened the device for R1's comfort. The progress note indicated "one day later a small bruise was noted on R1's wrist" and determined the bruise was from R1 striking the ULP.					
	indicated on Novement and 12:00 p.m. R1 unit twice to go down her newspaper. The the code to the lock document indicated code and placed a R1 as a "second lay contained no inform refusing the wander received. The document of resignidelines of report the building at all timestructed "they were the door code and the door code and the second lay and the door code and the door code and the second lay and the door code and the door code and the second lay and the door code and the second lay and the door code and the second lay are second lay and the second lay and the second lay are seco	ent titled Internal Investigation aber 1, 2022, at 11:00 a.m. left the locked memory care on to the front desk looking for e document indicated R1 knew ted memory care door. The the facility changed the door wanderguard wrist bracelet on yer of security". The document nation about the resident rguard or the bruise she ment concluded "no sident and incident does not fit ing as resident was secure in the secure in the secure of the property of				

Minnesota Department of Health

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		 ` ´	E CONSTRUCTION	COMPLETED		
		36021	B. WING		C 02/06/2023	
	PROVIDER OR SUPPLIER	2600 DAL	DRESS, CITY, S E STREET N LE, MN 5511			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODE DEFICIENCY)	D BE	(X5) COMPLETE DATE
02310	14:14 (2:14 p.m.) in standing at the from to enter and exit the The progress note is code written in a not indicated staff escothe locked memory the code, which was The progress note is coordinator remove established a new of During an interview p.m., R1 stated she had not receive to call the front desidelivered. R1 stated she had not receive to call the front desidelivered. R1 stated she went downs newspaper. R1 state three staff held her bracelet on her, who disturbing. R1 stated her wrist. During an interview p.m., RN-B stated a RN-B was the clinic facilities, and reside updates were the renurse. During an interview a.m., family member responded to the face wery upset R1. FM-exercises and reside wery upset R1. FM-exercises and reside wery upset R1. FM-exercises and reside were updates.	dated December 6, 2022, at adicated nursing staff noted R1 in desk. R1 verbalized the code a locked memory care unit. Indicated the resident had the atebook. The progress note arted the resident back up to care unit and had R1 enters an old code but still worked. Indicated maintenance and all old codes and one. On February 6, 2022, at 12:00 a recalled the first incidents and had recalled the first incidents and had recalled the first incidents and had been and no one answered the phone, tairs to look for her are the next thing he knew down to force an alarm inch was unnecessary and and the staff caused a bruise on on February 6, 2023, at 2:08 at the time of the incidents, all educator for multiple ent assessments and IAPP esponsibility of the facility On February 7, 2023, at 10:45 ar (FM)-C stated she iclity after getting a call from a				

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	` '	(X3) DATE SURVEY COMPLETED	
		36021	B. WING			C 06/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
THE PRE	ESERVE OF ROSEVIL	l F	LE STREET NO LE, MN 55113			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
02310	want to wear the alathe regional director additional staff and shared the photgraph investigator). During an interview p.m., R1's power of had never behaved the day the staff for wrist. POA-D stated place the wanderguno, so they left, call came back to force POA-D stated she of the regional director R1 to independently wore the wandergunonal director R1 needed to be or During an interview a.m., former register was not part of the wanderguard on R1 IAPP but was sure stated the service pupdated. During an interview a.m., regional director contacted her and swanderguard on R1 restrain R1 to put the stated R1's bruise was being too tight, but	her R1 said "no", she did not arm bracelet, so staff called r, who told them to get put it on R1 anyway. (FM-C phs of the bruise with the on February 7, 2023, at 1:00 attorney (POA)-D stated R1 in an aggressive way before ced the wanderguard on her d R1 told her they asked to lard on R1's wrist and she said ed the regional director, and the wanderguard on R1. discussed the situation with r adn asked if they would allow y leave the locked unit if she ard, and was told no, because				
	dated August 1, 202	21, indicated the licensee had manage wandering, minimize				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
					С	
		36021	B. WING		02/06/2023	
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		
THE PRE	ESERVE OF ROSEVIL	LE	LE, MN 551			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIES (CROSS-REFERENCE)	D BE COMPLETE	
02310	Continued From pa	ge 18	02310			
	opportunities for elopement, and procedures in place to implement if a resident when a resident was missing or eloped.					
	policy dated August resident reassessm	Reviews, and Monitoring to 1, 2021, indicated ongoing nent and monitoring must be ed based on changes in the ent.				
	The Service Plan policy dated August 1, 2021, indicated all residents receiving assisted living services would have a service plan in place based on the outcomes of initial and subsequent assessments, reassessments, and individual reviews of the resident's needs and preferences.					
	TIME PERIOD FOR Days	R CORRECTION: Seven (7)				
02360	144G.91 Subd. 8 F	reedom from maltreatment	02360			
	sexual, and emotion exploitation; and all	right to be free from physical, nal abuse; neglect; financial I forms of maltreatment Vulnerable Adults Act.				
	by: The facility failed to reviewed (R1) was	ent is not met as evidenced ensure one of one residents free from maltreatment.		No Plan of Correction (PoC) requi Please refer to the public maltreat report (report sent separately) for	ment	
	issued a determination and the facility was maltreatment, in co	partment of Health (MDH) tion maltreatment occurred, responsible for the nnection with incidents which flity. Please refer to the public		of this tag.		

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3		(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPI	LEIED
		36021	B. WING		C 02/06/2023	
					1 02/0	0/2023
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THE PRE	SERVE OF ROSEVIL	LE	E STREET N			
ROSEVIL			LE, MN 5511			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
02360	02360 Continued From page 19		02360			
	maltreatment repor	t for details.				
03000 626.557 Subd. 3 Timing of report SS=G		03000				
	(a) A mandated rep	orter who has reason to				
		rable adult is being or has				
	•	r who has knowledge that a sustained a physical injury				
		ably explained shall				
		the information to the				
	7 1	t. If an individual is a				
		lely because the individual is				
	-	y, a mandated reporter is not				
	individual that occu	uspected maltreatment of the rred prior to admission,				
	unless: (1) the individual wa	as admitted to the facility from				
		the reporter has reason to				
	•	ble adult was maltreated in the				
	previous facility; or					
	•	ws or has reason to believe				
		s a vulnerable adult as defined				
	(a), clause (4).	2, subdivision 21, paragraph				
		quired to report under the				
	` ' '	ection may voluntarily report as				
	described above.					
	• /	ection requires a report of				
	•	d maltreatment, if the reporter				
		on to know that a report has common entry point.				
		section shall preclude a				
	` '	reporting to a law enforcement				
	agency.					
	•	orter who knows or has				
		nat an error under section				
		on 17, paragraph (c), clause make a report under this				

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subdivision. If the reporter or a facility, at any time

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		36021	B. WING		C 02/06/2023	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE PRE	SERVE OF ROSEVIL	LE	E STREET N LE, MN 5511			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF CORRECTION SHOULD CROSS-REFERENCED TO THE APPROPERTION (INC.)	D BE	(X5) COMPLETE DATE
03000	Continued From page 20		03000			
	investigative agency determine that the raccording to the critical subdivision 17, parareporter or facility mentry point or direct agency information meets the criteria usubdivision 17, paralead investigative agency information when meets the report under subdivision subdivision when meets the report under subdivision when meets the report under subdivision subdivision when meets the report under subdivision subdiv					
	by: Based on interview licensee failed to for report an incident of one residents (R1), staff held a R1 downwanderguard alarm	and document review, the llow their policy to immediately f suspected abuse of one of reviewed for restraints, when n, forced placement of a bracelet on R1's wrist which the licensee did not file a gency.				
	violation that harmed not including serious or a violation that has serious injury, impairs a limited number of a limited number of	ed in a level three violation (a ed a resident's health or safety, injury, impairment, or death, as the potential to lead to irment, or death), and was discope (when one or a esidents are affected or one or staff are involved or the red only occasionally).				
	the locked memory	ed the licensee admitted R1 to care unit on August 24, 2020, at included mild cognitive				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		36021	B. WING		C 02/06/2023	
NIAME OF				TATE 710 000E	1 02/0	70720
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
THE PR	ESERVE OF ROSEVIL	l F	.E STREET N LE, MN 5511			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETE DATE
03000	Continued From pa	ge 21	03000			
	impairment, genera insomnia.	lized anxiety, and primary				
	dated June 22, 202, "behaviors posing a wandering/elopeme The IAPP further indrisk to self or others potential harm such biting, or grabbing."	ent)", thus no interventions. dicated R1 posed no potential with "physical violence or as hitting, kicking, pushing,				
	received.	silicili was requested but not				
		ated) contained no goals, staff iff tasks related to elopement				
	dated November 1, indicated [unnamed locked memory care desk looking for her note indicated R1 stout the door. The property out the door.	(identified as "late entry") 2022, at 15:51 (3:51 p.m.) I] staff found R1 outside of the e unit, downstairs at the front newspaper. The progress tated she followed someone rogress note indicated corted R1 back up to the e unit.				
	dated November 1, indicated R1 again about her newspape escorted her back than and "made sure the secured". The prograture out the local knew the code. The	(identified as "late entry") 2022, at 15:55 (3:55 p.m.) went to the front desk to ask er and [unnamed] staff o the locked memory care unit door to the area was gress note indicated R1 initially staff] she again followed cked door, then indicated R1 e progress noted indicated an member gave R1 the code.				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		`	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		36021	B. WING		C 02/06/2023	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
THE PRE	SERVE OF ROSEVIL	l F	E STREET N LE, MN 5511			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
03000	Continued From page 22		03000			
	dated November 1, indicated R1 "struck (unknown ULP) atte wanderguard on R1 R1 hit the ULP with not want to wear a vante indicated the Unit on R12's left wrist at the device for R1's indicated "one day I on R1's wrist" and of from R1 striking the An undated docume	ent titled Internal Investigation				
	and 12:00 p.m. R1 unit twice to go down her newspaper. The the code to the lock document indicated code and placed a v R1 as a "second lay contained no inform refusing the wander received. The document maltreatment of resignidelines of reports	ber 1, 2022, at 11:00 a.m. left the locked memory care in to the front desk looking for e document indicated R1 knew ed memory care door. The the facility changed the door wanderguard wrist bracelet on yer of security". The document hation about the resident rguard or the bruise she ment concluded "no ident and incident does not fit ing as resident was secure in hes. No negative outcomes."				
	p.m., R1 stated she well. R1 stated on the not received her new the front desk to see stated no one answ downstairs to look finishe followed some of the she she she she she she she she she s	on February 6, 2022, at 12:00 recalled the incident very he day of the incident she had wspaper, so decided to call e if it had been delivered. R1 ered the phone, so she went or her newspaper. R1 stated one out the door. R1 stated the e and someone brought her				

Minnesota Department of Health

					(X3) DATE SURVEY COMPLETED	
	36021	B. WING		02/0	; 6/2023	
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
	_ 2600 DAL	E STREET NO	ORTH			
THE PRESERVE OF ROSEVILL	ROSEVIL	LE, MN 5511	3			
PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
03000 Continued From page	e 23	03000				
back upstairs. R1 staknew, three staff held forced this alarm brashe was really scared R1 stated she called made them remove to it made no sense to it made no sense to it force her to wear an lived on a locked unit. During an interview of p.m., assisted living of she was new in her procurred before she information about filing agency.	ated, the next thing she d her down on the bed and celet on her wrist. R1 stated d and then was really angry. her sister, who came and the alarm bracelet. R1 stated her why the staff tried to alarm bracelet because she t. on February 6, 2023, at 1:48 director ALD-A stated stated position and the incidents started, so had no and a report with the state					
p.m., RN-B stated sh locked memory care	on February 6, 2023, at 2:08 he brought R1 up to the unit, filled out the first part of hd left for the day. RN-B did the state agency.					
a.m., family member memory care exit cook when taking R1 on or have watched her endown. FM-C stated sincident did not call have wanderguard alarm to because she would have alled her after the wrist, crying hysterical stated she saw a bruphotos of the injury. Fewer working on R1's member of the working of	on February 7, 2023, at 10:45 (FM)-C stated she knew the de and used it frequently utings. FM-C stated R1 must staff working on the day of the her about wanting to place a pracelet on R1's wrist, have said no. FM-C stated ney forcefully placed it on her ally and very upset. FM-C hise on R1's wrist and took FM-C identified the person mory care unit as ULP-E. on February 7, 2023, at 1:00 ney (POA)-D stated she					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		36021	B. WING		C 02/06/2023		
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE			
THE PRE	ESERVE OF ROSEVIL	l F	E STREET NO LE, MN 55113				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
03000	POA-D stated R1 w distress. POA-D stated that way before, and violated about staff to wear the wander the facility did not a the wanderguard and to place the wander the regional director the wanderguard or During an interview a.m., former registed did not file a report stated he "was not those who were "high state agency. Requests for an interview a.m., regional on February 9, 2022, at the voicemail on February February 9, 2022, at the voicemail by interview request.) During an interview a.m., regional direct conducted the investment with R1. RD-I concluded there was had done anything stated R1 did have wanderguard being personally did not so the facility failed to the facility failed to the facility failed to the concluded there was had done anything stated R1 did have wanderguard being personally did not so the facility failed to the	R1 about the incident. As screaming and in mental ated R1 had never behaved d stated R1 was afraid and felt holding her down to force her guard bracelet. POA-D stated sk her for permission to place and had no right to restrain R1 reguard bracelet. POA-D stated r had directed ULP-E to put an R1. On February 8, 2023, at 9:14 ered nurse (RN)-G stated he with the state agency. RN-G allowed" to file a report, only gher up" filed reports with the erview were made to ULP-E ary 7, 2023, at 2:25 p.m., by ary 8, 2023, at 11:05 a.m. and at 9:13 a.m. (ULP-E responded text, but did not respond to the stated the investigation as no reason to believe anyone to harm or injure R1. RD-I a bruise from the on too tight, but she see.					
		the restraint and placement of					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED				
			D. MAINIO		C	;		
		36021	B. WING		02/0	6/2023		
NAME OF PR	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3600 DALE STREET NORTH							
THE PRES	THE PRESERVE OF ROSEVILLE ROSEVILLE, MN 55113							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE		
03000	Continued From pag	ge 25	03000					
1	he wanderguard or	n R1's wrist.						
	and Reporting policy ndicated staff who staff who staff who staff who staff who staff who staff and sustained a physical policy of the staff and s	It Maltreatment -Prevention y dated August 1, 2021, suspect maltreatment of a knowledge that a resident visical injury which is not ed will contact the assisted policy indicated if the assisted ms the suspicion of will contact the Minnesota ing Center (MAARC) no later maltreatment was first cy further indicated staff had uspected maltreatment directly a CORRECTION: Seven (7)						