Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL365693004M **Date Concluded:** October 16, 2024
Compliance #: HL365693042C

Name, Address, and County of Licensee Investigated:
Senior Living LLC
7949 Brunswick Avenue North
Brooklyn Park, MN, 55443
Hennepin County

Facility Type: Assisted Living Facility (ALF) **Evaluator's Name:** Jennifer Segal RN, BSN
Special Investigator

Finding: Substantiated, facility responsibility

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

Initial Investigation Allegation(s):
The facility neglected Resident #1 (R1), Resident #2 (R2), and Resident #3 (R3) when they neglected to provide appropriate supervision. R1, R2, and R3 had a history of unsafe and aggressive behavior and the facility failed to implement interventions to ensure the residents' health and safety.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated for R1, R2, and R3. The facility was responsible for the maltreatment. The facility neglected to provide appropriate supervision to R1, R2, and R3 based on their history of aggression and unsafe behaviors, which contributed to repeated resident-to-resident altercations resulting in injury and law enforcement assistance. In the first incident, R1 hit R2 in the head, and R2 sustained a lump on his head. In the second incident, R3 threw a landscaping block at R2, and R2 sustained multiple fractured ribs and required hospitalization. In the third incident, R1 hit R2 over the head with a plywood board resulting in a laceration.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement, case managers, and other mental health providers for each resident. The investigation included a review of the resident records, hospital records, pharmacy records, facility incident reports, personnel files, staff schedules, police reports, and related facility policies and procedures.

R1 was admitted to the assisted living facility from a crisis center with diagnoses including anxiety, depression, and substance use disorder. R1's initial nursing assessment and Individual Abuse Prevention Plan, completed three days following admission, indicated R1 was not vulnerable or susceptible to abuse by others, and R1 was not at risk of abusing other vulnerable adults. R1's service plan included assistance with medication administration, safety checks, and management of mental health symptoms and substance use disorder.

A review of R1's medical record three months before incident #1 indicated R1 had ongoing aggressive and unsafe behavior including, R1 smoked crack in her bedroom, broke facility property, and punched doors. R1 verbally abused and threatened staff, other residents, and disturbed neighbors. 911 was required multiple times, not only for the three incidents investigated. Records reflect drugs and alcohol contributed to R1's spiraling aggression and unsafe behavior and the facility failed to implement interventions to support R1.

R2 was admitted to the assisted living facility from a crisis center with diagnoses including fetal alcohol syndrome, post-traumatic stress disorder, anxiety, and substance use disorder. R2's initial nursing assessment and individual abuse prevention plan were completed two days following admission, indicated R2 was not vulnerable or susceptible to abuse by others and R2 was not at risk of abusing other vulnerable adults. R2's service plan included assistance with medication administration, safety checks, and management of mental health symptoms and substance use disorder.

A review of R2's medical record three months before incident #1 reflected the ongoing risk of R2's lack of fire safety when R2 set off the smoke alarm multiple times when R2 smoked inside the facility. R2 cooked while intoxicated and refused to turn the temperature on a burner down, setting off the fire alarm. One night, staff found R2 sleeping in bed with a lit cigarette. No interventions were put in place to address fire safety. Additionally, R2's aggressive and unsafe behavior was reflected in additional police reports, which indicated R2 was aggressive toward police officers and spoke "very loud and belligerent." At the same time R2 "pointed his fingers" and talked "very angrily" at officers. Another report indicated officers observed "large amounts of alcohol" in R2's bedroom.

R3 was admitted to the assisted living facility from a correctional facility with diagnoses including asthma, depression, attention deficit hyperactivity disorder (ADHD), and substance use disorder. R3's initial nursing assessment and individual abuse prevention plan were completed two days following admission and indicated R3 was vulnerable and susceptible to abuse by other residents and R3 was at risk of abusing others. Interventions included, staff monitoring behavior, intervening, redirecting, and engaging R3 in activity.

A review of R3's record two months before the incident reflected aggressive and violent behavior when R3 broke and stole items in the facility, including breaking into the staff office. R3 started a fire in the backyard, and staff could not redirect R3. Staff watched R3 and waited for R3 to "go inside so that staff can put water on the fire." Additionally, R3 was without medication, which contributed to aggressive behavior. R3 notified the RN he had been without his medication for ADHD for two weeks since admission. The RN "encouraged [R3]to be patient" while he waited for the appointment with the psychiatrist to obtain a new prescription. Three weeks later, staff reported R3 screamed at staff and accused staff of withholding his ADHD medication. The RN spoke again with R3 and reminded him of the appointment with psychiatrist for a refill request but suggested R3 "should continue to be patient and continue to stay out of trouble," while waiting for the appointment. There was no record that the facility notified the provider or attempted to obtain the medication.

Incident #1

A police report indicated one evening, R2 called 911 for help. When officers arrived, they observed R2 with a large lump on his forehead. R2 reported R1 struck R2 in the head multiple times with an unknown object. Officers indicated R1 was a clear danger to self and others and determined R1 was transported to the hospital for an emergency hold for safety.

R1's medical record indicated R1 returned to the facility at 3:00 a.m. sober and tired. Staff also noted when R1 was drunk, R1 went into other residents' space and started arguments.

Incident #2

Approximately three weeks later, a police report indicated one evening, staff called 911 for help when two residents were intoxicated and had a physical altercation. The report indicated officers observed redness on R2's stomach area, and R2 was in pain. The paramedics were dispatched to transport R2 to the hospital. Officers viewed security footage and described the incident; R2 and R3 were outside and R3 yelled at R2, then R3 climbed up the railing at the front entrance and hit R2. R2 attempted to escape, but R3 picked up a large landscaping block and threw it at R2. Immediately after R2 was hit, he crouched down and appeared in pain. He stood back up but crouched back down again. R2 eventually stood up, held his side, and walked into the house.

R2's hospital record indicated R2 was admitted to the hospital with rib pain. R2 sustained multiple fractured ribs and required hospitalization for two days.

The following day, R3's medical record and police record indicated R3 was arrested at the facility and charged with assault. R3 would not return to the facility.

<u>Incident #3</u>
Approximately three weeks later, a police report indicated officers were dispatched to the facility when a resident attacked another resident with a board. The police report indicated R1 and R2 had an argument, which resulted in R1 hitting R2 over the head with a piece of wood. R2 reported R1 hit R2 at least five times over the head, and a facility staff member confirmed the incident. Officers suggested medical evaluation for R2; however, R2 declined. Officers placed R1 under arrest for domestic assault, and R1 was transported to jail.

According to R1's medical record, facility management emailed R1's case manager (CM) three days after the incident, indicating R1 was arrested and spent the weekend in jail but noted R1 "was fine and has no issues". The facility also informed CM that R1 was charged with domestic assault and disorderly conduct and a court date was scheduled.

During the investigation, it was noted that R1, R2, and R3's service recap summaries reflect identical and ongoing documentation of aggressive and violent behavior.

R1's Service Recap summary reviewed over four months indicated facility staff noted R1 was a "little drunk" 63 times. R1 paced back and forth 22 times. R1 was upset waiting for a friend who never showed up 24 times. R1 reported feeling anxious and staff offered R1 a medication that was used as needed for anxiety but R1 refused 24 times. However, R1 had no record of as needed medication prescribed for anxiety.

R2's Service Recap summary reviewed over four months indicated R2 was a "little drunk" seven times. R2 paced back and forth 46 times. R2 was upset waiting for a friend who never showed up 24 times. R2 reported feeling anxious, and staff offered as needed medication 39 times. Also reflected was R2's lack of fire safety when staff noted that R2 triggered the smoke alarm when R2 smoked inside the facility 20 times and R2 warmed food on the stovetop and refused to lower it to a safe heat setting six times.

R3's Service Recap summary contained only two weeks of documentation indicating R3 was a "little drunk", seven times. R3 reported feeling anxious, and staff offered as needed medication five times. R3 smoked inside the facility seven times, and R3 warmed food on the stovetop and refused to lower it to a safe heat setting two times.

The facility interventions for R1, R2, and R3, were the same for all residents and included staff-maintained distance while closely monitoring residents, conducted safety checks, allowed residents space, called management or 911, offered as needed medication for anxiety, and encouraged staff to protect themselves. The facility failed to address or implement individualized interventions to minimize the risk of harm to R1, R2, R3, and others.

During interview an unlicensed staff member stated R1 and R2 only "misbehaved" and argued when they mixed crack and vodka; R1 tolerated beer better. Staff reported when R1 returned to the facility "tipsy," interventions included asking R1 if she was OK, suggesting R1 relax, and offering R1 as needed medication. ULP stated when interventions failed, ULP called the nurse, and the nurse would come to the facility to assess the resident. Regarding R3's aggression, the staff member stated before R3's admission leadership and unlicensed staff reviewed R3's criminal history, diagnoses, and behavior reports, then "tried our best." The staff member stated R3's interventions included watching R3 closely and call 911 if needed.

During interview, leadership stated R1 and R2 had a habit of smoking crack and drinking alcohol together. When R1 and R2 were high, they had misunderstandings and arguments, and alcohol and drugs contributed to their aggressive behavior. Leadership stated no new interventions were implemented because it was typical for R1 and R2 to become aggressive when intoxicated. In addition, leadership stated later when R1 and R2 were sober, they apologized and got along well, and leadership stated R1 and R2 never caused injury to each other. Leadership stated the facility had a strict no alcohol or drugs policy, however, the residents were their own guardians, and the facility could not control what they did on the streets.

During interview registered nurse (RN) stated she had no knowledge R1 or R2 had any physical altercations or R1 and R2 used alcohol or illegal drugs since living at the facility. RN stated staff were required to notify her of any change in condition, altercation, unsafe or aggressive behavior with any resident and stated the first time she was made aware of the incidents #1 and #2 was during the investigation. RN stated staff members did not report the incidences to her and leadership withheld information from her. In addition, the RN stated she did not have access to the facility's electronic medical records. Therefore, the RN did not review incident reports, progress notes, or service recap summaries. The RN stated both R1 and R2 had a history of severe mental health illness and substance use and indicated alcohol and drugs contributed to R1 and R2s aggression and physical altercations. When the investigator inquired what as needed medication unlicensed staff offered R1 when drunk and needed help to relax, RN stated R1 did not have a prescription for any as needed medication, and she was unaware of any medication that was used for that reason. The RN stated she had not assessed R1, R2, or R3 prior to admission to the facility and learned about the resident's admission during a routine visit to the facility. The RN stated R3 was inappropriate to reside at the facility, but the resident was admitted before the RN was able to complete any assessment.

During interview, R1's case manager stated during the first visit to R1 at the facility, case manager was "appalled" and had "no confidence" in the facility. CM stated the facility had "no programs," "no enrichment," "no communication," and "no nurse."

During interview, an outside member of R1's mental health team stated the facility was a "ticking time bomb" and R1's mental health and chemical dependency posed a high risk of harm. The team member stated there was a lot of conflict in the facility and they often heard yelling in the facility.

During interview, R3's case manager stated the facility was provided detailed information before R3 was admitted. The case manager reported specific inquiry to facility leadership if the facility could manage R3's aggressive and violent behavior and confirmed the facility was aware R3 had recently been discharged from two facilities due to aggressive behavior, and before that, R3 was in prison related to violent crimes. The case manager stated facility leadership indicated they were aware of R3's behavior and criminal history and felt the facility could safely manage R3's needs. The case manager stated R3 had bizarre and taunting behavior toward other residents, and she did not feel R3 was safe to live in a facility with very vulnerable people.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: Yes, R1 and R2. R3 not available.
Family/Responsible Party interviewed: Not applicable.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
No action taken.

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

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

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

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

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

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Hennepin County Attorney
Brooklyn Park City Attorney
Brooklyn Park Police Department

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER 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: #HL365693042C/ #HL365693004M On July 23, 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 four residents receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL365693042C/ #HL365693004M tag identification 2310 and 2360	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
02310 SS=H	144G.91 Subd. 4 (a) Appropriate care and services	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36569	A. BUILDING: ______ B. WING ______	C 07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR LIVING LLC	7949 BURNSWICK AVENUE NORTH BROOKLYN PARK, MN 55443

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(a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards.

This MN Requirement is not met as evidenced by:
Based on observation interview and document review, the facility failed to provide care and services according to acceptable health care standards and medical or nursing standards for three of three residents (R1, R2, and R3) reviewed for mental health and substance use disorder. R1, R2, and R3 were harmed when the facility failed to assess and intervene on multiple occasions when R1, R2, and R3 were intoxicated and unsafe to themselves and others. In addition, R1, R2, and R3's medication regimens failed to contain all prescribed medication.

This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).

The findings include:

R1
R1 admitted to the facility on August 3, 2023, from a crisis center due to diagnoses including anxiety, depression, post-traumatic stress disorder, and substance use disorder. R1 was under court-ordered voluntary commitment for

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02310	Continued From page 2 mental health and chemical dependency through February 2024. R1 received services that included medication administration, mental health management for agitation, anxiety, verbal and physical aggression, impulsivity, and orientation. R1's Resident Agreement dated August 5, 2023, indicated R1 and assisted living director (ALD)-B signed and agreed to conduct that would not create a danger to self, other residents, and staff or unlawful and dangerous behavior including, no smoking inside the facility, no possession or use of alcohol or drugs inside the facility. However, the facility failed to enforce their policy. R1's Resident Evaluation dated August 6, 2023, completed by RN-C indicated R1 was independent with personal care and had a history of non-compliance with medication. R1's mood was anxious. R1 was forgetful, cooperative, and easily redirected. R1 reported using alcohol and/or drugs "but not heavy, 1-2 times weekly." R1's Individual Abuse Prevention Plan (IAPP) dated August 6, 2023, completed by RN-C indicated "no" (indicating no vulnerability) under the category of susceptibility to abuse by others in the facility and "no" risk for abusing other vulnerable adults. In addition, the IAPP indicated that R1 was able to report abuse and neglect. The IAPP failed to reflect R1's individual needs, vulnerabilities, and interventions. An email dated September 13, 2023, from R1's parole officer to R1's facility and outside care team indicated R1 had recently experienced additional trauma and loss and noted concern that R1 appeared to be falling through the cracks and needed help.	02310		

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R1's Nurse Reassessment Visit and IAPP dated November 25, 2023, completed by RN-C indicated R1 was stable, there were no new concerns or changes to IAPP. The assessment failed to address R1's individual needs.

R1's progress notes contained the following entries:
-February 13, 2024, facility smoke alarm sounded, and staff discovered R1 and R2 smoked a substance from a glass pipe in R1's bedroom. Staff redirected R1 and R2 to smoke outside and recommended R1 and R2 not smoke any substance from the glass pipe.
-February 14, 2024, R1 returned to the facility drunk, attempted to punch staff, broke two glasses, and punched a door. Staff intervened and R1 left the facility.
-April 2, 2024, R1 was "heavily drunk and was not following redirections". R1 threatened staff and residents, paced back and forth, and threw a glass of water at staff. Staff interventions included protecting self, provide space, remain quiet and watch R1 closely.

R1's Nurse Reassessment Visit and IAPP dated February 26, 2024, completed by RN-C indicated R1 "continued to be stable no changes to medication, doing fine with no complaints". Although, multiple concerns were noted prior to assessment the facility failed to address or implement individualized interventions.

R1's Service Plan dated March 7, 2023, indicated the resident received medication assistance and staff would manage mental health needs including agitation, anxiety, aggression, and repetitive and self-injurious behavior.

A police report dated March 19, 2024, at 11:24

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p.m. indicated officers responded to the facility when R1 was intoxicated, harassed staff and residents, banged on doors, and screamed at others. Officers advised R1 stay in her bedroom and go to bed and advised staff call 911 again if needed. In addition, the report indicated R1 smoked an unknown substance in the backyard.

A police report dated April 3, 2024, at 9:50 p.m. indicated officers were dispatched to the facility for an assault when R1 struck R2 in the head. Officers determined R1 was a danger to self and others in the facility and transported R1 to the hospital.

A police report dated May 17, 2024, at 10:40 p.m. indicated officers were dispatched to the facility for an assault when R1 hit R2 five times on the head with a piece of wood. R1 was placed under arrest for domestic assault, bodily harm, and disorderly conduct. R1 was released from the detention center three days later.

An email dated May 21, 2024, at 12:51 p.m. assisted living director (ALD)-B updated case manager (CM)-E R1 was "doing fine and has no issues". In addition, ALD-B attached R1's court document that resulted from the incident on May 17, 2024, when R1 assaulted R2 although ALD-B described R1 as "doing fine".

R1's Nurse Reassessment visit and IAPP dated May 23, 2024, indicated R1 had no changes "doing fine and taking meds as prescribed". The assessment did not accurately reflect R1's problems, needs or interventions.

R1's facility obtained medication orders dated May 28, 2024, included quetiapine 200mg every night at bedtime. The provider returned the order

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with a handwritten note "quetiapine was decreased March 15, 2024, to 150mg every night at bedtime". In addition, R1's medication administration record (MAR) reflected quetiapine 200mg three times daily since admission to present.

R2
R2 admitted to the facility on August 11, 2023, from a crisis center due to diagnoses including, fetal alcohol syndrome, post-traumatic stress disorder, depression, anxiety, and substance use disorder. R2 required assistance with medication management and behavioral/mental health needs. R2 was his own decision-maker.

An email dated August 11, 2023, at 9:53 a.m. ALD-B informed R2's case manager R2 toured the facility liked it and wanted to move in the same day. ALD-B requested an update on R2's status, diagnosis, and how to move forward. However, R2 was not yet assessed by registered nurse (RN) as required to determine appropriateness and establish a plan for R2 to receive services from the facility.

R2's Resident Agreement dated August 13, 2023, indicated R2 signed and agreed to conduct that would not create a danger to self, other residents, and staff or unlawful and dangerous behavior including, no smoking inside the facility, no possession or use of alcohol or drugs inside the facility. However, the facility failed to follow its policy.

R2's Resident Evaluation dated August 13, 2023, completed by RN-C three days after admission indicated R2 was independent with personal care, pleasant, cooperative, and easily redirected. In addition, his mood was anxious, forgetful, and

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depressed. R2 was his own decision-maker and reported current use of alcohol and drugs.

R2's Individual Abuse Prevention Plan (IAPP) dated August 13, 2023, completed by RN-C three days after admission indicated "no" (indicating no vulnerability) under the category of susceptibility to abuse by others in the facility and "no" risk for abusing other vulnerable adults. In addition, the IAPP indicated R2 was able to report abuse and neglect. The IAPP did not reflect R2's vulnerabilities or staff interventions.

R2's Nurse Reassessment dated November 22, 2023, completed by RN-C indicated mental health continued to be stable no changes to plan, no safety concerns, and IAPP remained appropriate.

R2's progress notes contained the following entries:
- January 1, 2024, at 11:53 p.m. R2 returned to the facility drunk, not listening to staff directions, and yelled at staff and other residents. R2 was in staff's space and threatened to beat staff up. R2 would not go to sleep and kept other residents awake until 3: 00 a.m. Staff interventions included calling the house manager.
-January 22, 2024, 12:12 a.m. R2 "was drunk and created chaos". Interventions included staff contacted the house manager at 1: 00 a.m. but R2's behavior was difficult to manage until R2 went to bed at 4: 00 a.m.
-February 10, 2024, 9:30 p.m. R2 was drunk and attempted to smoke inside the facility. The same night at 1:00 a.m. R2 used the stove and refused to turn the burner down and the fire alarm sounded. Around 2:00 a.m. staff checked R2 and found R2 in bed asleep with a lit cigarette. Staff removed the cigarettes and lighter from R2's room and notified a supervisor of the situation. No

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interventions were put into place to prevent fires.
-February 13, 2024, the fire alarm went off in the facility and staff found R1 and R2 in R1's bedroom smoking a substance from a glass pipe.

R2's Service Plan dated February 15, 2024, indicated R2 received services including medication management, support for anxiety, agitation, verbal aggression, and other cognitive and mental health needs.

R2's Nurse Reassessment Visit dated February 22, 2024, completed by RN-C indicated R2's mental health and behavior remained stable, and no changes to R2's individual abuse prevention plan. The assessments failed to accurately reflect numerous safety concerns.

A police report dated March 1, 2024, at 11:47 p.m. indicated R2 was loud and belligerent with facility staff and police officers and became increasingly aggressive and agitated. Officers explained to R2 that they expected R2 kept his hands to himself otherwise R2 would be sent to the hospital or arrested for assault. In addition, officers noted large amounts of alcohol in R2's bedroom.

A police report dated April 29, 2024; indicated officers dispatched to facility due to assault, Officers described video surveillance of incident, showed R3 walked at a fast pace to the front of deck, took off his shirt and appeared to be flexing and yelling at R2. R3 walked closer to R2 and R3 climbed up the railing and hit R2. When R2 attempted to get away from R3, R3 was heard yelling and then picked up a large landscaping block and threw the block at R2. Immediately after R3 hit R2, R2 crouched down appeared in pain. R2 stood back up crouched down again and

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after several seconds of crouching and holding his side he walked into the house. R2 was transported to the hospital and admitted for multiple rib fractures.

R2's nursing note dated April 30, 2024, indicated R2 was involved in an altercation with another resident and required evaluation for injury to his side. According to RN note, R2 returned from the hospital with new orders for Tylenol 1000 mg three times daily for pain.

R2's hospital discharge summary dated May 1, 2024, included four new medications for pain management. Upon review of R2's facility medication administration record (MAR) May 2024, did not contain all prescribed medication. In addition, the facility noted Tylenol 1,000mg three times daily however the hospital paperwork instructed Tylenol 1,000 mg four times daily.

R2's progress note dated May 2, 2024, indicated R2 was drunk and unable to follow directions. Interventions included staff tried to calm R2 and offered PRN medication. R2's behavior continued for four hours until R2 went to bed.

An email dated May 6, 2024, indicated ALD-B replied to an inquiry from R2's outside care team about an incident over the weekend. ALD-B informed R2's team that R1 and R2 "are always in the habit of smoking crack and drinking alcohol/smoking together." "Whenever both get high that always have misunderstandings between each other". Although ALD-B acknowledged R1 and R2 substance use and vulnerabilities there were no interventions in place to manage R1 and R2 behavior. In addition, ALD-B suggested R1 was not capable of harming R2 due to R1's age and gender and noted R1

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02310	Continued From page 9 "cannot pick up weights or hit [R2]". Although R1 had history of physical aggression toward R2 A police report dated May 17, 2024, at 10:40 p.m. indicated officers were dispatched to the facility for an assault when R1 hit R2 five times on the head with a piece of wood. The same report indicated the staff member stated the assault was not as bad as it sounded because there was no blood, therefore officers did not need to visit R1. However, police officers visited R2 and noted blood on R2's forehead but R2 declined medical attention. R2's Nurse Reassessment Visit dated May 22, 2024, completed by RN-C indicated R2 was "doing fine" and continued at his baseline with no changes to care plan. The assessment failed to include R2's vulnerabilities, needs and interventions. R2's Incident Report dated May 31, 2024, indicated R2 was highly intoxicated "It looks like he has taken some illegal substance like meth or crack". R2 was aggressive towards staff and other residents and going into other resident's space. Staff attempted to redirect but R2 did not listen. The incident report listed several questions including Any precipitating event? "no", "he was just intoxicated". Any injuries? "No". Was 911 called? "No". How has the situation resolved? "Yes". An email dated June 12, 2024, indicated ALD-B informed R2's team that R2 returned to the facility intoxicated, getting into others' space, and would not follow directions. R2 was up the entire night loud and aggressive. In the morning staff noted R2 was fine and apologized for behavior.	02310		

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R2's incident report dated July 10, 2024, indicated R2 came out of his bedroom, intoxicated, and believed someone outside looked through R2's window. Staff noted R2 shouted, called names, and stayed awake until 2:00 a.m. Staff intervention included telling R2 no one looked at him through the window. The same document listed questions including were there any precipitating events? "No". Was 911called? "No". How was the situation resolved? "Yes".

R3

R3 admitted to the facility on February 23, 2024, from a Minnesota Correctional Facility with diagnoses including asthma, depression, anxiety, attention deficit hyperactive disorder (ADHD), obsessive-compulsive disorder, and substance use disorder. R3 required assistance with medication administration, meals, and mental health support.

An email communication dated Feb 23, 2024, at 5:11 p.m. ALD-B informed CM-H R3 was admitted to the facility and ALD-B planned to send documentation for R3's plan of care next week.

R3's Resident Evaluation and IAPP dated February 25, 2024, completed by RN-C indicated R3 was independent in personal care needs and his own decision-maker. R3 was described as "irritable, dishonest, lack of energy, verbal aggression". In addition, R3 was described as cooperative and polite but impulsive and easily distracted. IAPP indicated R3 susceptible to abuse by other residents and R3 at risk of abusing others. Interventions included, staff monitor behavior, intervene, redirect, and engage R3 in activities.

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R3's Nursing Note dated March 4, 2024, indicated R3 was "very aggressive, threatening to hit another housemate but he was redirected, and he apologized promising that he won't do that again". The same note indicated R3 complained he was without medication for ADHD. The facility nurse encouraged R3 to be patient and request a refill at upcoming appointment.

R3's Nurse Reassessment Visit dated March 8, 2024, indicated mental health "stable as per baseline" no safety concerns at the time of assessment, and no changes to IAPP. The nursing assessment failed to address R3's threatening behavior or missed medication.

R3's Nursing Note dated March 25, 2024, indicated facility staff contacted RN-C and reported R3 screamed at staff for refusing to administer R3's medication. RN-C noted she spoke with R3 and "told him he is scheduled to see his provider, until then he should continue to be patient and continue to stay out of trouble". No documentation to reflect RN-C or facility staff contacted the pharmacy or provider regarding missed medication.

R3's Behavior Care Plan undated and unsigned indicated R3 had a problem with wandering when R3 "goes out here and there to streets" R3 "intends to buy alcohol, marijuana, meth, a glass pipe and sneak into room". Staff interventions included check R3 "that he does not do it every time", encourage R3 not to take drugs when out and explain side effects. In addition, staff were directed to channel energy, pace activities, prevent stimulation, and provide positive support strategies.

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R3's progress note dated April 12, 2024, at 10:26 a.m., indicated R3 broke into the facility office with a card and wire. Per staff, R3 looked suspicious and appeared to be stealing something. Staff interventions included staff to watch R3 closely.

R3's nursing note dated April 14, 2024, indicated R3 was "very pleasant, he had no complaints."

R3's nursing note dated April 15, 2024, indicated staff reported R3 had threatening behavior toward staff and residents. RN-C noted "had a one-to-one talk with resident and he agreed that he was violating house protocol, but he promised he will do better".

An email dated April 15, 2024, from ALD-B to CM-H noted "We have to evict immediately before anything major happens". CM-H replied, inquired if ALD-B notified the police each time R3 had unlawful or unsafe behavior. ALD-B stated no, we have not. CM-H reminded ALD-B 911 must be called when R3's a danger to self or others.

R3's progress notes dated April 18, 2024, at 6:43 p.m., indicated a pre-termination meeting was held based on lease violations, lack of payment, drinking and smoking in the facility, using illegal drugs, breaking, or stealing items in the facility and threatening behavior toward staff and other residents.

R3's Service Plan dated April 19, 2024, nearly two months after admission indicated R3 received services including medication administration, staff would monitor for signs of drug overdose. IN addition, staff would manage anxiety, repetitive, or self-injurious behavior, agitation, and verbal

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aggression.

R3's Incident Report dated April 19, 2024, at 7:00 p.m. indicated R3 was aggressive toward staff and residents took the remote control for facility TV and broke into pieces. An incident report listed questions including Were there any precipitating events? Were injuries sustained? Was 911 called? The response reflected "no" to each question. How was situation resolved? The response reflected "yes". The remaining questions included was the supervisor, physician, or family or Minnesota Adult Abuse Reporting Center notified? Were any additional actions recommended? All questions were left unanswered.

An email communication dated April 22, 2024, from ALD-B to CM-H indicated R3 placed worms outside of another resident's door and broke the house phone.

R3's progress notes dated April 24, 2024, 7:46 p.m. indicated R3 "started a fire in the backyard staff tried to redirect him, but he didn't listen and started abusing staff, staff watch him and waiting him to go inside so that staff can put water on the fire".

A police report dated April 26, 2024, at 9:19 p.m. Indicated R3 contacted officers because a staff member refused to administer R3's evening medication. It was determined that R3 did not receive his medication due to a facility documentation error. As a result, staff administered R3's scheduled and as-needed medication. Officers noted R3 was cooperative the entire time and went to bed after he received his medication. Officers encouraged staff members to keep accurate records. No evidence

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RN was aware or involved with medication error.

An email termination notice dated April 29, 2024, 7:41 p.m. written by ALD-B and sent to CM-H indicated R3 displayed aggressive behavior when R3 broke a window and blinds in the facility. R3 smoked inside the facility and brought random items to the facility that did not belong to R3, and ALD-B stated, "I have a feeling he is stealing/ or doing burglary at people places".

A police report dated April 29, 2024, at 9:11 p.m. indicated officers were dispatched to the facility because R3 threw a brick at R2 while they stood on the ramp near entrance to facility. Officers viewed surveillance video of incident. Video showed R3 walked at a fast pace to the front of deck, took off his shirt and appeared to be flexing and yelling at R2. R3 walked closer to R2 and R3 climbed up the railing and hit R2. When R2 attempted to get away from R3, R3 was heard yelling and then picked up a large landscaping block and threw a block at R2. R2 was transported to the hospital and admitted for multiple rib fractures. The following day R3 was arrested and taken into custody and would not be allowed to return to the facility.

R1, R2, and R3's monthly Service Recap Summary reviewed from January 2024 to July 2024 included space for each scheduled service provided. When staff completed the service they initialed a box to verify service completion. In addition, the notes section contained blank space for ULP to note an unusual or resident specific concern. The investigator noted all residents had the same four comments repeated verbatim in R1, R2, and R3 notes section as follows:

- "Client was pacing back and forth from

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his room to the living room. Staff asked him if he needed anything. He refused and later he went to his room. Staff checked he was watching TV later on".
- "Client was wandering in and out of the house and then went to backyard. He said he has anxiety. Staff offered him to PRNs, but he refused. Later staff redirected him to listen to some music or watch TV with him."
- "Client was wandering in and out of his room. He said he is being picked up by his friend, he was pacing back and forth. Nobody came and he was upset about it, staff intervened and redirected him".
- "Client was little drunk and was wandering in and out of her room, staff redirected".

R1, R2, and R3 lacked individualized care and services when the same vulnerabilities and interventions were copy and pasted verbatim to each resident's record.

During an observation the investigator arrived for an unannounced investigation to the facility on July 23, 2024, at 8:58 a.m. The facility appeared dark inside, with no cars in the driveway or on the street. Most window coverings closed. A sign on the front door noted no visitors and it appeared a camera was in place at the front door and near the garage door. The investigator rang the doorbell and knocked on the door multiple times there was no answer. The investigator waited outside the facility for thirty minutes and observed no activity before leaving the premises. The investigator called the facility same day around 10:30 a.m. and unlicensed personnel (ULP)-A stated he had been at the facility since 7:00 a.m. and never heard the doorbell or knock on the door. ULP-A stated he must have been in the basement.

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02310	Continued From page 16 During an interview on July 23, 2024, at 11:30 a.m. R1's case manager (CM)-D reported multiple concerns with the facility including the lack of safety and supervision. CM-D stated once during a visit CM-D observed the only staff member working leave the facility with one resident while other residents were left in the home without any staff members and the resident verbalized that was a normal occurrence. CM-D stated the communication from facility staff lacked, once the resident was taken either to jail or the hospital and the facility failed to inform CM-D. CM-D stated R1 wanted to move out of the facility because the resident feared some staff, however, someone (unknown) convinced R1 to stay. During an interview on July 23, 2024, at 12:50 p.m. ALD-B stated he was the owner, ALD and primary ULP. ALD-B stated there were staff onsite 24/7, and RN-C generally visited weekly for medication management and clinical needs including all new admissions. ALD-B stated RN-C was involved with preadmission assessments and initial assessments for R1, R2 and R3. During a follow up interview on August 1, 2024, at 11:15 a.m. ALD-B explained the facility primarily focused on providing mental health care. ALD-B stated he received no formal training in mental health care or substance use disorder but completed the annual required training. ALD-B stated R1 and R2 had no history of physical altercations, however, he stated he recalled R1 may have hit R2 in the head once but there was no injury, they were both intoxicated and the next day R1 and R2 were happy therefore ALD-B believed the incident was "normal" for R1 and R2.	02310		

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02310	Continued From page 17 During an interview August 2, 2024, at 1:20 p.m. unlicensed personnel (ULP)-A stated R1 and R2 only "misbehaved" and had arguments when they mixed crack and vodka. ULP-A stated the residents were their own guardians they would come and go as desired, and staff would not follow the residents to the streets, but the residents knew when they returned to the facility there was a strict no alcohol or drug policy. ULP-A stated R1 and R2 had ongoing issues with substance use/abuse and interventions included offering a prn medication to help calm them, encourage rest, separate R1 and R2 because they argued when both were intoxicated, call ALD-B or RN-C or call 911. ULP-A stated before R3 was admitted to the facility they received paperwork from the Re-Entry program and R3's case manager, including diagnosis, history, and behavior reports. All staff read though the information and then just tried to do their best. ULP-A stated R3's interventions included, watching R3 closely and call 911 if needed. During an interview August 2, 2024, at 5:20 p.m. RN-C stated she was unaware of any medication prescribed for R1 to take when intoxicated, and there was no medication for any of the residents to take PRN for intoxication. RN-C stated she never received a call from facility staff about any resident being intoxicated and had no awareness of any crack, meth, or alcohol use in the facility. In addition, RN-C stated she had no knowledge of resident-to-resident altercations except the incident between R2 and R3, when RN-C was notified the following day of R3's discharge from the facility. RN-C stated the staff were expected to call her with any change in condition but generally staff only reported issues while onsite or more commonly RN-C would find evidence of a change when she reviewed resident medication	02310		

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lists from the pharmacy. RN-C stated she did not have access to the resident's electronic medical record and did not have a confidential email for communicating any resident information. RN-C was unable to clarify medication orders with the investigator.RN-C stated she did not review incident reports, was unaware of police interventions, and stated she did not have any input to R1, R2 or R3's admissions. RN-C stated she was made aware of the admissions after they occurred when she next visited. RN-C shared two text messages she sent to ALD-B indicating concerns about lack of compliance with assessments and medications and ALD-B assured RN-C the concerns would be corrected. In addition, RN-C stated ALD-B provided staff training, made admission decisions, created behavior plans and interventions, coordinated with the providers, pharmacies, and case managers.

During another interview on August 12, 2024, at 1:00 p.m. ALD-B stated he spoke with RN-C prior to admitting R1, R2, and R3. ALD-B stated it was a collaborative process between ALD-B, RN-C, resident, and case manager. ALD-B stated R3 may have been assessed the following week by RN-C because R3 had no place to go, R3 had all his belongings in garbage bags and ALD-B stated he felt bad for R3 but stated RN-C was informed ahead of time because ALD-B shared all the clinical information with RN-C. The investigator asked ALD-B if aware the RN was required to complete a nursing assessment before admission. ALD-B stated "yes" and further indicated when they see on a referral there are no tubes or any medical issues like wounds or physical disabilities, we (ALD-B and RN-C) look at all the documents provided by the CM and/or discharging facility and we make a collective

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02310	Continued From page 19 decision. ALD-B stated it was simple then to have pharmacies transfers medications and deliver to the facility. ALD-B stated medication orders were obtained by the pharmacy. During an interview August 12, 2024, at 4:15 p.m. with pharmacy the investigator confirmed ALD-B was the primary contact for the facility and no history noted of coordination between pharmacy and RN-C. Pharmacy also verified R1's quetiapine was decreased from 200mg every night to 150mg every night in March 2024 although R1 MARS reviewed from March to current indicate R1 prescribed quetiapine 200mg. During an interview on August 14, 2024, at 3:15 p.m. CM-H stated ALD-B was made aware of safety concerns with R3 at past assisted living facilities and aware of R3's criminal history before admission. CM-H shared concern with ALD-B if the facility could safely manage R3 especially the risk to other vulnerable adults. ALD-B assured CM-H the facility was aware and planned to move forward with R3's admission. CM-H stated she was not made aware of the problems the facility had with R3's behavior until just before a pretermination meeting was scheduled. CM-H asked if the facility contacted 911 for each incident and ALD-B stated "no". CM-H stated the expectation was the staff would call 911 if R3 was a danger to self or others or unlawful activity. CM-H stated she was not aware of a facility RN or any RN involvement in addition CM-H requested R3 care plan and assessments on several occasions and was not provided until two months following admission. The licensee's Acceptance of Residents policy dated August 1, 2021, indicated the licensee would evaluate the needs of residents and the	02310		

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	36569	A. BUILDING: ______ B. WING ______	C 07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR LIVING LLC	**7949 BURNSWICK AVENUE NORTH BROOKLYN PARK, MN 55443**

(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
02310	Continued From page 20 licensee's ability to provide sufficient number of qualified staff. A final decision for admission is made by the registered nurse and the director at the time of the assessment. The licensee's Comprehensive Nursing Assessment policy dated August 1, 2021, indicated the registered nurse would conduct a comprehensive assessment for all residents to determine the services required and to develop an individualized care plan for staff to implement. In addition, the RN would reassess the resident no more than fourteen days after admission. In addition, the RN would complete ongoing assessments not to exceed 90 days from the last assessment or with any change of condition. The licensee's Vulnerable Adult policy dated August 1, 2021, indicated Senior Living responsibilities included admitting residents who care can be safely provided. In addition, the facility had responsibility to assess each resident's vulnerability status upon admission, develop an individual abuse prevention plan with immediate implementation and ongoing evaluation of the plan. No further information was provided. 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.	02360		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02360	Continued From page 21 This MN Requirement is not met as evidenced by: The facility failed to ensure three of three residents reviewed (R1, R2 and R3) were free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		