Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL369133683M
Compliance #: HL369136058C

Date Concluded: July 21, 2023

Name, Address, and County of Licensee Investigated:
Hayden Grove Senior Housing
8715 Portland Avenue South
Bloomington, MN 55420
Hennepin County

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

Evaluator's Name: Peggy Boeck, RN,
Special Investigator
Jennifer Segal, RN
Special Investigator

Finding: Substantiated, facility responsibility
Inconclusive

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 Perpetrators (APs), facility staff, neglected Resident 1 and Resident 2 when they failed to answer call lights in a timely manner and refused to toilet Resident 1 and Resident 2.

It is alleged the APs neglected Resident 1 when they refused to wear personal protective equipment (masks and gloves) when caring for the resident and moved Resident 1's call light and phone, preventing the resident access to call for staff assistance.

It is also alleged the APs abused Resident 1 when they caused bruises during transfers.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was substantiated for Resident 1 and Resident 2. The facility was responsible for the maltreatment of Resident 1. The facility failed to ensure staff responded to the residents call light and request with toileting assistance. Resident 1 acquired bladder infections related to the lack of staff assistance.
The facility was responsible for the maltreatment of Resident 2. The facility failed to ensure staff responded to the residents call light and assist the resident with cares. Resident 2 did not receive assistance with toileting and urinated in cups related to lack of staff assistance.

The facility was aware the staff did not answer call lights in a timely manner and made no system changes to ensure Resident 1 and Resident 2 were receiving the necessary care and services. The facility was aware several staff (identified as APs by first name only, seen on residents' apartment videos) would not provide residents assistance with services that were not in the resident's service plan (such as unscheduled toileting). The facility was aware staff told residents the facility would charge them more money for extra services. In addition, the facility would not require staff to wear personal protective equipment in Resident 1's room, which was ordered by a physician.

The Minnesota Department of Health determined abuse was inconclusive. Resident 1 had fragile skin due to advanced age. Although Resident 1 had bruising, it could not be determined who caused the bruising or when the bruises occurred.

The investigators conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family members and reviewed video evidence. The investigation included review of incidents, personnel files, medical records, personnel files, policies, and procedures related to assessments, complaints, infection control, service plans, job responsibilities, staffing, and maltreatment of vulnerable adults. Also, the investigator observed Resident 1 and Resident 2's rooms, as well as resident/staff interactions.

Resident 1's medical record indicated the resident had diagnoses including heart disease, osteoarthritis, advanced age-related decline in functional status, and recurrent urinary tract infections. The resident's service plan included assistance with toileting every two hours. Resident 1 was independent with using her call light and phone, was alert and oriented, and able to make her needs known.

During an interview Resident 1's family member stated a camera placed in the resident's apartment captured multiple staff (including AP1) denying Resident 1's request to use the toilet, often telling the resident, "It's not time". The family member stated Resident 1 had several urinary tract infections, and she observed on video many times the resident activating her call light to request staff assistance and staff would not respond to the residents call light for hours. The family member stated she notified the administrator and nurse she observed on video staff moving Resident 1's call light and phone out of her reach.

During an interview, a nurse stated there had been a change in management and the facility was aware of the long call light response times. The nurse stated she felt the facility staffing was adequate.

During investigative interviews, multiple staff members stated they went out of their way to not work with Resident 1 (switching assignments or changing shifts) because they did not want to interact with the family. Several staff stated if they were busy, they would acknowledge resident 1's call light on their phone so the call light would stop beeping, but they did not go to Resident 1's room to provide the resident with assistance. Staff stated the call light system alerted all staff working. Two staff stated they did not wear masks in Resident 1's apartment because they were tired of masking since the pandemic and thought it was not needed.

A review of four months of Resident 1's call light logs indicated there were 82 instances of staff response times of greater than one hour.

Resident 2's medical record indicated the resident moved into the facility due to limited mobility. The resident was non ambulatory and a high fall risk. Resident 2 required assistance with toileting every two to three hours, and as needed. Resident 2 required assistance from 1 to 2 staff with transfers, toileting, dressing, and getting to and from meals and activities. Resident 2 was independent with using her the call light, telephone, and was able to communicate and make her needs known.

During an observation the investigator observed multiple plastic cups stacked in Resident 2's apartment. Two of the cups were full of urine, and the linen was soiled. Resident 2's apartment smelled of urine.

During interview, Resident 2 stated she used the cups to urinate in when the staff did not respond to the call light. Resident 2 stated she had waited up to six hours for staff to respond to a call light. Resident 2 stated her skin got sore from sitting in soiled briefs and sometimes she pinched her skin when using the plastic cup between her legs to urinate. Resident 2 stated earlier that day, staff did not come until 9:00 a.m. so she missed breakfast with peers which made her feel lonely. Resident 2 stated she was also late to a morning activity. Resident 2 stated "I'm scared, I want to run away but I don't know where to go."

During interview, Resident 2's family member stated they placed four cameras in the resident's apartment and captured the lack of staff response. The family member stated the video confirmed the resident missed meals and activities when staff did not arrive for scheduled service. The video showed slow to no response when Resident 2 pushed her call light. The family member observed video of a staff who told Resident 2 she would not help her to the toilet because the last time she did not go. The family heard Resident 2 on the video state "I really have to go". Family stated Resident 2 called 911 twice for help when staff did not respond. Once when staff left Resident 2 on the toilet and did not return to assist the resident when she was finished. Another time the resident called 911 was when no staff came to assist

Resident 2 with her scheduled morning care. The family member stated Resident 2 missed breakfast and lunch while she laid in a wet bed and called 911 for assistance. The family member stated Resident 2 did not want to go on, she had lost hope, and did not trust the facility would provide needed services.

During an interview, a nurse acknowledged the excessive call light wait times and stated it's been a long term and repetitive problem. The nurse stated the facility was working on incentives with staff to improve the wait time and the customer service.

During investigative interviews, multiple staff members stated Resident 2's call light frequently went unanswered for long periods of time. Staff members acknowledged silencing the call light alerts and allowing Resident 2 to urinate in cups rather than provide the services agreed upon.

A review of five months of Resident 2's call light logs confirmed there were 42 instances of response times greater than one hour.

In conclusion neglect is substantiated and abuse is inconclusive.

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

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.

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;
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.

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

Vulnerable Adults interviewed: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: AP1 declined, AP2/AP3/AP4/AP5 were not fully identified.

Action taken by facility:
The facility suspended several staff and ended the employment of AP1. The facility indicated it started a quality improvement project to decrease wait times and improved customer service.

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36913	A. BUILDING: _____ B. WING _____	C 07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYDEN GROVE SENIOR HOUSING	8715 PORTLAND AVENUE SOUTH BLOOMINGTON, MN 55420

(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 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: #HL369126058C/#HL369133683M On July 10, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 66 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL369126058C/#HL369133683M, tag identification 2310 and 2360.	0 000		
02310 SS=H	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care	02310		

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02310	Continued From page 1 standards. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to provide appropriate care and services according to acceptable health care, medical, or nursing standards for 2 of 2 residents (R1 and R2) reviewed for maltreatment when staff failed to answer call lights in a timely manner. Harm occurred when R1 was diagnosed with urinary tract infections after pushing her call light up to 62 times and waiting up to 912 minutes for staff assistance. Harm occurred when R2 resorted to urinating in cups, after pushing her call light up to 38 times and waiting up to 620 minutes for staff assistance. R2 stated she lost hope. 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). Findings include: R1 R1 moved into the facility on June 28, 2022, due to syncope, atrial fibrillation, advanced age-related decline in functional status, coronary artery disease, history of humerus and arm fractures, osteoarthritis, and recurrent urinary tract infections.	02310	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.	

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02310	Continued From page 2 R1's service agreement dated June 23, 2022, indicated services received included full assist with showers, morning cares (activities of daily living, grooming, hygiene), bedtime cares (activities of daily living, grooming, hygiene), toileting (offers at 9:00 a.m., 11:00 a.m., 1:00 p.m., 3:00 p.m., 5:00 p.m., 7:00 p.m., 12:00 a.m., 3:00 a.m.), laundry, and safety checks every two hours (6:00 a.m., 8:00 a.m., 10:00 a.m., 12:00 p.m., 2:00 p.m., 4:00 p.m., 6:00 p.m., 8:00 p.m., 10:00 p.m., 12:00 a.m., 2:00 a.m., and 4:00 a.m.) R1's lab report dated September 24, 2022, indicated R1's urine tested positive for e-coli bacteria and R1 required an antibiotic. R1's call light report dated October 2022, included the following number of times R1 pushed her call light and staff response times: October 3, 2022, 2:55 p.m., 25 pushes, 44 minutes October 3, 2022, 8:56 p.m., 4 pushes, 117 minutes October 3, 2022, 11:32 p.m., 11 pushes, 328 minutes October 6, 2022, 9;01 p.m., 17 pushes, 311 minutes October 7, 2022, 4:24 a.m., 29 pushes, 273 minutes October 8, 2022, 8:23 p.m., 6 pushes, 189 minutes October 9, 2022, 3:04 p.m., 7 pushes, 136 minutes October 10, 2022, 9:38 p.m., 1 push, 70 minutes October 13, 2022, 4:52 p.m., 1 push, 61 minutes October 26, 2022, 3:06 a.m., 2 pushes, 147 minutes October 27, 2022, 9:52 a.m., 5 pushes, 252 minutes October 29, 2022, 2:39 a.m., 4 pushes, 912	02310		

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02310	Continued From page 3 minutes October 31, 2022, 4:50 p.m., 2 pushes, 343 minutes R1's progress note dated October 29, 2022, at 11:55 p.m. indicated R1 reported not feeling well and the nurse advised staff to push fluids. R1's record contained no nursing assessment on or about October 29, 2022. R1's call light report dated February 2023, indicated the following number of times R1 pushed her call light and staff response times: February 2, 2023, 1:18 a.m., 1 push, 52 minutes February 2, 2023, 2:35 a.m., 13 pushes, 27 minutes February 7, 2023, 4:04 a.m., 4 pushes, 60 minutes February 8, 2023, 12:48 a.m., 2 pushes, 69 minutes February 9, 2023, 1:09 a.m., 3 pushes, 188 minutes February 11, 2023, 2:36 a.m., 13 pushes, 91 minutes February 11, 2023, 5:05 p.m., 1 push, 296 minutes February 12, 2023, 4:21 a.m., 11 pushes, 76 minutes February 13, 2023, 12:09 a.m., 8 pushes, 67 minutes February 13, 2023, 12:09 a.m., 8 pushes, 67 minutes February 13, 2023, 3:36 a.m., 2 pushes, 121 minutes February 13, 2023, 10:09 p.m., 3 pushes, 67 minutes February 14, 2023, 1:08 a.m., 4 pushes, 86 minutes February 14, 2023, 3:42 a.m., 1 push, 102	02310		

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02310	Continued From page 4 minutes February 15, 2023, 2:09 a.m., 8 pushes, 186 minutes February 16, 2023, 12:18 a.m., 10 pushes, 66 minutes February 16, 2023, 9:28 p.m., 2 pushes, 107 minutes February 17, 2023, 9:20 p.m., 21 pushes, 539 minutes February 18, 2023, 7:27 p.m., 4 pushes, 130 minutes February 21, 2023, 1:25 a.m., 1 push, 230 minutes February 22, 2023, 12:09 a.m., 16 pushes, 323 minutes February 26, 2023, 4:46 a.m., 4 pushes, 65 minutes February 27, 2023, 6:11 a.m., 1 push, 111 minutes February 27, 2023, 8:22 p.m., 1 push, 146 minutes R1's progress note dated February 27, 2023, at 9:29 p.m. indicated family member (FM)-A notified the nurse that R1 had a urinary tract infection. The note indicated FM-A brought R1's urine sample to the lab, and it tested positive for bacteria. R1's call light report dated May 2023, indicated the following number of times R1 pushed her call light and staff response times: May 2, 2023, 2:24 p.m., 3 pushes, 121 minutes May 3, 2023, 10:24 p.m., 5 pushes, 173 minutes May 6, 2023, 1:15 a.m., 62 pushes, 61 minutes May 7, 2023, 5:44 p.m., 2 pushes, 82 minutes May 8, 2023, 10:55 a.m., 1 push, 67 minutes May 8, 2023, 2:06 p.m., 1 push, 89 minutes May 9, 2023, 4:24 a.m., 3 pushes, 79 minutes May 10, 2023, 12:34 a.m., 2 pushes, 109 minutes	02310		

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02310	Continued From page 5 May 10, 2023, 4:59 a.m., 1 push, 75 minutes May 10, 2023, 11:00 p.m., 11 pushes, 91 minutes May 11, 2023, 10:49 p.m., 6 pushes, 63 minutes May 12, 2023, 10:03 p.m., 12 pushes, 86 minutes May 13, 2023, 3:22 a.m., 2 pushes, 70 minutes May 13, 2023, 4:37 a.m., 3 pushes, 78 minutes May 13, 2023, 11:20 p.m., 2 pushes, 570 minutes May 14, 2023, 9:15 p.m., 9 pushes, 76 minutes May 15, 2023, 3:23 a.m., 10 pushes, 71 minutes May 17, 2023, 8:54 p.m., 1 push, 191 minutes May 18, 2023, 6:35 a.m., 1 push, 69 minutes May 18, 2023, 9:52 p.m., 3 pushes, 79 minutes May 19, 2023, 5:54 a.m., 3 pushes, 179 minutes May 19, 2023, 8:56 a.m., 1 push, 146 minutes May 19, 2023, 4:35 p.m., 1 push, 66 minutes May 19, 2023, 11:38 p.m., 10 pushes, 72 minutes May 20, 2023, 12:56 a.m., 2 pushes, 76 minutes May 20, 2023, 11:33 p.m., 1 push, 93 minutes May 23, 2023, 4:26 p.m., 4 pushes, 66 minutes May 24, 2023, 6:31 a.m., 1 push, 63 minutes May 24, 2023, 10:36 a.m., 1 push, 116 minutes May 25, 2023, 1:42 a.m., 3 pushes, 171 minutes May 26, 2023. 11:24 p.m., 6 pushes, 115 minutes May 27, 2023, 1:52 a.m., 10 pushes, 89 minutes May 27, 2023, 3: 31 a.m., 7 pushes, 179 minutes May 27, 2023, 6:22 p.m., 2 pushes, 186 minutes May 31, 2023, 3:48 a.m., 4 pushes, 65 minutes R1's nursing assessment dated May 26, 2023, indicated R1 had recurrent urinary tract infections, required assistance of one for toileting and/or incontinence cares, was independent with operation of the call light, was independent with use of the phone, was alert and oriented (to person, place, time, and situations), communicated, and was able to make her needs known. R1's call light report dated June 2023, included the following number of times R1 pushed her call	02310		

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02310	Continued From page 6 light and staff response times: June 1, 2023, 12:15 p.m. 1 push, 81 minutes June 2, 2023, 9:19 p.m., 6 pushes, 116 minutes June 3, 2023, 9:42 a.m., 1 push, 107 minutes June 5, 2023, 7:48 p.m., 2 pushes, 104 minutes June 6, 2023, 3:07 a.m., 14 pushes, 152 minutes June 7, 023, 4:52 a.m., 4 pushes, 131 minutes June 11, 2023, 7:29 p.m., 1 push, 73 minutes June 13, 2023, 3:02 a.m., 6 pushes, 105 minutes June 20, 2023, 2:45 a.m., 6 pushes, 88 minutes June 24, 2023, 2:18 a.m., 3 pushes, 104 minutes June 24, 2023, 4:08 a.m., 21 pushes, 97 minutes R1's service plan dated July 10, 2023, indicated staff were to perform the following tasks: "staff are to wear a mask and gloves during cares (assigned once per shift AM, PM, Nights); check on resident at start of shift, check toileting log, if resident has not toileted in 3 hours take her to the bathroom, document on log sheet (assigned once per shift AM, PM, Nights); take resident to the bathroom if not toileted in 3 hours, check log, assist with toileting (no days/shifts/or times assigned). During observation of FM-A's video of R1's room (dated October 26, 2022, at 1:00 a.m.), unlicensed personnel (ULP)-C was seen and heard stating to R1 "What's your problem? You don't go back to the toilet again until 4:00 o'clock!" During an interview on July 10, 2023, at 2:12 p.m. FM-A stated the family was told by the facility that the care suites where R1 resided had "immediate call light responses, but not longer than 10 to 15 minutes" but that had not proven true. FM-A requested call light logs, but the facility did not provide them, so the family installed a camera and regularly reviewed the footage. FM-A stated	02310		

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02310	Continued From page 7 she had multiple videos showing staff responding to R1's call light but refusing to offer assistance to the toilet (often stating "No, you just went" or "I was just in here"). FM-A stated R1 had repeated urinary tract infections and believed R1 did not receive appropriate care. FM-A stated she felt it necessary to spend a lot of time in R1's apartment. During an interview on July 10, 2023, at 4:48 p.m. interim director of nursing (DON)-B stated she had worked at the facility for three weeks and was aware of the facility problem with long wait times for answering resident call lights. DON-B stated the previous administration encouraged staff to refuse services that were not in the service plan, and DON-B was working on changing that culture with staff education, observation, and coaching. During an interview on July 12, 2023, at 8:00 a.m., ULP-D stated she was uncomfortable providing cares for R1 while family was in the apartment. ULP-D stated she masked during the pandemic, but now ("due to asthma") she would not mask. ULP-D stated if R1's light went off, she would not answer it, but allow another staff to. ULP-D stated the staff phones (on which they received the call light notification) had a function to shut off the sound of the alarm without entering the resident's room to reset the call light. During an interview on July 12, 2023, at 9:00 a.m., ULP-E stated when a call light goes off, it alerts with a noise to the phone of everyone who is in the building, and if not answered, continues to go off until it is reset in person in the resident's room. ULP-E stated staff press "take" on the phone to stop the sound of the call light. ULP-E stated she told residents they would get charged	02310		

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	36913	A. BUILDING: _____ B. WING _____	C 07/10/2023

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02310	Continued From page 8 if they asked for something not on the service plan. ULP-E stated wearing masks in R1's room bothered staff because they were tired of wearing masks. R2 R2's nursing assessment dated February 22, 2023, indicated R2 was non ambulatory, required two staff for transfers and received assistance with dressing, showers, toileting, and incontinence care. R2 moved into the facility on February 24, 2023, due to frequent falls and limited mobility. R2's service plan dated February 25, 2023, indicated R2's service plan included assistance with personal care and hygiene, escort to all meals and safety checks. R2's progress note dated March 22, 2023, indicated R2 needed to use the bathroom. The writer (a nurse) instructed R2 to push her call button to obtain staff assistance, after 15 minutes there had been no response from staff. The nurse attempted to reach staff and still got no response from staff. 15 minutes after that two staff arrived to assist R2 to use the bathroom. R2's call light report dated March 2023, included the following number of times R2 pushed her call light and staff response times: March 1, 2023, 8:22 a.m., 4 pushes, 82 minutes March 5, 2023, 2:03 a.m., 10 pushes, 481 minutes March 9, 2023, 1:13 p.m., 4 pushes, 213 minutes March 10, 2023, 3:43 a.m., 1 push, 160 minutes March 12, 2023, 3:10 a.m., 2 pushes, 145 minutes March 14, 2023, at 9:44 p.m., 1 push, 127	02310		

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02310	Continued From page 9 minutes March 19, 2023, at 2:39 a.m., 1 push, 137 minutes March 19, 2023, at 7:13 a.m., 13 pushes, 237 minutes R2's call light report dated April 2023, included the following number of times R2 pushed her call light and staff response times: April 1, 2023, at 7:36 a.m., 2 pushes, 61 minutes April 5, 2023, at 5:55a.m., 2 pushes, 86 minutes April 10, 2023, at 1:46 a.m., 4 pushes, 170 minutes April 10, 2023, at 8:48 a.m., 2 pushes, 251 minutes April 11, 2023, at 9:07 a.m., 2 pushes, 620 minutes April 12, 2023, at 10:08 a.m., pushes not indicated, 176 minutes April 18, 2023, at 6:48 a.m., 1 push, 106 minutes R2's call light report dated May 2023, included the following number of times R2 pushed her call light and staff response times: May 1, 2023, at 7:51 a.m., 6 pushes, 90 minutes May 3, 2023, at 7:27 a.m., 5 pushes, 158 minutes May 9, 2023, at 7:07 a.m., 9 pushes, 80 minutes May 13, 2023, at 9:24 p.m., pushes not indicated, 98 minutes May 14, 2023, at 8:57 p.m., 11 pushes, 187 minutes May 15, 2023, at 9:27 p.m., 3 pushes, 95 minutes May 18, 2023, at 1:53 p.m., 4 pushes, 116 minutes May 19, 2023, at 9:28 p.m., 2 pushes, 110 minutes May 20, 2023, at 2:14 p.m., 2 pushes, 105 minutes May 22, 2023, at 9:39 p.m., 1 push, 152 minutes May 23, 2023, at 9:31 a.m., 41 pushes, 61	02310		

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02310	Continued From page 10 minutes May 24, 2023, at 11:54 p.m., 7 pushes, 127 minutes May 26, 2023, at 9:51 p.m., 1 push, 66 minutes May 27, 2023, at 7:43 a.m., 2 pushes, 133 minutes May 29, 2023, at 10:53 a.m., 15 pushes, 100 minutes May 31, 2023, at 6:55 a.m., 3 pushes, 61 minutes R2's call light report dated June 2023, included the following number of times R2 pushed her call light and staff response times: June 3, 2023, at 10:25 p.m., 25 pushes, 148 minutes June 8, 2023, at, 4:45 a.m., 2 pushes, 112 minutes June 11, 2023, at 10:55 p.m., 7 pushes, 62 minutes June 15, 2023, at 7:04 a.m., 3 pushes, 128 minutes June 17, 2023, at 9:20 p.m., 7 pushes, 266 minutes June 19, 2023, at 6:30 p.m., 22 pushes, 135 minutes June 27, 2023, at 9:38 p.m., 18 pushes, 243 minutes R2's nursing assessment dated June 28, 2023, indicated R2 had difficulty sleeping at night due to toileting needs and indicated R2 "reports she is voiding into a cup between scheduled visits at 0100 and 0500". The assessment indicated R2 was able to communicate all needs without difficulty and was independent with using her call button. The assessment indicated a diagnosis of depression that was not noted on previous nursing assessment. R2's service plan dated June 28, 2023, included	02310		

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02310	Continued From page 11 staff assistance every morning at 7:30 a.m. and every evening at 9:00 p.m. to include transfers, dressing/undressing, hygiene, and toileting. The service plan directed staff to ensure R2's bed and clothing were clean and dry at 7:30 a.m. and 9:00 p.m. daily, empty her trash and complete laundry if needed. In addition, staff were directed to assist R2 daily with toileting at 8:15 a.m., 11:15 a.m., 1:30 p.m., 4:00 p.m., 7:00 p.m., 10:15 p.m., 1:00 a.m., and 5:00 a.m. There were no interventions in R2's service plan related to R2 urinating in cups. R2's progress notes dated July 6, 2023, indicated R2 was in bed crying, said she felt depressed and had difficulty talking with others. R2's call light report dated July 2023, included the following number of times R2 pushed her call light and staff response times: July 4, 2023, at 11:36 a.m., 3 pushes, 124 minutes During an observation on July 10, 2023, at 3:30 p.m. the investigator saw multiple clear plastic cups stacked on the table next to R2's bed. Two of the cups were full of urine. In R2's living room area, another stack of clear plastic cups was observed on the table. R2's apartment smelled like urine. During an interview on July 10, 2023, at 3:30 p.m. R2 stated she used the cups to urinate in when the staff did not respond to the call button. R2 stated since she moved into the facility staff did not respond to her call light. R2 stated she had waited up to six hours for staff to respond to her call light. R2 stated she recently had to call 911 because staff did not answer her call light. R2	02310		

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02310	Continued From page 12 stated this morning staff did not come until 9:00 a.m., and R2 missed breakfast with peers and that made her feel lonely and then was late to morning activity. R2 stated her skin got sore from sitting in soiled briefs and sometimes she pinched her skin when using the plastic cup between her legs. R2 stated "I'm scared, I want to run away but I don't know where to go". During an interview on July 10, 2023, at 5:00 p.m., interim director of nursing (DON)-B stated her expectation was for staff to answer call lights within 10-15 minutes. DON-B stated they were working on the excessive call light wait times and acknowledged it's been a long term and repetitive problem. DON-B stated she expected staff to assist R2 when she pressed her call light and expected staff to empty the cups of urine. DON-B stated that R2's bottom was red and planned to obtain an order to apply barrier cream. During an interview on July 12, 2023, at 12:15 p.m., ULP-H stated R2's call light frequently went unanswered. ULP-H stated that when any resident pushed the call light, it alerted all staff's phones. ULP-H acknowledged seeing cups of urine in R2's apartment and stated it was staff responsibility to empty the cups of urine. ULP-H acknowledged R2's light was on for a long time the morning of the interview. During an interview on July 13, 2023, at 12:30 p.m., family member (FM)-G stated they installed four cameras in R2's apartment shortly after R2 moved in because R2 frequently called to report staff did not respond to call lights or to compete scheduled services. FM-G stated he notified facility management of concerns and stated the concerns were not addressed until months later. FM-G stated that in a meeting with facility	02310		

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02310	Continued From page 13 management family shared observations from video of missed meals, missed activities and slow to no response for call lights. FM-G stated he observed video of a staff who told R2 she would not help R2 to the toilet because last time R2 did not go. FM-G stated R2 was heard on the video stating "I really have to go". FM-G stated one time R2 was left on the toilet and when staff did not return, R2 called 911 for assistance. On another day staff did not go to R2's apartment for morning cares. FM-G stated R2 missed breakfast and lunch while she laid in a wet bed and called 911 for assistance. FM-G stated R2 did not want to go on, she had lost hope and did not trust the facility to provide needed services. FM-G hoped for improvement with new management. During an interview July 13, 2023, at 11:00 a.m., ULP-I stated it was not uncommon to see R2 and other residents call lights on for hours. ULP-I stated when a resident pushed their call button an alert went out to all staff and management phones. ULP-I stated some staff would silence the alert but not go to the resident apartment. The investigator requested R2's Individual Abuse Prevention Plan. DON-B stated there was not an individual plan. The Staffing Plan and Daily Schedule policy dated July 28, 2021, indicated the licensee would provide qualified direct-care staff sufficient to meet the residents scheduled and reasonably unforeseen needs and staff would respond to resident request for assistance within a reasonable amount of time. The Resident Assistant Job Description document dated November 2014, indicated the	02310		

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02310	Continued From page 14 resident assistant (unlicensed personnel ULP) responsibilities and duties included answering all pendant (call lights) calls promptly and taking proper action. TIME PERIOD FOR CORRECTION: Seven (7) Days	02310		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure two of two resident(s) reviewed (R1, R2) 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	No plan of correction is required for this tag.	