Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL368492241M
Compliance #: HL368493949C

Date Concluded: January 9, 2023

Name, Address, and County of Licensee Investigated:
Personal Care Management
525 Cutter Street
Anoka, MN 55303
Anoka County

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

Evaluator's Name: Peggy Boeck, RN
Special Investigator

Finding: Substantiated, individual responsibility

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

Initial Investigation Allegation(s):
The alleged perpetrator (AP), facility staff, abused a resident when the AP squeezed the resident's finger/hand, which were swollen due to cellulitis, causing the resident to yell out in pain. The AP did this to place medication in the resident's mouth.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. Video from the resident's room showed the AP attempting to wake the resident without success, and then squeezed the resident's sore hand until he yelled out in pain. The AP then placed a medication in the resident's mouth and walked out of the room.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of resident records, facility

policies and procedures related to background studies, medication administration, medication refusals, and maltreatment of vulnerable adults.

The resident lived in an assisted living memory care unit with diagnoses including dementia and diabetes. The resident's service plan included assistance with bed mobility, dressing, grooming, incontinence care, meals, medication administration, safety checks, and transfers. The resident received hospice services from an outside provider who prescribed comfort medications given every four hours around the clock. The resident's medication administration record had specific instructions for placing the medications under the resident's tongue or in the resident's cheek as the medications were quick dissolve and did not require a drink of water to ingest.

During an interview, a family member stated the resident had cellulitis of his left hand and it was swollen and painful due to an infection. The family placed a video camera in the resident's room shortly after admission to ensure the resident received medications. The family member stated one night she observed the AP (on video) grab the resident's sore hand and the resident yell out. (The family member took a screen shot of the interaction, which was shared with the investigator.) The family member stated the next night family saw on the video the AP intentionally grab the resident's hand again to wake him and the resident yelled out. The family member stated the AP "tossed a pill in" the resident's mouth and left the room. The family member stated she notified the facility the next day.

During an interview, a nurse stated the residents family member showed her video from the previous night of an incident with the AP. The nurse stated the video showed the AP squeeze the resident's sore hand. The nurse stated the AP appeared intentional in her action of squeezing the resident's hand and it was "awful" to watch. The nurse stated she saw on the video the resident opened his mouth to yell out in pain and the AP put medication in the resident's mouth.

During an interview, a management staff stated she viewed the video and saw the AP squeeze the resident's hand, which was swollen.

During an interview, the AP stated the resident was aggressive during cares. The AP stated during the interview that no one told her that the resident had a sore finger/hand, but later in the interview stated that she saw that his finger was swollen. The AP stated if a resident did not want to take a medication, a person could try to force them "nicely" to take it. The AP stated the facility would not let her watch the video, however, the AP stated the video was "wrong."

At the time of the investigation the video from the date of the incident was no longer available to the investigator.

In conclusion, abuse is substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.

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

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;

Vulnerable Adult interviewed: No, the resident passed away.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility investigated the incident, and the AP no longer works at the facility.

Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:
https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html
If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.
You may also call 651-201-4200 to receive a copy via mail or email

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36849	A. BUILDING: _____ B. WING _____	C 12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSONAL CARE MANAGEMENT LLC	525 CUTTER STREET ANOKA, MN 55303

(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 Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL368493949C/#HL368492241M On December 20, 2022, 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 31 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL368493949C/#HL368492241M, tag identification 0620, 1290, 2360, and 3000.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 620 SS=F	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36849	A. BUILDING: _____ B. WING _____	C 12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSONAL CARE MANAGEMENT LLC	525 CUTTER STREET ANOKA, MN 55303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 620	Continued From page 1 144G.42 Subd. 6. Compliance with requirements for reporting maltreatment of vulnerable adults; abuse prevention plan. (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected abuse of one of one residents (R1) reviewed for maltreatment. R1's family member showed several facility staff video of unlicensed personnel (ULP)-C squeezing R1's swollen finger/hand, (which had cellulitis- a skin infection in which the affected area is swollen and inflamed and is typically painful and warm to the touch). This action made R1 yell out, after which ULP-C placed medication in R1's open mouth. Facility staff did not file a MAARC report for eight days. This had the potential to affect all 31 residents receiving services from the licensee. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include:	0 620	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36849	A. BUILDING: _____ B. WING _____	C 12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSONAL CARE MANAGEMENT LLC	525 CUTTER STREET ANOKA, MN 55303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 620	Continued From page 2 A MAARC report dated August 2, 2022, at 4:25 p.m. indicated family expressed concern after they viewed video from R1's room that occurred the previous night. According to the report, family observed ULP-C enter R1's room to deliver medications and R1 would not open his mouth. ULP-C squeezed R1's infected/swollen left finger/hand until R1 yelled out in pain. ULP-C placed a pill into R1's open mouth and left the room. During an interview on December 21, 2022, at 9:30 a.m. house manager (HM)-B stated she heard of the incident from family and viewed the video of the incident. HM-B stated it appeared ULP-C entered R1's room around 4:00 a.m. and could not wake R1, so she squeezed his finger/hand, which was swollen. HM-B stated it appeared ULP-C knowingly caused R1 pain. HM-B stated a report was not immediately filed as they were waiting for direction from administration. During an interview on December 23, 2022, at 10:30 a.m. licensed practical nurse (LPN)-F stated she heard from the family the day after the incident and viewed the video that showed ULP-C squeeze R1's finger/hand. LPN-F stated the facility waited eight days before filing a report with MAARC, as they were waiting for clarification from administration. LPN-F stated she believed they were required to file a report within 24 to 48 hours of the incident. The facility Vulnerable Adult Maltreatment-Prevention and Reporting policy dated August 22, 2022, indicated all staff received education about how to report suspected maltreatment internally and to MAARC. The policy further indicated the report must be made	0 620	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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36849	A. BUILDING: _____ B. WING _____	C 12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSONAL CARE MANAGEMENT LLC	525 CUTTER STREET ANOKA, MN 55303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 620	Continued From page 3 no later than 24 hours after the maltreatment was first suspected. TIME PERIOD FOR CORRECTION: SEVEN (7) DAYS	0 620		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation and document review, the licensee failed to ensure one of one employees (unlicensed personnel (ULP)-C) reviewed for maltreatment received a Department of Human Services (DHS) background study clearance prior to providing direct contact services or access to residents. This had the potential to affect all 31 residents receiving services from the licensee. 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	01290	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36849	A. BUILDING: _____ B. WING _____	C 12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSONAL CARE MANAGEMENT LLC	525 CUTTER STREET ANOKA, MN 55303

(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
01290	Continued From page 4 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: A search of the Minnesota Department of Human Services (DHS) background study website (https://netstudy2.dhs.mn.us/Live/Employees/SearchRoster) conducted on December 12, 2022, at 3:27 p.m. indicated the employee roster affiliation for the licensee (HFID #36849) did not include ULP-C as a current or former employee. A search of the DHS background study website (https://netstudy2.dhs.state.mn.us/Live/PersonSearch) conducted December 12, 2022, at 3:37 p.m. indicated the former licensee (HFID #33942) requested a background study of ULP-C on May 3, 2022, and received documentation on May 18, 2022, to immediately remove ULP-C from their position, as ULP-C did not provide fingerprints and photo as required. During an interview on December 22,2022 at 9:30 a.m. house manager (HM)-B stated the previous owners did not provide copies of employee files when they changed ownership in August 2022. HM-B stated she was not aware that ULP-C did not have a cleared background study from DHS. The licensee did not provide ULP-A's personnel file. The Background study policy dated August 1, 2021, indicated no employee may provide direct services and have independent direct contact with any residents until an acceptable result of the	01290	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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36849	A. BUILDING: _____ B. WING _____	C 12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSONAL CARE MANAGEMENT LLC	525 CUTTER STREET ANOKA, MN 55303

(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
01290	Continued From page 5 background study had been received by the licensee. TIME PERIOD FOR CORRECTION: SEVEN (7) DAYS	01290		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: Based on interviews and document review the facility failed to ensure one of one residents (R1) reviewed was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual staff person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details. No plan of correction is required for this tag.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	
03000 SS=F	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36849	A. BUILDING: _____ B. WING _____	C 12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSONAL CARE MANAGEMENT LLC	525 CUTTER STREET ANOKA, MN 55303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
03000	Continued From page 6 vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time 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	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36849	A. BUILDING: _____ B. WING _____	C 12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSONAL CARE MANAGEMENT LLC	525 CUTTER STREET ANOKA, MN 55303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
03000	Continued From page 7 information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to follow their policy of reporting suspected maltreatment to the state agency (Minnesota Adult Abuse Reporting Center (MAARC)) no later than 24 hours after the maltreatment was first suspected for of one of one residents (R1) reviewed for maltreatment. R1's family member showed several facility staff video of unlicensed personnel (ULP)-C squeezing R1's swollen finger (which had cellulitis- a skin infection in which the affected area is swollen and inflamed and is typically painful and warm to the touch), which made R1 yell out but no one at the facility filed a report with MAARC for eight days. This had the potential to affect all 31 residents receiving services from the licensee. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). A MAARC report dated August 2, 2022, at 4:25 p.m. indicated family expressed concern after they viewed video from R1's room that occurred the previous night. According to the report, family observed ULP-C enter R1's room to deliver medications and R1 would not open his mouth. ULP-C then squeezed R1's infected/swollen left finger/hand until R1 yelled out in pain. ULP-C	03000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36849	A. BUILDING: _____ B. WING _____	C 12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSONAL CARE MANAGEMENT LLC	525 CUTTER STREET ANOKA, MN 55303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
03000	Continued From page 8 placed a pill into R1's open mouth and left the room. During an interview on December 21, 2022, at 9:30 a.m. house manager (HM)-B stated she heard of the incident from family and viewed the video of the incident. HM-B stated it appeared ULP-C entered R1's room around 4:00 a.m. and could not wake R1, so she squeezed his finger, which was swollen. HM-B stated it appeared ULP-C knowingly caused R1 pain. HM-B stated a report was not immediately filed with MAARC as they were waiting for direction from administration. During an interview on December 23, 2022, at 10:30 a.m. licensed practical nurse (LPN)-F stated she heard from the family the day after the incident and viewed the video that showed ULP-C squeeze R1's finger. LPN-F stated the facility waited eight days before filing a report with MAARC, as they were waiting for clarification from administration. LPN-F stated she believed they were required to file a report within 24 to 48 hours of the incident. The facility Vulnerable Adult Maltreatment-Prevention and Reporting policy dated August 22, 2022, indicated all staff received education about how to report suspected maltreatment internally and to MAARC. The policy further indicated the report must be made no later than 24 hours after the maltreatment was first suspected. TIME PERIOD FOR CORRECTION: SEVEN (7) DAYS	03000		