

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL374842002M
Compliance #: HL374843590C

Date Concluded: April 7, 2023

Name, Address, and County of Licensee

Investigated:

Stonecrest Living
3601 Shady Oak Road
Minnetonka, MN, 55305
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:

Brooke Anderson, RN Special Investigator
Willette Shafer, RN 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 a resident when supervision was not provided in accordance with the resident's plan of care. The resident was sent to the hospital with many self-inflicted injuries, despite an identified need for 1:1 supervision, and weeks later a staff member quit during the night shift due to the resident's escalating behavior, leaving the facility unattended.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to provide supervision in accordance with the resident's care plan and failed to develop and implement resident specific interventions to ensure the resident's safety. Despite known safety vulnerabilities and identified patterns of self-injurious behavior, facility staff were not directed or educated on behavior monitoring, de-escalation techniques, or interventions on how to manage the resident's behavior. As a result, facility staff left in the middle of a night shift when they became frustrated with the

resident's escalating behavior and calls made to request assistance went unanswered. Police were contacted by another resident as the facility was left unattended, and no staff were available to provide resident assistance.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted law enforcement and the resident's case manager. The investigation included review of the resident's medical record, police reports, personnel files, and facility policies and procedures. Also, the investigator conducted a tour of the facility and observed interactions between staff and residents.

The resident resided in an assisted living facility. The resident's diagnoses included traumatic brain injury, schizoaffective disorder, and mood disorder. The resident's service plan indicated the resident required assistance with medication management, dressing, bathing, transfers, and mental health management. The resident had a history of self-injurious behavior and had a suicide prevention plan that directed staff to ensure no sharp objects were available to the resident.

Review of the resident's medical record identified multiple incidents of the resident engaging in self-injurious behavior by banging his head on the table, hitting himself with his fists, and throwing himself on the ground.

After the first incident of self-injurious behavior, the facility implemented 1:1 staffing and supervision of the resident. However, the behaviors continued, and further incidents occurred. No further assessments were completed to evaluate, identify, and implement new interventions to prevent further occurrences and ensure the resident's safety. No additional direction or education was provided to staff on how to mitigate, respond, or manage the resident's behavior.

Despite the facility's identified need for 1:1 supervision of the resident, the resident sustained an unwitnessed fall where self-inflicted injuries were observed. Staff contacted emergency medical services and the resident was transported to the hospital.

Hospital records identified the resident was found by staff between the headboard and the mattress of his bed. The hospital records identified concerns over the extent of injuries on the resident which included multiple bruises and abrasions over his extremities, torso, and face, and two puncture wounds to the abdomen. The wounds were treated and the resident later returned to the facility.

Hospital discharge paperwork indicated to strongly consider 2:1 supervision of the resident. Upon the resident's return to the facility no assessment was completed, no updates were made to the resident's medical record or service plan, and no additional supervision was implemented.

Approximately three weeks later, an incident occurred during the night shift where the resident's behavior escalated to the point of the resident throwing feces at staff and residents. The unlicensed personnel (ULP) #1 working at the time became frustrated and did not know how to respond or de-escalate the resident's behavior. The staff member contacted administrative staff and additional staff who did not answer his calls. The resident's behavior continued and the staff member became frustrated and left. Another resident contacted police due to the facility being left unattended and the increase in behavior of the resident.

Review of a police report from the night of the incident indicated paramedics arrived at the facility and found the resident on the bathroom floor covered in feces. The police report indicated the resident had been on the ground for a "substantial amount of time." Paramedics were onsite for 20 minutes and never observed a staff member at the facility. According to the police report, the facility's administrative staff were unable to contact ULP# 1 and were unsure why ULP #1 left the facility.

During an interview, a police officer stated he did not see staff present at the facility until ULP #3 arrived when the resident was in the ambulance.

During an interview, ULP #3 stated he worked at the licensee's other facility the evening of the incident. ULP #1 called while he was assisting another resident with a shower. ULP #3 stated he attempted to call ULP #1 back, but no one answered, so he ran to the facility. ULP #3 stated when he got to the facility, the resident was in the ambulance and the facility had been left unattended. ULP#3 remained at the facility for the rest of the night shift.

During an interview, administrative staff confirmed the facility was left unattended until ULP #3 arrived. The administrative staff also confirmed the second employee that was scheduled for the resident's 1:1 staffing was a float employee (ULP #3) and was scheduled at a different facility. Administrative staff stated if a staff member needed to leave the facility during their shift, they were to notify administration and they would find a replacement for the staff member. If the situation was an emergency, staff had been directed to call 911. A review of staffing schedules was completed with the administrative staff who confirmed the facility was not consistently staffed to accommodate the resident's need for 1:1 supervision.

During an interview, ULP #1 stated he was working at the facility alone the night of the incident. ULP #1 assisted the resident into the bathroom and the resident began to smear feces all over. ULP #1 called another facility where ULP #3 was working to ask for help, and no one answered. ULP #1 then called administrative staff and the other locations of the company and left voicemails regarding the urgency of the situation. ULP #1 stated he waited 20-30 minutes for assistance and didn't think to call 911. ULP #1 said he had been working long hours in the weeks prior to the incident and was frustrated when no one answered to help, and he left the facility. ULP #1 stated he was not trained on how to handle the resident's behaviors and was not trained how to handle an emergency. ULP #1 stated that usually only one staff member was scheduled at the facility which did not allow for the resident to be provided 1:1 supervision.

Investigative interviews completed with additional staff members indicated the facility typically staffed one person on each shift and the resident was not provided the 1:1 supervision the facility had determined was required to ensure the resident's safety.

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: No, unable to interview due to cognitive impairment.

Family/Responsible Party interviewed: No, family did not respond to interview request.

Alleged Perpetrator interviewed: Yes.

Action taken by facility:

Following the incident, the facility worked with the resident's care team and the hospital to determine appropriate interventions for the resident's mental health.

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

Hennepin County Attorney

Minnetonka City Attorney

Minnetonka Police Department

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37484	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/15/2023
NAME OF PROVIDER OR SUPPLIER STONECREST LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 3601 SHADY OAK ROAD MINNETONKA, MN 55305			
(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	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.</p> <p>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.</p> <p>INITIAL COMMENTS: #HL374843590C/#HL374842002M</p> <p>On February 15, 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 5 residents receiving services under the provider's Comprehensive Assisted Living license.</p> <p>The following correction orders are issued for #HL374843590C/#HL374842002M, tag identification 0470, 0630, and 2360.</p>	0 000	<p>Assisted Living Provider 144G.</p> <p>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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>THE LETTER IN THE LEFT COLUMN IS</p>		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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0 000	Continued From page 1	0 000	USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 470 SS=G	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the	0 470			

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0 470	<p>Continued From page 2</p> <p>licensee failed to provide adequate staffing to meet the needs of one of one resident (R1) who required one to one staffing, with records reviewed.</p> <p>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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>R1 admitted to the facility on May 12, 2022, due to diagnoses that included a traumatic brain injury, schizoaffective disorder, and mood disorder.</p> <p>R1 ' s service plan indicated R1 required assistance with medication management, dressing, bathing, transfers, and mental health management services.</p> <p>R1's incident report dated May 16, 2022, indicated R1 got up without assistance and was found on the ground. The incident report indicated the follow up intervention implemented was one to one staffing.</p> <p>R1's fall assessment dated May 16, 2022, indicated the resident fell and the licensee implemented one-to-one staffing.</p> <p>The staffing schedule for May 2022 through December 2022, indicated two unlicensed personnel (ULP) were scheduled to work daily,</p>	0 470			

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0 470	<p>Continued From page 3</p> <p>starting June 2, 2022, and ending August 1, 2022. One ULP was assigned to supervise R1 at all times.</p> <p>The police report dated July 9, 2022, indicated paramedics were called to the facility and found R1 on the ground in the bathroom. The report indicated no staff were observed at the facility for 20 minutes while the emergency services personnel were assisting R1.</p> <p>During an interview on February 16, 2022, at 2:30 p.m. a police officer stated there were no staff at the facility. The police officer stated he observed other residents at the facility.</p> <p>During an interview on February 23, 2023, at 1:00 p.m. administrator (ADM)-B acknowledged the second employee for the one-to-one staffing was a float employee who was scheduled at another house. ADM-B acknowledged the facility was left unsupervised on July 9, 2022, and a resident at the facility called 911 for assistance.</p> <p>During an interview on February 16, 2023, at 11:00 a.m., licensed assisted living director (LALD)-A stated if the staff need to leave the facility during their shift, they must notify administration and they would find a replacement for the staff member. If the situation is an emergency the staff are to call 911.</p> <p>The licensee's policy dated August 1, 2021, titled "Staffing & Scheduling," indicated the licensee will assure employees will be scheduled and present to meet the needs of residents.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	0 470			

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0 630	Continued From page 4	0 630			
0 630 SS=G	<p>144G.42 Subd. 6 (b) Compliance with requirements for reporting ma</p> <p>(b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was updated to include specific measures to minimize the risk of abuse to residents for one of two residents (R1) reviewed.</p> <p>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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>R1 admitted to the facility on May 12, 2022, due to diagnoses that included traumatic brain injury,</p>	0 630			

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0 630	<p>Continued From page 5</p> <p>schizoaffective disorder, and mood disorder.</p> <p>R1's service plan indicated R1 required assistance with medication management, dressing, bathing, transfers, and mental health management services.</p> <p>R1's IAPP assessment dated May 12, 2022, indicated R1 was unable to ambulate safely, had chronic conditions, pain, illness, disability, chronic mental health disorder, lack of social system, elopement risk, falls, frequent bruising and R1 was not oriented to person, place, or time.</p> <p>R1's incident report dated May 20, 2022, indicated R1 was seen hitting himself in the head with his fists. The incident report indicated the follow up intervention implemented was one to one staffing.</p> <p>R1's incident report dated June 8, 2022, indicated R1 declined to eat and began banging his head on the table. The incident report indicated the follow up intervention implemented was one to one staffing.</p> <p>R1's incident report dated June 10, 2022, indicated R1 wanted to die and began banging his head on the table. The incident report indicated the follow up intervention implemented was one to one staffing.</p> <p>R1's incident report dated June 22, 2022, indicated staff attempted to assist R1 with a transfer from R1's bed. R1 refused staff assistance resulting in a witnessed fall. R1 was sent to the hospital for evaluation.</p> <p>R1's hospital records dated, June 22, 2022, indicated R1 was found at the facility between the</p>	0 630			

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0 630	<p>Continued From page 6</p> <p>headboard and mattress with multiple bruises throughout his body at various stages of healing and puncture wounds on his lower abdomen. R1's wounds were treated, and R1 returned to the facility.</p> <p>R1's change in condition review dated June 29, 2022, indicated R1 returned from the hospital. R1's change in condition review indicated to see progress notes for changes.</p> <p>R1's progress notes dated June 29, 2022, indicated R1 returned from the hospital and the care plan and IAPP were updated.</p> <p>R1's progress notes dated July 5, 2022, indicated R1 was seen removing bandages and picking at his wounds and was sent to the hospital for wound infection treatment.</p> <p>R1's change in condition review dated July 8, 2022, indicated R1 returned from the hospital and wound care was set up with an outside agency. R1's change in condition review indicated no additional changes to R1's plan of care.</p> <p>The police report dated July 9, 2022, indicated R1 was found on the ground covered in feces and R1 was sent to the hospital for evaluation.</p> <p>R1's IAPP change in condition review dated July 11, 2022, indicated R1 returned from the hospital. R1's IAPP change in condition review indicated no updates or changes.</p> <p>R1's IAPP was created May 12, 2022. The licensee failed to update R1's IAPP with new vulnerabilities and failed to implement new interventions to ensure R1's safety despite multiple incidents of self-injurious behavior.</p>	0 630			

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0 630	Continued From page 7 In an interview dated February 27, 2023, at 9:00 a.m. licensed assisted living director (LALD) indicated, IAPPs are completed at the time of admission and updated as needed with any resident changes or if there is a need for new interventions. IAPPs are reviewed in the 90-day assessments, change of conditions, and annually. The licensee's policy dated August 1, 2021, titled "Individual Abuse Prevention Plan" indicated the licensee will implement and update an IAPP for each resident that assesses specific measures to minimize abuse including self-abuse. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R1) was 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			

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02360	Continued From page 8 No plan of correction is required for this tag.	02360			