Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL362523862M
Compliance #: HL362524331C

Date Concluded: August 26, 2024

Name, Address, and County of Licensee Investigated:
The Pillars of Prospect Park
22 Malcolm Ave. SE
Minneapolis, MN 55414
Hennepin County

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

Evaluator's Name: Brooke Anderson, RN
Special Investigator

Finding: Inconclusive

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 the resident when the AP tied the resident's legs with a bed sheet resulting in a blood clot in the left leg.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. Due to incomplete and conflicting accounts of the incident, it could not be determined if maltreatment occurred. In addition, there was no evidence to support that the blood clot was directly related to the incident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted the physician. The investigation included review of the resident record, hospital records, facility internal investigation documentation, facility incident reports, personnel files, staff schedules, and

related facility policies and procedures. Also, the investigator observed interactions between staff and residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included primary progressive aphasia (is a rare nervous system syndrome that affects the ability to communicate), and dementia. The resident's service plan included assistance with dressing, grooming, and bathing but was independent with bed mobility. The resident's assessment indicated the resident was not able to report abuse or neglect and was not at risk for abuse. The resident's assessment indicated the resident had memory loss and confusion.

Facility documentation indicated two unlicensed staff members reported to the nurse that they found the resident with her legs tied up with a bedsheet when they went in the resident's room to provide morning cares. When facility management became aware of the incident, an internal investigation was initiated, and camera footage was reviewed to identify which staff members last provided care to the resident.

Internal investigation documentation identified two night-shift staff were last witnessed going into the resident's room. One of the two night-shift staff members was identified as the alleged perpetrator (AP #1) as they were assigned to provide care to the resident; the second staff member (AP #2) was not listed as an alleged perpetrator. AP #1 was suspended for two days pending the outcome of the investigation; AP #2 was not suspended. The resident's family was not contacted the day of the incident and the family was not notified of the incident or investigation until seven days later. AP #1 and AP #2 both denied tying the resident's legs with a sheet and the facility's internal investigation indicated they could not substantiate the allegation.

The resident's medical record indicated the family reported concerns of redness and swelling in the resident's lower leg around the same time the incident occurred, despite having no knowledge of the incident. The resident was seen by the medical provider four days after the incident and diagnosed with a deep vein thrombosis (DVT). The medical provider ordered a medication to treat the DVT (blood clot).

During an interview, the medical provider stated the family notified her of the incident and their concerns with the developing redness and swelling observed on the resident's left leg. The medical provider did not think that the DVT was caused from a sheet being tied on the resident's legs.

During interview with the staff members who initially reported the incident, one staff member denied seeing the sheet tied to the resident's leg and stated she was told by the second staff member about the finding. The staff member stated she went to gather supplies and clothes for the resident while the other staff assisted the resident out of bed and found the sheet tied around the resident's leg. The staff members stated they did not observe injuries to the resident's legs and reported the incident immediately to the nurse.

During an interview, the nurse stated that staff reported when they pulled back the resident's blanket, the resident's legs and feet were tied together with a sheet. The sheet was wrapped around her legs above the ankles and tied one time. Staff reported it was like untying a shoelace when they removed the sheet. The nurse stated she did not assess the resident but was told by staff that the resident had no injuries. The nurse reported the incident to facility management.

During investigative interviews, both AP #1 and AP #2 denied tying a sheet around the resident's legs. They stated they did not utilize a sheet when assisting the resident and did not see a sheet in the room that night. AP #1 stated he was suspended for two days after the incident and received corrective action. AP #2 stated he was not suspended, did not receive a corrective action, and did not receive education after the incident.

During an interview, facility management stated an internal investigation was initiated immediately but the family was not notified for seven days because the allegation was so "egregious", and he wanted to gather all the facts for the investigation before informing the family. Facility management stated although both AP #1 and AP #2 left the resident's room at the same time, he was familiar with AP #2's pattern of conduct so only AP #1 was listed as the alleged perpetrator. Facility management stated the resident was not assessed by the nurse the day of the incident for injuries. Facility management stated that following the incident, education was completed to prevent further occurrence.

During an interview, a family member stated they were not told of the incident until seven days after it occurred. The family stated the facility was evasive, did not provide requested documents regarding the incident, and felt facility management wasn't equipped to supervise the staff at the facility.

In conclusion, the Minnesota Department of Health determined abuse was inconclusive.

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.

Vulnerable Adult interviewed: No, due to cognitive impairment.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrators interviewed: Yes.

Action taken by facility:
The facility investigated the incident and suspended AP #1 for two days.

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

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Minnesota Board of Executives for Long Term Services and Supports

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36252	A. BUILDING: _____ B. WING _____	C 07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PILLARS OF PROSPECT PARK	22 MALCOLM AVENUE SE MINNEAPOLIS, MN 55414

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL362524331C/#HL362523862M On July 2, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 104 residents receiving services under the provider ' s Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for #HL362524331C/#HL362523862M , tag identification 0620, 2320	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL	

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0 000	Continued From page 1	0 000	ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 620 SS=D	144G.42 Subd. 6 (a) / 626.557, Subd. 3 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. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (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	0 620		

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0 620	Continued From page 2 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 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 comply with statute requirements to ensure cases of suspected maltreatment were reported for one of one resident (R1). Facility staff did not report an allegation of suspected maltreatment unitl seven days after the initial report and after completion of an internal investigation into the incident. 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	0 620		

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0 620	Continued From page 3 cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1's medical record indicated R1 admitted to the facility on August 30, 2023. R1's service plan indicated R1 required the physical assist of two staff for bathing, dressing, and grooming. R1's Individual Abuse Prevention Plan (IAPP) dated March 8, 2024, indicated R1 was not at risk for physical abuse. R1 was not able to report abuse or neglect. R1's assessment indicated R1 had significant orientation concerns that required redirection related to her frontotemporal dementia. An internal investigation document dated May 24, 2024, at 9:30 a.m., indicated morning shift unlicensed personnel (ULP)-E and ULP-F reported to the assistant director of nursing (ADON)-H that they found R1 with her legs tied up with a bedsheet when they went in R1's room to provide morning care. ULP-E and ULP-F reported to ADON-H that they did not observe any injuries on R1. The ADON-H immediately reported this to the executive director (ED)-A. ED-A initiated an internal investigation on May 24, 2024. The internal investigation did not indicate that a maltreatment report was submitted to the state agency. The ED-A interviewed ULP-E and ULP-F and reviewed facility camera footage from the previous night. ULP-C and ULP-D were the	0 620		

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0 620	Continued From page 4 last staff in R1's room prior to R1 being found by ULP-E and ULP-F. ULP-C and ULP-D were seen entering R1's room together around 5:10 a.m. ULP-D exited R1's room at 5:15 a.m. and ULP-E exited R1's room at 5:16 a.m. ED-A contacted ULP-C on May 24, 2024, at 1:16 p.m. about the incident. ULP-C reported he and ULP-D assisted the resident with incontinent care and denied knowledge of a sheet tied around R1's legs. ED-A contacted ULP-D at 1:51 p.m. on May 24, 2024, who also denied knowledge of the incident. The internal investigation identified ULP-C as an alleged perpetrator (AP) of maltreatment. ULP-C was suspended for the next two days (May 25 and 26th) pending the outcome of the investigation. The internal investigation included no information of ULP-D being identified as an AP or suspended pending investigation but indicated that human resources (HR) was contacted about the investigation involving the two-night shift ULPs. R1's family was not contacted on May 24, 2024 about the incident and investigation and were not contacted as part of the internal investigation completed by ED-A. R1's medical record included no documentation on May 24, 2024, of notes regarding the incident and R1 was not assessed for harm or injury following staff's report of being found with her legs tied with a sheet. On May 28, 2024, the director of health services (DHS)-B re-interviewed ULP-E about the incident and asked ULP-E to demonstrate how the sheet was tied around R1's legs. On May 29, 2024, the ED-A and DHS-B re-interviewed ULP-C. ULP-C reported he did not	0 620		

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0 620	Continued From page 5 tie the sheet around R1's legs and reported that it feels horrible to be accused of such a thing and how hard it is to report to work, do his best, and be accused. On May 29, 2024, ED-A contacted R1's family and informed R1's family member of the investigation. On May 30th, 2024, ULP-C returned to work as scheduled. The internal investigation indicated abuse could not be substantiated and included a plan of correction included issuing a final written warning to ULP-C and ULP-D due to their responsibility to ensure residents are in a safe position and that the resident's environment is safe at the end of their shift. The internal investigation included no evidence of retraining or education provided to ULP-C or ULP-D and no additional supervision or monitoring of ULP-C or ULP-D was completed to ensure competency in providing resident cares. No additional staff training or re-education was completed following the incident or following completion of the internal investigation. The internal investigation included no documentation of monitoring R1 for pain, injury, or other adverse effects as a result of the incident. The internal investigation did not indicate a report was made to the state agency regarding the allegation of maltreatment. On May 30, 2024, ED-A filed a vulnerable adult report with the state agency regarding the allegation of R1 being found with their legs tied up with a bed sheet. The report identified ULP-C as an AP and that ULP-C was suspended pending investigation. ULP-D was not identified as an AP. During an interview on July 10, 2024, at 11:00 a.m., ADON-H stated ULP-F reported to her at	0 620		

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0 620	Continued From page 6 9:30 a.m. that she had something concerning to report. ULP-F stated her, and ULP-E were in R1's room to provide care and when they pulled back the sheets her legs were tied together. ADON-H reported this to the Executive Director (ED)-A but did not make a report to the state agency since ED-A handled the investigation. During an interview on July 2, 2024, at 1:00 p.m., ED-A stated abuse allegations are typically reported immediately but this case was not reported immediately because the allegation was so egregious and ED-A wanted to gather all the facts before reporting. ED-A stated he did not believe the incident occurred but did not have evidence it did not occur. During an interview July 2, 2024, at 1:30 p.m., CNS-B stated she was out of the office the day the incident occurred on May 24, 2024. CNS-B stated she questioned why a MAARC report wasn't filed but was told ED-A was handling the investigation. CNS-B stated if abuse is reported the facility does an investigation and typically files a MAARC report within 24 hours or as soon as possible. The licensee's policy entitled Vulnerable Adult Reporting and Investigation dated December 2, 2020, indicated upon hearing the witness' description of the incident, if the incident appears to be suspected abuse, the DHS shall immediately make a web-based report. "Immediately" means as soon as possible, but no longer than 24 hours from the time the incident occurred. The DHS will coordinate with ED regarding the investigation of any incident and implementation of any necessary steps to reduce the risk of other similar incidents. The DHS and ED will implement steps necessary to keep the	0 620		

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0 620	Continued From page 7 victim of maltreatment from additional threats that the perpetrator may pose. No further information was provided. Time period for correction: Seven (7) Days.	0 620		
02320 SS=G	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure appropriate care and services were provided when staff failed to adhere to the steps outlined in the procedure of immediate action required following a report of suspected maltreatment and an alleged perpetrators (AP) of maltreatment remained working at the facility during investigation of the incident and failed to implement additional measures to reduce the risk of further occurrence. In addition, facility nursing staff failed to assess and monitor the resident after a change in condition was observed and reported by unlicensed staff and the resident's family. 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	02320		

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02320	Continued From page 8 serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally) The findings include: R1's medical record indicated R1 admitted to the facility on August 30, 2023. R1's service plan indicated R1 required the physical assist of two staff for bathing, dressing, and grooming. R1's Individual Abuse Prevention Plan (IAPP) dated March 8, 2024, indicated R1 was not at risk for physical abuse. R1 was not able to report abuse or neglect. R1's assessment indicated R1 had significant cognition concerns that required redirection related to her frontotemporal dementia. An internal investigation document dated May 24, 2024, at 9:30 a.m., indicated morning shift unlicensed personnel (ULP)-E and ULP-F reported to the assistant director of nursing (ADON)-H that they found R1 with her legs tied up with a bedsheet when they went in R1's room to provide morning care. ULP-E and ULP-F reported to ADON-H that they did not observe any injuries on R1. ADON-H immediately reported this to the executive director (ED)-A. ED-A initiated an internal investigation on May 24, 2024. The ED-A interviewed ULP-E and ULP-F and reviewed facility camera footage from the previous night. ULP-C and ULP-D were the last staff in R1's room prior to R1 being found by ULP-E and ULP-F. ULP-C and ULP-D were seen entering	02320		

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02320	Continued From page 9 R1's room together around 5:10 a.m. ULP-D exited R1's room at 5:15 a.m. and ULP-E exited R1's room at 5:16 a.m. ED-A contacted ULP-C on May 24, 2024, at 1:16 p.m. about the incident. ULP-C reported he and ULP-D assisted the resident with incontinent care and denied knowledge of a sheet tied around R1's legs. ED-A contacted ULP-D at 1:51 p.m. on May 24, 2024, who also denied knowledge of the incident. The internal investigation identified ULP-C as an alleged perpetrator (AP) of maltreatment. ULP-C was suspended for the next two days (May 25 and 26th) pending the outcome of the investigation. ULP-D was not suspended and remained working as scheduled. The internal investigation included no information of ULP-D being identified as an AP or suspended pending investigation but indicated that human resources (HR) was contacted about the investigation involving the two-night shift ULPs. R1's family was not contacted on May 24, 2024 about the incident or investigation and were not contacted as part of the internal investigation completed by ED-A. R1's medical record included no documentation on May 24, 2024, of notes regarding the incident and R1 was not assessed for harm or injury following staff's report of being found with her legs tied with a sheet. R1's medical record lacked evidence of additional monitoring for pain or injuries related to the incident. R1's progress note dated May 25, 2024, at 9:12 p.m., indicated that R1's family reported R1's left leg and ankle were swollen. A registered nurse (RN) indicated R1's husband reported left leg and	02320		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PILLARS OF PROSPECT PARK	22 MALCOLM AVENUE SE MINNEAPOLIS, MN 55414

(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
02320	Continued From page 10 ankle swelling and denied pain and redness. The RN documented they advised to elevate R1's leg on a pillow and "please follow up". R1's record contained no evidence of an assessment or follow-up monitoring of the left leg and ankle. R1's progress note on May 26th, 2024, at 4:16 p.m., indicated R1's family member noticed left leg and ankle swelling. A facility RN assessed R1 and noted swelling but documented no pitting edema, no pain, and no sign of redness. R1's progress note included no evidence of additional monitoring of the left leg and ankle swelling noted by R1's family and the facility RN. R1's progress note on May 28th, 2024, at 11:55 a.m. indicated R1's nurse practitioner (NP) ordered an ultrasound related to a swollen leg to rule out deep vein thrombosis (DVT). The ultrasound results indicated a DVT was present in the left lower leg. The NP wrote orders for medications to treat the DVT. R1's progress notes included no additional information of observation or assessment of the area, or why or when the NP was first contacted. On May 28, 2024, the director of health services (DHS)-B re-interviewed ULP-E about the incident involving R1 and asked ULP-E to demonstrate how the sheet was tied around R1's legs. On May 29, 2024, the ED-A and DHS-B re-interviewed ULP-C. ULP-C reported he did not tie the sheet around R1's legs and reported that it feels horrible to be accused of such a thing and how hard it is to report to work, do his best, and	02320		

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02320	Continued From page 11 be accused. On May 29, 2024, ED-A contacted R1's family and informed R1's family member of the investigation. On May 30th, 2024, ULP-C returned to work as scheduled. The internal investigation indicated abuse could not be substantiated and included a plan of correction an a final written warning to issued to ULP-C and ULP-D due to their responsibility to ensure residents are in a safe position and that the resident's environment is safe at the end of their shift. The internal investigation included no evidence of retraining or education provided to ULP-C or ULP-D and no additional supervision or monitoring of ULP-C or ULP-D was completed to ensure competency in providing resident cares. No additional staff training or re-education was completed following the incident or following completion of the internal investigation. The internal investigation included no documentation of monitoring R1 for pain, injury, or other adverse effects as a result of the incident. No evidence was provided to the investigator of ULP-D being provided a final written warning or any additional action or supervision of ULP-D. On May 30, 2024, ED-A filed a vulnerable adult report with the state agency regarding the allegation of R1 being found with their legs tied up with a bed sheet. The report identified ULP-C as an AP and that ULP-C was suspended pending investigation. ULP-D was not identified as an AP despite being noted in the facility investigation and after completion of the investigation being issued a final written warning.	02320		

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02320	Continued From page 12 Review of May 2024 staffing schedules indicated ULP-C worked as scheduled for the dates of May 29th, 30th, and 31st with no additional education, training, or supervision. ULP-D worked as scheduled for the dates of May 26th, 27th, 30th, and 31st. June 2024 staffing schedules indicated ULP-C and ULP-D continued to work in the memory care units as scheduled. ULP-C was removed from R1's unit and scheduled as a float memory care ULP to assist on all units. ULP-C's employee record was reviewed and indicated ULP-C received a vulnerable adult refresher training on January 20, 2024. ULP-C's record indicated ULP-C received a final written advisement dated June 6, 2024. The final written advisement indicated a memory care resident was found with their legs and feet together and a draw sheet around her legs from below knees to ankles, tied 1 time. ULP-C's record lacked evidence that education was provided after the incident.Facility documentation dated February 16, 2024, indicated ULP-C had a previous allegation of abuse from February 16, 2024 regarding another resident at the facility. ULP-C's record lacked evidence disciplinary action, suspension or education was provided after the Februay 16, 2024 incident. ULP-D's employee record was reviewed and indicated ULP-D received a vulnerable adult refresher training on April 15, 2021. ULP-D's record lacked evidence ULP-D received corrective action for the May 24, 2024 incident. ULP-D's record lacked evidence education was provided after the May 24, 2024 incident.Based on interview and document review, the licensee	02320		

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02320	Continued From page 13 failed to implement their written procedure and comply with statute requirements to ensure cases of suspected maltreatment were reported for one of one resident (R1). Facility staff failed to adhere to the steps outlined in the procedure of immediate action required following a report of suspected maltreatment and the alleged perpetrators (AP) of maltreatment remained working at the facility during investigation of the incident. In addition, the facility failed to implement additional measures to reduce the risk of further occurrence. The findings include: R1's medical record indicated R1 admitted to the facility on August 30, 2023. R1's service plan indicated R1 required the physical assist of two staff for bathing, dressing, and grooming. R1's Individual Abuse Prevention Plan (IAPP) dated March 8, 2024, indicated R1 was not at risk for physical abuse. R1 was not able to report abuse or neglect. R1's assessment indicated R1 had significant orientation concerns that required redirection related to her frontotemporal dementia. An internal investigation document dated May 24, 2024, at 9:30 a.m., indicated morning shift unlicensed personnel (ULP)-E and ULP-F reported to the assistant director of nursing (ADON)-H that they found R1 with her legs tied up with a bedsheet when they went in R1's room to provide morning care. ULP-E and ULP-F reported to ADON-H that they did not observe any injuries on R1. The ADON-H immediately	02320		

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02320	Continued From page 14 reported this to the executive director (ED)-A. ED-A initiated an internal investigation on May 24, 2024. The ED-A interviewed ULP-E and ULP-F and reviewed facility camera footage from the previous night. ULP-C and ULP-D were the last staff in R1's room prior to R1 being found by ULP-E and ULP-F. ULP-C and ULP-D were seen entering R1's room together around 5:10 a.m. ULP-D exited R1's room at 5:15 a.m. and ULP-E exited R1's room at 5:16 a.m. ED-A contacted ULP-C on May 24, 2024, at 1:16 p.m. about the incident. ULP-C reported he and ULP-D assisted the resident with incontinent care and denied knowledge of a sheet tied around R1's legs. ED-A contacted ULP-D at 1:51 p.m. on May 24, 2024, who also denied knowledge of the incident. The internal investigation identified ULP-C as an alleged perpetrator (AP) of maltreatment. ULP-C was suspended for the next two days (May 25 and 26th) pending the outcome of the investigation. The internal investigation included no information of ULP-D being identified as an AP or suspended pending investigation but indicated that human resources (HR) was contacted about the investigation involving the two-night shift ULPs. R1's family was not contacted on May 24, 2024 about the incident and investigation and were not contacted as part of the internal investigation completed by ED-A. R1's medical record included no documentation on May 24, 2024, of notes regarding the incident and R1 was not assessed for harm or injury following staff's report of being found with her legs tied with a sheet. R1's medical record lacked evidence of additional monitoring for pain or injuries related to the	02320		

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02320	Continued From page 15 incident. R1's progress note dated May 25, 2024, at 9:12 p.m., indicated that R1's family reported R1's left leg and ankle were swollen. A registered nurse (RN) indicated R1's husband reported left leg and ankle swelling and denied pain and redness. The RN documented they advised to elevate R1's leg on a pillow and "please follow up". R1's progress note on May 26th, 2024, at 4:16 p.m., indicated R1's family member noticed left leg and ankle swelling. A facility RN assessed R1 and noted swelling but documented no pitting edema, no pain, and no sign of redness. R1's progress note included no evidence of additional monitoring of the left leg and ankle swelling noted by R1's family and the facility RN. R1's progress note on May 28th, 2024, at 11:55 a.m. indicated R1's nurse practitioner (NP) ordered an ultrasound related to a swollen leg to rule out deep vein thrombosis (DVT). The ultrasound results indicated a DVT was present in the left lower leg. The NP wrote orders for medications to treat the DVT. R1's progress notes included no additional information of observation or assessment of the area, or why or when the NP was first contacted. On May 28, 2024, the director of health services (DHS)-B re-interviewed ULP-E about the incident and asked ULP-E to demonstrate how the sheet was tied around R1's legs. On May 29, 2024, the ED-A and DHS-B re-interviewed ULP-C. ULP-C reported he did not tie the sheet around R1's legs and reported that it	02320		

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02320	Continued From page 16 feels horrible to be accused of such a thing and how hard it is to report to work, do his best, and be accused. On May 29, 2024, ED-A contacted R1's family and informed R1's family member of the investigation. On May 30th, 2024, ULP-C returned to work as scheduled. The internal investigation indicated abuse could not be substantiated and included a plan of correction included issuing a final written warning to ULP-C and ULP-D due to their responsibility to ensure residents are in a safe position and that the resident's environment is safe at the end of their shift. The internal investigation included no evidence of retraining or education provided to ULP-C or ULP-D and no additional supervision or monitoring of ULP-C or ULP-D was completed to ensure competency in providing resident cares. No additional staff training or re-education was completed following the incident or following completion of the internal investigation. The internal investigation included no documentation of monitoring R1 for pain, injury, or other adverse effects as a result of the incident. No evidence was provided to the investigator of ULP-D being provided a final written warning or any additional action or supervision of ULP-D. On May 30, 2024, ED-A filed a vulnerable adult report with the state agency regarding the allegation of R1 being found with their legs tied up with a bed sheet. The report identified ULP-C as an AP and that ULP-C was suspended pending investigation. ULP-D was not identified as an AP. Review of May 2024 staffing schedules indicated	02320		

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02320	Continued From page 17 ULP-C worked as scheduled for the dates of May 29th, 30th, and 31st with no additional education, training, or supervision. ULP-D worked as scheduled for the dates of May 26th, 27th, 30th, and 31st. June 2024 staffing schedules indicated ULP-C and ULP-D continued to work in the memory care units as scheduled. ULP-C was removed from R1's unit and scheduled as a float memory care ULP to assist on all units. ULP-C's employee record was reviewed and indicated ULP-C received a vulnerable adult refresher training on January 20, 2024. ULP-C's record indicated ULP-C received a final written advisement dated June 6, 2024. The final written advisement indicated a memory care resident was found with their legs and feet together and the draw sheet around her legs from below knees to ankles, tied 1 time. ULP-C's record lacked evidence that education was provided after the incident. ULP-D's employee record was reviewed and indicated ULP-D received a vulnerable adult refresher training on April 15, 2021. ULP-D's record lacked evidence ULP-D received corrective action for the May 24, 2024 incident. ULP-D's record lacked evidence education was provided after the May 24, 2024 incident. Facility documentation dated February 16, 2024, indicated ULP-D had previous allegation of abuse from February 16, 2024 regarding another resident at the facility. ULP-D's record lacked evidence disciplinary action, suspension or education was provided after the Februay 16, 2024 incident. During an interview on July 10, 2024, at 11:00	02320		

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02320	Continued From page 18 a.m., ADON-H stated ULP-F reported to her at 9:30 a.m. that she had something concerning to report. ULP-F stated her, and ULP-E were in R1's room to provide care and when they pulled back the sheets her legs were tied together. ULP-F reported ULP-E untied the sheet. Later ULP-E reported the tie was like a shoe tie. The sheet was not lose or crumpled but was tied neat. ADON-H stated she asked if there was redness or swelling and ULP-E told her no. ADON-H stated she should have assessed R1 herself. ADON-H stated ED-A handled the investigation. ADON-H stated she believed R1 was found tied up but does not know why. During an interview on July 2, 2024, at 1:00 p.m., ED-A stated abuse allegations are typically reported immediately but this case was not reported immediately because the allegation was so egregious and ED-A wanted to gather all the facts before reporting. ED-A acknowledged both ULP-C and ULP-D were in the room with R1. ED-A stated ULP-D was not identified as an AP because the facility was aware of ULP-D's previous conduct and ULP-D wasn't the staff assigned to care for R1 the night of the incident so only ULP-C was identified as an AP and suspended for a two days. ED-A stated R1 was not assessed for injuries by ADON-H the day of the incident. ED-A stated he did not believe the incident occurred but did not have evidence it did not occur. The facility implemented preventions for reoccurrence by conducting the investigation, following up with both team members, and provided education at stand-up meetings. ED-A stated there was no documentation of the education. ED-A stated the next staff meeting was scheduled for August and the incident would be discussed at that meeting.	02320		

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02320	Continued From page 19 During an interview July 2, 2024, at 1:30 p.m., CNS-B stated she was out of the office the day the incident occurred on May 24, 2024. CNS-B stated when she returned to work on May 28, 2024, she looked at R1 but stated an assessment wasn't completed until May 31, 2024. CNS-B stated she questioned why a MAARC report wasn't filed but was told ED-A was handling the investigation. CNS-B stated if abuse is reported the facility does an investigation and typically files a MAARC report within 24 hours or as soon as possible. The licensee's policy entitled Vulnerable Adult Reporting and Investigation dated December 2, 2020, indicated upon hearing the witness' description of the incident, if the incident appears to be suspected abuse, the DHS shall immediately make a web-based report. "Immediately" means as soon as possible, but no longer than 24 hours from the time the incident occurred. The DHS will coordinate with ED regarding the investigation of any incident and implementation of any necessary steps to reduce the risk of other similar incidents. The DHS and ED will implement steps necessary to keep the victim of maltreatment from additional threats that the perpetrator may pose. During an interview on July 10, 2024, at 11:00 a.m., ADON-H stated ULP-F reported to her at 9:30 a.m. that she had something concerning to report. ULP-F stated her, and ULP-E were in R1's room to provide care and when they pulled back the sheets her legs were tied together. ULP-F reported ULP-E untied the sheet. Later ULP-E reported the tie was like a shoe tie. The sheet was not lose or crumpled but was tied neat. ADON-H stated she asked if there was redness	02320		

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02320	Continued From page 20 or swelling and ULP-E told her no. ADON-H stated she should have assessed R1 herself. ADON-H stated ED-A handled the investigation. ADON-H stated she believed R1 was found tied up but does not know why. During an interview on July 2, 2024, at 1:00 p.m., ED-A stated abuse allegations are typically reported immediately but this case was not reported immediately because the allegation was so egregious and ED-A wanted to gather all the facts before reporting. ED-A acknowledged both ULP-C and ULP-D were in the room with R1. ED-A stated ULP-D was not identified as an AP because the facility was aware of ULP-D's previous conduct and ULP-D wasn't the staff assigned to care for R1 the night of the incident so only ULP-C was identified as an AP and suspended for a two days. ED-A stated R1 was not assessed for injuries by ADON-H the day of the incident. ED-A stated he did not believe the incident occurred but did not have evidence it did not occur. The facility implemented preventions for reoccurrence by conducting the investigation, following up with both team members, and provided education at stand-up meetings. ED-A stated there was no documentation of the education. ED-A stated the next staff meeting was scheduled for August and the incident would be discussed at that meeting. During an interview July 2, 2024, at 1:30 p.m., CNS-B stated she was out of the office the day the incident occurred on May 24, 2024. CNS-B stated when she returned to work on May 28, 2024, she looked at R1 but stated an assessment wasn't completed until May 31, 2024. CNS-B stated she questioned why a MAARC report wasn't filed but was told ED-A was handling the investigation. CNS-B stated if abuse is reported	02320		

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02320	Continued From page 21 the facility does an investigation and typically files a MAARC report within 24 hours or as soon as possible. The licensee's policy entitled Vulnerable Adult Reporting and Investigation dated December 2, 2020, indicated upon hearing the witness' description of the incident, if the incident appears to be suspected abuse, the DHS shall immediately make a web-based report. "Immediately" means as soon as possible, but no longer than 24 hours from the time the incident occurred. The DHS will coordinate with ED regarding the investigation of any incident and implementation of any necessary steps to reduce the risk of other similar incidents. The DHS and ED will implement steps necessary to keep the victim of maltreatment from additional threats that the perpetrator may pose. No further information was provided. Time period for correction: Seven (7) Days	02320		