Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #:
HL361563306M / HL361564245M

Date Concluded: May 22, 2023

Compliance #:
HL361565344C / HL361567181C

Name, Address, and County of Licensee Investigated:
Bethel Care Services
1150 West 4th Street
Hastings, MN 55033
Dakota County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Nicole Myslicki, RN
Special Investigator

Finding: Substantiated, facility and individual responsibility

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

Initial Investigation Allegation(s):
The alleged perpetrator (AP) abused resident #1 when he forced resident #1 to touch someone's urine. The AP also abused resident #2 when the AP held him down on the floor, hit him, and threw a heater, hitting him in the head.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse against resident #2 was substantiated. The facility and AP were responsible for the maltreatment. Resident #2 became angry and started destroying the facility's property after being told he could not watch something on the television. The AP, who was also the facility owner, hit, kicked, and placed resident #2 in a hold. Bruises throughout resident #2's body were noted after the incident by photo evidence. The AP failed to provide truthful and accurate information throughout the investigation. Additionally, the Minnesota Department of Health determined abuse against resident #1 was inconclusive.

Although two people were able to provide similar accounts of the incident, the AP denied the allegations, and resident #1 declined to comment on the investigation. There was a lack of evidence to meet preponderance of proof for resident #1's allegation.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement, case managers, and guardians. The investigation included review of resident medical records, hospital medical records, policies and procedures including Vulnerable Adult and Bill of Rights, and the AP's personnel record. Also, the investigator observed staff interactions with residents.

Resident #2 resided in an assisted living facility. Resident #2's diagnoses included bipolar disorder. Resident #2's care plan included assistance with mental health management. Resident #2's vulnerability assessment identified resident #2 as being at risk of abuse from others.

An incident report indicated resident #2 flipped furniture, punched, and kicked walls due to not being allowed to watch something on the television. Staff called 911 who came to the facility and arrested resident #2. The facility also discharged resident #2.

Three days later, resident #2 left the county jail and went to the emergency department to be evaluated. Pictures were taken of resident #2's injuries. Resident #2 had numerous bruises of various sizes on both knees, lower legs, and thighs, as well as a shoulder, elbows, forearms, wrist, and bicep. Additionally, resident #2 had scratches and red marks on his upper arms and chest near his armpits, as well as a swollen lip.

Hospital medical records indicated resident #2 reported he had been hit and kicked in his face, legs, chest, and head. Resident #2 appeared anxious and tearful. These hospital records identified resident #2 as status post marked assault to the head with nausea over the previous few days and had many faded bruises with no point tenderness. After an assessment and scan of the head, resident #2 discharged from the emergency department to a crisis home.

During an interview, the guardian stated resident #2 called her the evening of the incident and left a voice mail asking for a call back. When she tried to call resident #2 back, she could not get ahold of him. She called the facility and the AP, but both went to voicemail. Resident #2 only had a phone with Wi-Fi calling. The AP knew resident #2 called her and shut off the Wi-Fi, so resident #2 could not text or call back.

During a follow up interview, resident #2's guardian identified resident #2 as overall being an accurate historian and truthful about his behavioral outbursts, as well as no known history of making up incidents.

During an interview, a case manager stated the team had been transparent with the AP regarding resident #2 including his needs and potential for behaviors. Prior to the incident, the AP told them he would purposely try to intimidate resident #2.

During an interview, a positive support consultant working with resident #2 stated several times, she suggested holding staff training regarding positive behavior support and trauma informed care. The AP never scheduled the training. At one point, the consultant told the AP she wanted to speak with the AP's staff, but the AP told her it was not necessary. The positive support consultant believed resident #2 was afraid of the AP.

During an interview, resident #2 stated the AP did not allow resident #2 to watch something on the television in the common living space, even though he had been able to previously. Resident #2 became upset because he felt like the AP was trying to control him when the AP said he could not watch the show. The AP argued back and forth with resident #2 until resident #2 became angry and flipped a coffee table over. After this, the AP put his hands on resident #2's neck, holding him against the wall. Resident #2 threw a heater towards the AP. The AP threw the heater back, hitting resident #2 in the head. After getting away from the AP, resident #2 began destroying things and throwing items. The AP punched and kicked resident #2, trying to bring him down to the floor. Prior to this incident, the AP told resident #2 more than one time he would hit resident #2 if resident #2 hit him. Resident #2 also stated he felt like the AP had been provoking him prior to the incident.

Resident #1 resided in an assisted living facility. Resident #1's diagnoses included fetal alcohol syndrome and depression. Resident #1's service delivery record included assistance with mental health management. Resident #1's vulnerability assessment identified resident #1 as being at risk of abuse from others.

During an interview, resident #1's family member stated the AP confronted resident #1, accusing him of urinating on the floor outside the bathroom door. The AP told resident #1 to touch the urine on the floor. Resident #1 felt grossed out, offended by the accusation, intimidated, and pressured by the AP. The family member also stated it seemed like the AP wanted a level of control, but he could not control resident #1. The family member identified resident #1 as truthful and stated resident #1 did not make up stories.

During the investigation, the AP discharged resident #1 from the facility.

Regarding the incident with resident #1, the AP stated he noticed urine on the floor. The AP went to resident #1 and asked him about the urine, but resident #1 denied it. Later, resident #1 came to the AP and admitted he urinated on the floor. The AP denied forcing resident #1 to touch the urine.

Regarding the incident with resident #2, the AP stated resident #2 began to punch walls, yell, and break items after being instructed to watch on the television in resident #2's room. The AP denied hitting, kicking, punching, throwing an object, or putting resident #2 into a hold.

In conclusion, regarding resident #2, the Minnesota Department of Health determined abuse was substantiated. Regarding resident #1, the Minnesota Department of Health determined abuse was inconclusive.

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.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

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

Vulnerable Adult interviewed: Resident #1: No. Declined to interview. Resident #2: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
No action taken.

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

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

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

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

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
Dakota County Attorney
Hastings City Attorney
Hastings Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36156	A. BUILDING: _____ B. WING _____	C 02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL CARE SERVICES INC	1150 4TH STREET WEST HASTINGS, MN 55033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: ***REVISED*** HL361567181C/HL361564245M HL361565344C/HL361563306M On February 21-27, 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 3 residents receiving services under the provider's Assisted Living license. An immediate correction order cited at tag 0470 was issued on February 21, 2023 at 11:00 a.m and on February 27, 2023, immediacy of tag 0470 was removed, however non-compliance remained at a S/L of F. In addition, on February 27, 2023, the immediacy	0 000	The Minnesota Department of Health documents 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors ' findings is the Time Period for Correction. Per Minnesota Statute §144G.30, Subd. 5 (c), the assisted living facilities must document any action taken to comply with the correction order. A copy of the provider ' s records documenting those actions may be requested for follow-up surveys. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider ' s Plan of Correction." The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144G.31, Subd. 2 and 3.	

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0 000	Continued From page 1 of correction order cited at tag 1290 was not removed. The following correction orders are issued for HL361567181C/HL361564245M and HL361565344C/HL361563306M, tag identification 0250, 0330, 0470, and 1290. The following correction order is issued for HL361567181C/HL361564245M, tag identification 2360.	0 000		
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of	0 250		

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0 250	Continued From page 2 the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to cooperate with the investigation. Additionally, the licensee failed to develop and implement policies and procedures in accordance with Minnesota (MN) Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 250		

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0 250	Continued From page 3 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: FAILURE TO COOPERATE During the entrance conference on February 21, 2023, at 10:10 a.m., the investigator requested the staff schedule for the day, staff roster, policy binder, discharged resident roster, and incidents, Minnesota Adult Abuse Reporting Center (MAARC) reports, and grievances for the last three months. Unlicensed personnel (ULP)-A stated licensed assisted living director (LALD)-I had the keys to the office and might not be able to make it to the licensee before the investigator left for the day. During an interview on February 21, 2023, at 10:33 a.m., ULP-A stated LALD-I was in a training in Wisconsin and could not leave it, so he could not provide any of the requested documentation besides the policy binder. ULP-A stated LALD-I would be back to the licensee the same day for her overnight shift starting at 7:00 p.m. During the exit of the facility on-site visit on February 21, 2023, at 1:07 p.m., ULP-A asked if the licensee could submit the requested documentation by Friday, February 24, 2023. The investigator stated LALD-I could begin obtaining the documentation during the overnight shift and should submit the documentation the following day, Wednesday, February 22, 2023.	0 250		

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0 250	Continued From page 4 The licensee provided the current resident roster, discharged resident roster, staff roster and staff schedule via email on Monday, February 27, 2023, at 1:48 a.m. The licensee failed to provide the incident reports, MAARC reports, and grievances at that time. The investigator emailed the licensee on February 27, 2023, at 7:01 a.m., to follow up on the incident reports, MAARC reports, and grievances. ULP-A responded via email on Tuesday February 28, 2023, at 2:27 a.m., indicating he would send the documents during working hours. ULP-A sent another email on March 3, 2023, at 1:12 a.m. stating the documents were faxed, but there were no MAARC reports filed, or grievances received from the last three months. POLICES AND PROCEDURES At the time of the onsite investigation on February 21, 2023, the licensee's policies and procedures referenced MN Statute 144A including the polices titled Background Studies, undated, and Complaint and Investigation Process, undated. During an interview on February 21, 2023, at 11:18 a.m., ULP-A stated the policy binder he provided were the current policies. ULP-A stated LALD-I had a new set of policies she just received, but they were not finalized yet. During an interview on April 3, 2023, at 10:32 a.m., LALD-I identified ULP-A as the staff person in charge of creating and keeping the policies updated.	0 250		

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0 250	Continued From page 5 TIME PERIOD FOR CORRECTION: Twenty-One (21) Days	0 250		
0 330 SS=F	144G.30 Subd. 4 Information provided by facility (a) The assisted living facility shall provide 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 record review, the licensee failed to provide truthful information to the department during the investigation and provided false documentation of services provided. The licensee provided inconsistent information regarding who had access to records, failed to provide requested records, had a practice of documenting services provided which resulted in inaccurate entries of services completed, provided inaccurate contact information for employees, and provided inconsistent information regarding facilities policies and staffing practices. This had the potential to affect all residents. 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	0 330		

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0 330	Continued From page 6 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: FAILURE TO PROVIDE ACCESS TO RECORDS During an interview on February 21, 2023, at 10:33 a.m., ULP-A stated only licensed assisted living director (LALD)-I had the key to access resident records, the staff roster, staff schedule, and the discharged resident roster. During an interview on March 21, 2023, at 10:00 a.m., ULP-L stated only ULP-A had access to the resident records. During an interview on April 3, 2023, at 10:32 a.m., LALD-I stated both she and ULP-A had a set of keys to access the resident and licensee records. ULP-A failed to provide resident records to the Minnesota Department Health at the time of the unannounced on-site visit on February 21, 2023, for a maltreatment complaint investigation with an allegation of abuse. FALSE DOCUMENTATION OF SERVICES R1 was admitted to the licensee September 16, 2022. R1's diagnoses included depression and fetal alcohol spectrum disorder. R1's service plan, dated September 16, 2022, indicated R1 received services including assistance with mediation and activities of daily living.	0 330		

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0 330	Continued From page 7 R1's service delivery record for September 2022, indicated ULP-A initialed every received service, every day and every shift for the month. R1's service delivery record for October 2022, indicated ULP-A initialed every received service, every day and every shift for the month. R1's service delivery record for November 2022, indicated ULP-A initialed every received service, every day and every shift for the month. R2 admitted to the licensee November 10, 2022. R2's diagnoses included bipolar disorder and depression. R2's care plan, dated November 10, 2022, indicated R2 received services including assistance with mental health management. R2's service delivery record for November 2022, indicated ULP-A initialed every received service, every day and every shift for the month. R2's service delivery record for December 2022, indicated ULP-A initialed every received service, every day and every shift for the month until discharge. During an interview on February 21, 2023, at 10:44 a.m., ULP-A stated he usually worked the morning shift from 7:00 a.m. to 7:00 p.m., and LALD-I worked the day shift as well. ULP-K mainly worked the overnight shift, but ULP-A, ULP-K, and LALD-I alternated working both shifts. During an interview on February 21, 2023, at 12:25 p.m., ULP-A stated service delivery records were kept in the locked area within the resident record. ULP-A stated the staff documented services as they provided them, but if not, the	0 330		

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0 330	Continued From page 8 staff let LALD-I know which services were provided, who would then document it when she came to the licensee. During an interview on March 21, 2023, at 10:00 a.m., ULP-L stated only ULP-A had access to the resident records and could not chart the services provided. ULP-L stated ULP-A completed all documentation. During an interview on April 3, 2023, at 10:32 a.m., LALD-I stated both she and ULP-A signed off in the resident service charts. During an interview on April 5, 2023, at 10:03 a.m., ULP-A denied ULP-J worked at the licensee. ULP-A stated he thought ULP-J may have been one of the people who came in looking for work, but ULP-J had never been staff or scheduled to work. ULP-A stated nobody else ever worked at the licensee except for the direct care employees listed on the provided rosters. Regarding the service delivery records, ULP-A stated he worked all the time, from about 7:00 a.m. to 1:00 am or 2:00 a.m., so he completed most of the services. ULP-A stated it would be normal for only his initials to be indicated on a medication administration record or service delivery record for an entire month. FALSELY PROVIDED EMPLOYEE PHONE NUMBERS During the course of the investigation, the investigator attempted to contact ULP-K and RN-G at the phone numbers indicated on the Employee List provided by ULP-A. These provided phone numbers did not belong to ULP-K and RN-G.	0 330		

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0 330	Continued From page 9 During an interview on March 9, 2023, at 10:47 a.m., ULP-A stated he did not have another number for ULP-K. ULP-A stated he would never need to contact his employees while they were at home with their families, and ULP-K just came to work when scheduled. ULP-A stated he did not contact ULP-K outside his working hours. During an interview on March 30, 2023, at 11:01 a.m., ULP-K stated ULP-A called ULP-K when needed for work, around two to three shifts per month. A review of Netstudy indicated ULP-K and RN-G's phone numbers were one digit off from the numbers ULP-A provided on the employee roster. POLICIES AND PROCEDURES At the time of the onsite investigation on February 21, 2023, the licensee's policies and procedures referenced MN Statute 144A including the polices titled Background Studies, undated, and Complaint and Investigation Process, undated. During an interview on February 21, 2023, at 11:18 a.m., ULP-A stated licensed assisted living director (LALD)-I had a new set of policies, but they were not finalized yet. ULP-A identified LALD-I as the person responsible for keeping the policies updated. During an interview on April 3, 2023, at 10:32 a.m., LALD-I identified ULP-A as the staff person responsible for creating and keeping the policies updated.	0 330		

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	36156	A. BUILDING: _____ B. WING _____	C 02/27/2023

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0 330	Continued From page 10 FAILURE TO PROVIDE ACCURATE STAFFING INFORMATION The investigator entered the licensee on February 21, 2023 at 9:50 a.m. unlicensed personnel (ULP)-B answered the door, allowed the investigator in, and called the owner, ULP-A. ULP-B identified herself as a staff member, stated three residents resided at the facility, and continued to clean the bathroom. On February 21, 2023, at 10:05 a.m., ULP-A entered the licensee. ULP-A stated ULP-B was not an employee but just the cleaner. ULP-A stated he was working the morning shift but ran out to get something. ULP-A stated the licensee did not have a personnel file or background study on ULP-B because she did not work for the licensee. During an interview on February 21, 2023, at 10:44 a.m., ULP-A stated he usually worked the morning shift from 7:00 a.m. to 7:00 p.m., but LALD-I worked the day shift as well. ULP-K mainly worked the overnight shift, but ULP-A, ULP-K, and LALD-I alternated working both shifts. During an interview on February 21, 2023, at 12:38 p.m., ULP-A stated he did not know ULP-B's last name because she just came to the licensee to clean. During an interview on March 16, 2023, at 1:31 p.m., family member (FM)-H identified ULP-B as a staff member. During an interview on March 21, 2023, at 10:00 a.m., ULP-L stated she worked at the licensee for about three months in 2022.	0 330		

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0 330	Continued From page 11 During an interview on March 21, 2023, at 1:39 p.m., R2 stated during the time he resided at the licensee, he only ever saw two employees working: ULP-A and ULP-J. ULP-A would work shifts sometimes, but ULP-J stayed at the licensee most of the time. ULP-J slept in the living room at night, like he lived there. During an interview on March 30, 2023, at 11:01 a.m., ULP-K stated ULP-A called ULP-K when needed for work, around two to three shifts per month. ULP-K stated he worked the overnight shift. ULP-K stated he last worked at the facility in January 2023. During an interview on April 3, 2023, at 10:32 a.m., LALD-I stated she has worked only the overnight shift Monday through Sunday, nearly every day since September of 2020. LALD-I stated ULP-K and ULP-M were on-call. LALD-I stated there have been no other direct care staff who have worked at the licensee. During an interview on April 5, 2023, at 10:03 a.m., ULP-A denied ULP-J worked at the licensee. ULP-A stated he thought ULP-J may have been one of the people who came in looking for work, like a walk-in, but ULP-J had never been employed or scheduled to work for the licensee. ULP-A stated nobody else ever worked at the licensee except for the direct care employees listed on the provided rosters. During email correspondence dated February 24, 2023, at 3:05 a.m., ULP-A stated ULP-K filled in for LALD-I on February 21, 2023 for the overnight shift. A law enforcement report dated December 23,	0 330		

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0 330	Continued From page 12 2022, indicated ULP-J stated he worked 10:00 a.m. to 5:00 p.m. on December 17, 2022. The licensee-provided Employee List, dated October 1, 2022 and November 1, 2022, indicated ULP-A, LALD-I, ULP-K, ULP-M, and RN-G were the only employees during those months. The licensee provided Employee List, dated December 1, 2022, indicated ULP-A, LALD-I, ULP-K, and ULP-M were the only employees in December 2022. The licensee-provided Employee List, dated March 1, 2023, indicated ULP-A, LALD-I, ULP-K, ULP-M, and RN-N were the only current employees. TIME PERIOD FOR CORRECTION: Two (2) Days	0 330		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster	0 470		

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0 470	Continued From page 13 situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a staff were present at the licensee at all times. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). An immediate correction order was issued on February 21, 2023 at 11:00 a.m and on February 27, 2023, immediacy of tag 0470 was removed, however non-compliance remained at a S/L of F. Findings include:	0 470		

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0 470	Continued From page 14 The surveyor entered the licensee on February 21, 2023, at 9:50 a.m. Unlicensed personnel (ULP)-B answered the door and allowed surveyor inside. No other staff members were present. On February 21, 2023 at 9:55 a.m., ULP-B confirmed there were three residents that currently resided at the licensee. ULP-A arrived at the licensee approximately 10:05 a.m. ULP-A denied ULP-B worked as an employee for the licensee. ULP-A stated the licensee did not have a personnel record or background study clearance for ULP-B because the licensee only completed those for staff members. During an interview on February 21, 2023, at 10:44 a.m., ULP-A stated he arrived to work around 7:00 a.m. He left for the gas station after ULP-B arrived at the licensee to clean around "eight- something" but confirmed there was not a staff member present upon the surveyor's entrance. The licensee failed to provide a staffing policy in accordance with Minnesota Statutes 144G. TIME PERIOD FOR CORRECTION: Immediate --- During the onsite investigation February 21, 2023, ULP-A did not remove ULP-B immediately. ULP-B cleaned the licensee until completion before leaving.	0 470		

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0 470	Continued From page 15 During email correspondence on February 24, 2023 at 1:05 p.m., the surveyor asked how this immediate order had been addressed by the licensee. ULP-A responded to the email on February 27, 2023, at 1:48 a.m., indicating ULP-B had been removed from the facility immediately. ULP-M had been added to the staffing schedule, and the licensee would ensure a staff member remained at the licensee while a cleaner was onsite. Additionally, ULP-A indicated the licensee started working on the documents as stated in the order and once completed, ULP-A would notify the surveyor and implement the documents immediately. The surveyor responded to the email on February 27, 2023, at 7:01 a.m., asking for clarification on the statement regarding the licensee working on documents and implementing them immediately. ULP-A responded on February 28, 2023, at 1:13 p.m., indicating, "regarding the clarification on the tag for documents, I apologize, I miss-read the tags." ULP-A also indicated, "I appreciate your understanding on the matter." Immediacy was removed on February 27, 2023, per ULP-A's email coorespondance indicating ULP-M was added to the schedule. However, correction to the staffing plan remains. TIME PERIOD FOR CORRECTION: Seven (7) Days	0 470		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section	01290		

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01290	Continued From page 16 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to complete a background study on ULP-B and left her with residents, unsupervised by staff. This had the potential to affect all residents. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). This was issued as an immediate order on February 21, 2023 at 11:00 a.m. Findings include: The surveyor entered the licensee on February 21, 2023, at 9:50 a.m. Unlicensed personnel (ULP)-B answered the door and allowed surveyor inside. No other staff members were present.	01290		

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01290	Continued From page 17 On February 21, 2023 at 9:55 a.m., ULP-B confirmed there were three residents currently at the licensee. ULP-A arrived at the licensee approximately 10:05 a.m. ULP-A denied ULP-B worked as an employee for the licensee. ULP-A stated the licensee did not have a personnel record or background study clearance for contractor-B because the licensee only completed those for staff members. During an interview on February 21, 2023 at 10:44 a.m., ULP-A confirmed ULP-B did not work for a cleaning company and stated ULP-B was someone the staff knew and brought in to come clean the licensee. ULP-A confirmed that the facility was left unattended, without a staff member present, and only ULP-B-B present upon the surveyor's entrance. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate ---------- During the onsite investigation February 21, 2023, ULP-A did not remove ULP-B immediately. ULP-B cleaned the licensee until completion before leaving. During email correspondence on February 24, 2023 at 1:05 p.m., the surveyor asked how this immediate order had been addressed by the	01290		

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01290	Continued From page 18 licensee. ULP-A responded to the email on February 27, 2023 at 1:48 a.m., indicating ULP-B had been removed from the facility immediately, and ULP-M had been added to the staffing schedule. Additionally, ULP-A indicated the licensee started working on the documents as stated in the order and once completed, ULP-A would notify the surveyor and implement the documents immediately. The surveyor responded to the email on February 27, 2023 at 7:01 a.m., asking for clarification on the statement regarding the licensee working on documents and implementing them immediately. ULP-A responded on February 28, 2023 at 1:13 p.m., indicating, "regarding the clarification on the tag for documents, I apologize, I miss-read the tags." ULP-A also indicated, "I appreciate your understanding on the matter." ULP-A did not provide documentation or evidence of rectifying the immediacy of this tag. During an interview on March 16, 2023 at 1:31 p.m., family member-H identified ULP-B as a staff member. TIME PERIOD FOR CORRECTION: Immediate	01290		
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 two residents	02360	No Plan of Correction (PoC) required.	

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02360	Continued From page 19 reviewed (R2) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility and an individual staff person were responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	Please refer to the public maltreatment report (report sent separately) for details of this tag.	