Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL360213705M
Compliance #: HL360216087C

Date Concluded: February 23, 2023

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36021	A. BUILDING: _____ B. WING _____	C 02/06/2023

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THE PRESERVE OF ROSEVILLE	2600 DALE STREET NORTH ROSEVILLE, MN 55113

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes,144G.08 to 144G.95, this correction order is 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: #HL360216087C/#HL360213705M On February 6, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 55 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL360216087C/#HL360213705M, tag identification 0330, 0620, 2310, 2360, and 3000.	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 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.	
0 330 SS=F	144G.30 Subd. 4 Information provided by facility (a) The assisted living facility shall provide	0 330		

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0 330	Continued From page 1 accurate and truthful information to the department during a survey, investigation, or other licensing activities. (b) Upon request of a surveyor, assisted living facilities shall within a reasonable period of time provide a list of current and past residents and their legal representatives and designated representatives that includes addresses and telephone numbers and any other information requested about the services to residents. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to cooperate with a Minnesota Department of Health Office of Health Facility Complaints (OHFC) investigation when they failed to provide accurate and truthful information and failed to provide requested documentation for one of one resident (R1), reviewed for maltreatment. Facility staff interviews, progress notes, and the facility internal investigation gave conflicting information regarding incidents of R1 leaving the locked memory care unit and the forced placement of a wanderguard on R1's wrist. The licensee failed to provide requested documentation despite repeated requests. This had the potential to affect all residents and staff at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include:	0 330		

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0 330	Continued From page 2 R1's record indicated the licensee admitted R1 to the locked memory care unit on August 24, 2020, due to diagnoses that included mild cognitive impairment, generalized anxiety, and primary insomnia. R1's individual abuse prevention plan (IAPP) dated June 22, 2022, indicated R1 had no "behaviors posing a risk to self (e.g., wandering/elopement)", thus no interventions. The IAPP further indicated R1 posed no potential risk to self or others with "physical violence or potential harm such as hitting, kicking, pushing, biting, or grabbing." R1's nursing assessments were requested but not received. R1's care plan (undated) contained no goals, staff interventions, or staff tasks related to elopement or wandering. R1's progress note (identified as "late entry") dated November 1, 2022, at 3:51 p.m. indicated [unnamed] staff found R1 outside of the locked memory care unit, downstairs at the front desk looking for her newspaper. The progress note indicated R1 stated she followed someone out the door. The progress note indicated [unnamed] staff escorted R1 back up to the locked memory care unit. R1's progress note (identified as "late entry") dated November 1, 2022, at 3:55 p.m. indicated R1 again went downstairs to the front desk to ask about her newspaper and [unnamed] staff escorted her back to the locked memory care unit and "made sure the door to the area was secured". The progress note indicated R1 initially	0 330		

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0 330	Continued From page 3 stated [to unknown staff] she again followed someone out the locked door, then indicated R1 knew the code to exit the locked unit. The progress noted indicated an [unnamed] family member gave R1 the code. R1's progress note (identified as "late entry") dated November 1, 2022, at 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. An undated document titled Internal Investigation indicated on November 1, 2022, at 11:00 a.m. and 12:00 p.m. R1 left the locked memory care unit twice to go down to the front desk looking for her newspaper. The document indicated R1 knew the code to the locked memory care door. The document indicated the facility changed the door code and placed a wanderguard wrist bracelet on R1 as a "second layer of security". The document contained no information about the resident refusing the wanderguard or the bruise she received. The document concluded "no maltreatment of resident and incident does not fit guidelines of reporting as resident was secure in the building at all times. No negative outcomes." The document indicated family and POA were instructed "they were no longer allowed to have the door code and that staff would need to let them in to the Memory Care unit and let them out when they were ready to leave."	0 330		

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0 330	Continued From page 4 During an entrance meeting on February 6, 2023, at 11:00 a.m. with assisted living director (ALD)-A and registered nurse clinical educator (RN)-B, the investigator requested a list of documents/information for the investigation including the following: surveillance video from outside memory care (2nd floor) on day of incident, staff schedule for day of incident, all staff names and contact information, incident reporting policy, permissions for use of wrist alarm (wanderguard) document, restraint policy, wanderguard policy, grievances received from October 1, 2022 through February 6, 2023, documentation of the internal investigation regarding R1 on day of incident including interviews, R1's nursing assessments, R1's incident reports, the personnel file for unlicensed personnel (ULP)-E, personnel file for ULP (unknown staff identified as person who assisted ULP-E with placement of wanderguard), and personnel file for former registered nurse (RN)-G. During an interview on February 6, 2022, at 12:00 p.m., R1 stated she recalled the incident very well. R1 stated on the day of the incident she had not received her newspaper, so decided to call the front desk to see if it had been delivered. R1 stated no one answered the phone, so she went downstairs to look for her newspaper. R1 stated she followed someone out the door. R1 stated the paper was not there and someone brought her back upstairs. R1 stated, the next thing she knew, three staff held her down on the bed and forced this alarm bracelet on her wrist. R1 stated she was really scared and then was really angry. R1 stated she called her sister, who came and made them remove the alarm bracelet. R1 stated the staff bruised her trying to put that bracelet on and her sister took a picture of it. R1 stated it	0 330		

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0 330	Continued From page 5 made no sense to her why the staff tried to force 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 it 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	0 330		

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0 330	Continued From page 6 stated she came to the facility to help calm R1 down and took photos of the bruise on R1's wrist (which she provided to the investigator). FM-C stated the regional director did not accuse FM-C of giving the code to R1 and did not tell FM-C that she would no longer have access to the door code. During an interview on February 7, 2023, at 1:00 p.m., R1's power of attorney (POA)-D stated she received a call from R1 about the incident. POA-D stated R1 was screaming and in mental distress. POA-D stated R1 had never behaved that way before, and stated R1 was afraid and felt violated about staff holding her down to force her to wear the wanderguard bracelet. POA-D stated the facility did not ask her for permission to place the wanderguard and had no right to restrain R1 to place the wanderguard bracelet. POA-D stated she called the regional director who admitted she had directed staff to put the wanderguard on R1. On February 7, 2023, at 2:55 p.m., the investigator sent an e-mail to ALD-A, RN-B, and the regional nurse requesting they send the remaining documents/information, or the investigation would close with current facts. During an interview on February 7, 2023, at 2:59 p.m., former facility registered nurse (RN)-G stated he documented the incidents regarding R1 leaving the locked memory care unit at the direction of the regional director. RN-G stated he documented as late entries because it happened earlier the same day. RN-G could not explain why he documented that "one day later " R1 had a "small bruise" when it happened on the same day, except to say he was directed by the regional director. RN-G stated he escorted the resident back to the locked unit, but never observed R1's	0 330		

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0 330	Continued From page 7 bruise. On February 7, 2023, at 4:33 p.m. ALD-A sent an e-mail with documents, however did not include the following requested documents/information: information/surveillance video from the day of the incident, complete list of current staff by position with contact information, information/documentation of which staff worked on the locked memory care unit where R1 resided at the time of the incident, the incident reporting policy, the restraint policy, the wanderguard policy, the permission for use of wanderguard documentation/information, grievances filed between October 1, 2022 though November 6, 2023, R1's nursing assessments, documentation of ULP-E's vulnerable adult training, documentation of ULP-E's performance evaluation, documentation/information of registered nurse (RN)-G's performance evaluation/any write-ups or coaching, information/documentation of which staff assisted ULP-E with placing the wanderguard on R1's wrist. During an interview on February 8, 2023, at 3:20 p.m., former concierge/administrative assistant (CAA)-F stated she was at the front desk on the day the resident walked herself out from the locked memory care unit down to look for her newspaper. CAA-F stated the resident frequently had difficulties getting her newspaper delivered to her. CAA-F stated she escorted the resident back to the locked memory care unit. During an interview on February 13, 2023, at 8:15 a.m., regional director (RD)-I stated she conducted the investigation remotely and did not meet with R1. RD-I stated the investigation file included a written statement from ULP-E and	0 330		

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0 330	Continued From page 8 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	0 330		
0 620 SS=G	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on interview and 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	0 620		

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(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
0 620	Continued From page 9 serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings include: R1's record indicated the licensee admitted R1 to the locked memory care unit on August 24, 2020, due to diagnoses that included mild cognitive impairment, generalized anxiety, and primary insomnia. R1's individual abuse prevention plan (IAPP) dated June 22, 2022, indicated R1 had no "behaviors posing a risk to self (e.g., wandering/elopement)", thus no interventions. The IAPP further indicated R1 posed no potential risk to self or others with "physical violence or potential harm such as hitting, kicking, pushing, biting, or grabbing." R1's nursing assessment was requested but not received. R1's care plan (undated) contained no goals, staff interventions, or staff tasks related to elopement or wandering. R1's progress note (identified as "late entry") dated November 1, 2022, at 15:51 (3:51 p.m.) indicated [unnamed] staff found R1 outside of the locked memory care unit, downstairs at the front desk looking for her newspaper. The progress note indicated R1 stated she followed someone out the door. The progress note indicated [unnamed] staff escorted R1 back up to the locked memory care unit.	0 620		

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	36021	A. BUILDING: _____ B. WING _____	C 02/06/2023

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0 620	Continued From page 10 R1's progress note (identified as "late entry") dated November 1, 2022, at 15:55 (3:55 p.m.) indicated R1 again went to the front desk to ask about her newspaper and [unnamed] staff escorted her back to the locked memory care unit and "made sure the door to the area was secured". The progress note indicated R1 initially stated [to unknown staff] she again followed someone out the locked door, then indicated R1 knew the code. The progress noted indicated an [unnamed] family member gave R1 the code. 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. A undated document titled Internal Investigation indicated on November 1, 2022, at 11:00 a.m. and 12:00 p.m. R1 left the locked memory care unit twice to go down to the front desk looking for her newspaper. The document indicated R1 knew the code to the locked memory care door. The document indicated the facility changed the door code and placed a wanderguard wrist bracelet on R1 as a "second layer of security". The document contained no information about the resident refusing the wanderguard or the bruise she received. The document concluded "no maltreatment of resident and incident does not fit guidelines of reporting as resident was secure in	0 620		

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0 620	Continued From page 11 the building at all times. No negative outcomes." During an interview on February 6, 2022, at 12:00 p.m., R1 stated she recalled the incident very well. R1 stated on the day of the incident she had not received her newspaper, so decided to call the front desk to see if it had been delivered. R1 stated no one answered the phone, so she went downstairs to look for her newspaper. R1 stated she followed someone out the door. R1 stated the paper was not there and someone brought her back upstairs. R1 stated, the next thing she knew, three staff held her down on the bed and forced this alarm bracelet on her wrist. R1 stated she was really scared and then was really angry. R1 stated she called her sister, who came and made them remove the alarm bracelet. R1 stated the staff bruised her trying to put that bracelet on and her sister took a picture of it. R1 stated it made no sense to her why the staff tried to force her to wear an alarm bracelet because she lived on a locked unit. 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 it frequently when taking R1 on outings. FM-C stated R1 must have watched her enter the code and written 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 stated she came to the facility to help calm R1 down and took photos of the bruise on R1's wrist. During an interview on February 7, 2023, at 1:00 p.m., power of attorney (POA)-D stated she received a call from R1 about the incident.	0 620		

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0 620	Continued From page 12 POA-D stated R1 was screaming and in mental distress. POA-D stated R1 had never behaved that way before, and stated R1 was afraid and felt violated about staff holding her down to force her to wear the wanderguard bracelet. POA-D stated the facility did not ask her for permission to place the wanderguard and had no right to restrain R1 to place the wanderguard bracelet. POA-D stated the regional director had directed staff to put the wanderguard on R1. During an interview on February 8, 2023, at 9:14 a.m., former registered nurse (RN)-G stated he did not file a report with the state agency. RN-G stated he "was not allowed" to file a report, only those who were "higher up" filed reports with the state agency. During an interview on February 13, 2023, at 8:15 a.m., regional director (RD)-I stated she conducted the investigation remotely and did not meet with R1. RD-I stated the investigation concluded there was no reason to believe anyone had done anything to harm or injure the resident, so did not require a report to the state agency. R1 stated R1 did receive a bruise during the incident from the wanderguard being too tight on R1's wrist. The Vulnerable Adult Maltreatment -Prevention and Reporting policy dated August 1, 2021, indicated staff who suspect maltreatment of a resident or who has knowledge that a resident has sustained a physical injury which is not reasonably explained will contact the assisted living director. The policy indicated if the assisted living director confirmed the suspicion of maltreatment, they would contact the Minnesota Adult Abuse Reporting Center (MAARC) no later than 24 hours after maltreatment was first	0 620		

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0 620	Continued From page 13 suspected. The policy further indicated staff had the right to report suspected maltreatment directly to MAARC. TIME PERIOD FOR CORRECTION: Seven (7) Days	0 620		
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to provide appropriate care and service for one of one resident (R1) reviewed for maltreatment when R1 had several incidents of independently leaving the locked memory care unit. The licensee failed to reassess and implement an individualized abuse prevention plan (IAPP) and failed to assess R1's needs and implement an up-to-date service place subject to accepted health care standards. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	02310		

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02310	Continued From page 14 Findings include: R1's record indicated the licensee admitted R1 to the locked memory care unit on August 24, 2020, due to diagnoses that included mild cognitive impairment, generalized anxiety, and primary insomnia. R1's individual abuse prevention plan (IAPP) dated June 22, 2022, indicated R1 had no "behaviors posing a risk to self (e.g., wandering/elopement)", thus no interventions. The IAPP further indicated R1 posed no potential risk to self or others with "physical violence or potential harm such as hitting, kicking, pushing, biting, or grabbing." R1's nursing assessments were requested but not received. R1's care plan (undated) contained no goals, staff interventions, or staff tasks related to elopement or wandering. R1's progress note (identified as "late entry") dated November 1, 2022, at 15:51 (3:51 p.m.) indicated [unnamed] staff found R1 outside of the locked memory care unit, downstairs at the front desk looking for her newspaper. The progress note indicated R1 stated she followed someone out the door. The progress note indicated [unnamed] staff escorted R1 back up to the locked memory care unit. R1's progress note (identified as "late entry") dated November 1, 2022, at 15:55 (3:55 p.m.) indicated R1 again went downstairs to the front desk to ask about her newspaper and [unnamed] staff escorted her back to the locked memory care unit and "made sure the door to the area	02310		

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02310	Continued From page 15 was secured". The progress note indicated R1 initially stated [to unknown staff] she again followed someone out the locked door, then indicated R1 knew the code. The progress noted indicated an [unnamed] family member gave R1 the code. 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. An undated document titled Internal Investigation indicated on November 1, 2022, at 11:00 a.m. and 12:00 p.m. R1 left the locked memory care unit twice to go down to the front desk looking for her newspaper. The document indicated R1 knew the code to the locked memory care door. The document indicated the facility changed the door code and placed a wanderguard wrist bracelet on R1 as a "second layer of security". The document contained no information about the resident refusing the wanderguard or the bruise she received. The document concluded "no maltreatment of resident and incident does not fit guidelines of reporting as resident was secure in the building at all times. No negative outcomes." The document indicated family and POA were instructed "they were no longer allowed to have the door code and that staff would need to let them in to the Memory Care unit and let them out	02310		

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02310	Continued From page 16 when they were ready to leave." R1's progress note dated December 6, 2022, at 14:14 (2:14 p.m.) indicated nursing staff noted R1 standing at the from desk. R1 verbalized the code to enter and exit the locked memory care unit. The progress note indicated the resident had the code written in a notebook. The progress note indicated staff escorted the resident back up to the locked memory care unit and had R1 enter the code, which was an old code but still worked. The progress note indicated maintenance coordinator removed all old codes and established a new one. During an interview on February 6, 2022, at 12:00 p.m., R1 stated she recalled the first incidents very well. R1 stated on the day of the incidents she had not received her newspaper, so decided to call the front desk to see if it had been delivered. R1 stated no one answered the phone, so she went downstairs to look for her newspaper. R1 stated the next thing he knew three staff held her down to force an alarm bracelet on her, which was unnecessary and disturbing. R1 stated the staff caused a bruise on her wrist. During an interview on February 6, 2023, at 2:08 p.m., RN-B stated at the time of the incidents, RN-B was the clinical educator for multiple facilities, and resident assessments and IAPP updates were the responsibility of the facility nurse. During an interview on February 7, 2023, at 10:45 a.m., family member (FM)-C stated she responded to the faiclity after getting a call from a very upset R1. FM-C stated she took photographs of the bruise on R1's wrist. FM-C	02310		

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02310	Continued From page 17 stated the staff told her R1 said "no", she did not want to wear the alarm bracelet, so staff called the regional director, who told them to get additional staff and put it on R1 anyway. (FM-C shared the photgraphs of the bruise with the investigator). During an interview on February 7, 2023, at 1:00 p.m., R1's power of attorney (POA)-D stated R1 had never behaved in an aggressive way before the day the staff forced the wanderguard on her wrist. POA-D stated R1 told her they asked to place the wanderguard on R1's wrist and she said no, so they left, called the regional director, and came back to force the wanderguard on R1. POA-D stated she discussed the situation with the regional director adn asked if they would allow R1 to independently leave the locked unit if she wore the wanderguard, and was told no, because R1 needed to be on the locked unit. During an interview on February 8, 2023, at 9:14 a.m., former registered nurse (RN)-G stated he was not part of the decision to place the wanderguard on R1 and did not update R1's IAPP but was sure someone else did. RN-G stated the service plan also should have been updated. During an interview on February 13, 2023, at 8:15 a.m., regional director (RD)-I stated ULP-E contacted her and she told ULP-E to put the wanderguard on R1. RD-I denied telling ULP-E to restrain R1 to put the wanderguard on her. RD-I stated R1's bruise was from the wanderguard being too tight, but had not seen it personally. The ALDC Wandering and Elopement policy dated August 1, 2021, indicated the licensee had systems in place to manage wandering, minimize	02310		

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02310	Continued From page 18 opportunities for elopement, and procedures in place to implement if a resident when a resident was missing or eloped. The Assessments, Reviews, and Monitoring policy dated August 1, 2021, indicated ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident. 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 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 one of one residents reviewed (R1) 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	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	

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02360	Continued From page 19 maltreatment report for details.	02360		
03000 SS=G	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time	03000		

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03000	Continued From page 20 believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to follow their policy to immediately report an incident of suspected abuse of one of one residents (R1), reviewed for restraints, when staff held a R1 down, forced placement of a wanderguard alarm bracelet on R1's wrist which gave R1 a bruise. 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 serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings include: R1's record indicated the licensee admitted R1 to the locked memory care unit on August 24, 2020, due to diagnoses that included mild cognitive	03000		

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03000	Continued From page 21 impairment, generalized anxiety, and primary insomnia. R1's individual abuse prevention plan (IAPP) dated June 22, 2022, indicated R1 had no "behaviors posing a risk to self (e.g., wandering/elopement)", thus no interventions. The IAPP further indicated R1 posed no potential risk to self or others with "physical violence or potential harm such as hitting, kicking, pushing, biting, or grabbing." R1's nursing assessment was requested but not received. R1's care plan (undated) contained no goals, staff interventions, or staff tasks related to elopement or wandering. R1's progress note (identified as "late entry") dated November 1, 2022, at 15:51 (3:51 p.m.) indicated [unnamed] staff found R1 outside of the locked memory care unit, downstairs at the front desk looking for her newspaper. The progress note indicated R1 stated she followed someone out the door. The progress note indicated [unnamed] staff escorted R1 back up to the locked memory care unit. R1's progress note (identified as "late entry") dated November 1, 2022, at 15:55 (3:55 p.m.) indicated R1 again went to the front desk to ask about her newspaper and [unnamed] staff escorted her back to the locked memory care unit and "made sure the door to the area was secured". The progress note indicated R1 initially stated [to unknown staff] she again followed someone out the locked door, then indicated R1 knew the code. The progress noted indicated an [unnamed] family member gave R1 the code.	03000		

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(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
03000	Continued From page 22 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 (unknown 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 R12'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. An undated document titled Internal Investigation indicated on November 1, 2022, at 11:00 a.m. and 12:00 p.m. R1 left the locked memory care unit twice to go down to the front desk looking for her newspaper. The document indicated R1 knew the code to the locked memory care door. The document indicated the facility changed the door code and placed a wanderguard wrist bracelet on R1 as a "second layer of security". The document contained no information about the resident refusing the wanderguard or the bruise she received. The document concluded "no maltreatment of resident and incident does not fit guidelines of reporting as resident was secure in the building at all times. No negative outcomes." During an interview on February 6, 2022, at 12:00 p.m., R1 stated she recalled the incident very well. R1 stated on the day of the incident she had not received her newspaper, so decided to call the front desk to see if it had been delivered. R1 stated no one answered the phone, so she went downstairs to look for her newspaper. R1 stated she followed someone out the door. R1 stated the paper was not there and someone brought her	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36021	A. BUILDING: _____ B. WING _____	C 02/06/2023

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03000	Continued From page 23 back upstairs. R1 stated, the next thing she knew, three staff held her down on the bed and forced this alarm bracelet on her wrist. R1 stated she was really scared and then was really angry. R1 stated she called her sister, who came and made them remove the alarm bracelet. R1 stated it made no sense to her why the staff tried to force 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., assisted living director ALD-A stated stated she was new in her position and the incidents occurred before she started, so had no information about filing a report with the state agency. During an interview on February 6, 2023, at 2:08 p.m., 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. RN-B did not file a report with the state agency. 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 it frequently when taking R1 on outings. FM-C stated R1 must have watched her enter the code and written 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, because 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 stated she saw a bruise on R1's wrist and took photos of the injury. FM-C identified the person working on R1's memory care unit as ULP-E. During an interview on February 7, 2023, at 1:00 p.m., power of attorney (POA)-D stated she	03000		

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03000	Continued From page 24 received a call from R1 about the incident. POA-D stated R1 was screaming and in mental distress. POA-D stated R1 had never behaved that way before, and stated R1 was afraid and felt violated about staff holding her down to force her to wear the wanderguard bracelet. POA-D stated the facility did not ask her for permission to place the wanderguard and had no right to restrain R1 to place the wanderguard bracelet. POA-D stated the regional director had directed ULP-E to put the wanderguard on R1. During an interview on February 8, 2023, at 9:14 a.m., former registered nurse (RN)-G stated he did not file a report with the state agency. RN-G stated he "was not allowed" to file a report, only those who were "higher up" filed reports with the state agency. Requests for an interview were made to ULP-E via e-mail on February 7, 2023, at 2:25 p.m., by voicemail on February 8, 2023, at 8:37 a.m., and by text on February 8, 2023, at 11:05 a.m. and February 9, 2022, at 9:13 a.m. (ULP-E responded to the voicemail by text, but did not respond to the interview request.) During an interview on February 13, 2023, at 8:15 a.m., regional director (RD)-I stated she conducted the investigation remotely and did not meet with R1. RD-I stated the investigation concluded there was no reason to believe anyone had done anything to harm or injure R1. RD-I stated R1 did have a bruise from the wanderguard being on too tight, but she personally did not see. The facility failed to provide requested information/documentation about which additional staff participated in the restraint and placement of	03000		

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03000	Continued From page 25 the wanderguard on R1's wrist. The Vulnerable Adult Maltreatment -Prevention and Reporting policy dated August 1, 2021, indicated staff who suspect maltreatment of a resident or who has knowledge that a resident has sustained a physical injury which is not reasonably explained will contact the assisted living director. The policy indicated if the assisted living director confirms the suspicion of maltreatment, they will contact the Minnesota Adult Abuse Reporting Center (MAARC) no later than 24 hours after maltreatment was first suspected. The policy further indicated staff had the right to report suspected maltreatment directly to MAARC. TIME PERIOD FOR CORRECTION: Seven (7) Days	03000		