Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL399031740M
Compliance #: HL399039373C

Date Concluded: March 4, 2024

Name, Address, and County of Licensee Investigated:
Axis Home Health Care
590 Ballantyne Northeast Lane
Spring Lake Park, MN 55432
Anoka County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Brandon Martfeld, RN BSN
Special Investigator

Finding: Not Substantiated

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

Initial Investigation Allegation(s):
The alleged perpetrator (AP), facility staff, abused the resident, when the resident was pushed to the ground during an altercation. In addition, the resident was neglected when facility staff did not provide the resident medications, food, and arrange for community outings. In addition, the facility staff financially exploited the resident when unknown staff stole the resident's car key and wallet.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. Although the resident indicated the AP pushed him to the ground, the AP and a witness said the resident tripped himself and was not pushed.

The Minnesota Department of Health determined neglect was not substantiated. The facility staff provided for the resident's needs including food, medications, and outings as the resident allowed.

The Minnesota Department of Health determined financial exploitation was not substantiated. Facility staff assisted the resident search his room and were able to find the resident's wallet. The resident declined assistance from staff to search his room for the car key.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's county case manager and law enforcement. The investigation included review of the resident records, facility incident report, personnel file, the law enforcement report, and related facility policy and procedures. Also, the investigator made an unannounced visit to the facility and observed the common area outside of the resident's bedroom.

During the on-site visit the common area directly outside the resident's room was observed packed with numerous miscellaneous items. Staff confirmed the miscellaneous items in the common area belonged to the resident. Staff also stated the resident's room was cluttered with miscellaneous items. The resident refused to allow the investigator into his room.

The resident resided in an assisted living facility. The resident's diagnoses included attention deficit disorder, bipolar, and delusional disorder. The resident's service plan included assistance with medication administration and housekeeping. The resident was independent with activities of daily living and was moderately cognitively impaired.

The facility incident report indicated unlicensed personnel (ULP) notified the AP the resident had thrown a television remote at the ULP. The AP came to the facility to assist the ULP and smelled alcohol on the resident's breath. Due to concerns of the resident becoming increasingly angry when consuming alcohol, the AP requested to search the resident's room. Once in the resident's room the AP observed a locked safe. The AP asked the resident to open the safe however, the resident refused. The resident called the police. Once the police arrived, the resident calmed down and eventually the police and AP left the facility.

The law enforcement report indicated the resident stated the AP was destroying his property, going through his personal items, and attempted to take his safe. The AP suspected the resident of drinking alcohol and wanted to search the resident's room for alcohol. The resident stated the facility did not provide him meals, activities, and staff stole his keys and wallet.

In an email from the AP to the resident's case manager, the AP stated he told the resident he was going to take the resident's safe or have someone open it to check for alcohol. The resident pushed the AP and called the police. When the police arrived, police asked the resident to open the safe, however the resident refused. After the resident refused to open the safe for the police and because the AP did not want the situation to escalate, the AP requested police leave the safe locked. Once the resident calmed down, the police and the AP left the facility.

During an interview, the case manager stated the resident had a history of reporting concerns. The case manager stated she had not witnessed neglect of the resident at the facility.

During an interview, the AP stated the resident's room was very cluttered. The AP denied trying to take the resident's safe. The AP stated the resident tripped over the clutter in his room and fell backwards onto his bed. The AP assisted the resident to a standing position. The AP denied pushing the resident.

During an interview, the unlicensed staff member (ULP), who was working the evening of the incident, stated the resident threw a TV remote at the ULP. The ULP called the AP to assist with the resident's behaviors. The ULP stated while in the room with the resident and the AP, the resident tripped over clutter on the floor of the resident's room. The ULP stated AP did not push the resident.

During an interview, leadership stated the resident had a history of making false accusations against the staff. Leadership stated there was no evidence the AP pushed the resident during the incident. Leadership stated the resident refused to follow through on appointments to establish a new primary doctor therefore, the facility had no way to reorder medications for the resident without a primary doctor. Leadership stated the resident accused staff of stealing personal items, however, due to the resident's hoarding, often the resident had difficulty finding his personal items. Leadership stated staff found the resident's wallet in his room, but the resident chose to decline staff assistance searching his car keys.

During an attempted interview, the resident stated everything was fine and declined an interview.

The additional concerns identified in the complaint were investigated. During a tour of the facility, the kitchen cupboards and refrigerator were observed to have a variety of foods. The resident's records indicated staff brought the resident into the community for shopping activities for food and personal items. The resident's record also indicated staff administered medications as the resident allowed.

In conclusion, the Minnesota Department of Health determined abuse, neglect and financial exploitation was not substantiated.

"Not Substantiated" means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of an attempt to violate, or aiding and abetting a violation of:

(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(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;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening;

Financial exploitation: Minnesota Statutes, section 626.5572, subdivision 9
"Financial exploitation" means:
(b) In the absence of legal authority, a person:
(1) willfully uses, withholds, or disposes of funds or property of a vulnerable adult;
(2) obtains for the actor or another the performance of services by a third person for the wrongful profit or advantage of the actor or another to the detriment of the vulnerable adult;
(3) acquires possession or control of, or an interest in, funds or property of a vulnerable adult through the use of undue influence, harassment, duress, deception, or fraud; or
(4) forces, compels, coerces, or entices a vulnerable adult against the vulnerable adult's will to perform services for the profit or advantage of another

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. The resident declined the interview.
Family/Responsible Party interviewed: No. The resident was responsible for self.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:

The facility made attempts to establish a new primary doctor so the resident's medications can be reordered. The facility staff also made attempts to assist the resident locating missing items.

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

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

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

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

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39903	A. BUILDING: _____ B. WING _____	C 02/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AXIS HOME HEALTH CARE LLC	590 BALLYTYNE NORTHEAST LANE SPRING LAKE PARK, MN 55432

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL399031740M/#HL399039373C On February 6, 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 was one resident receiving services under the provider's Assisted Living license. The following correction order is issued for #HL399031740M/#HL399039373C, tag identification 0630,0800, and 1620.	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.	
0 630 SS=G	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma	0 630		

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0 630	Continued From page 1 (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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to assess and develop individualized interventions to ensure safety and prevent self-harm and harm to others for one of one resident (R1) after multiple incidents occurred related to aggressive behaviors, threats of self-harm, and threats of harming others. 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). The findings include: R1 admitted to the licensee on August 17, 2023, for diagnoses that included attention deficit disorder, bipolar disorder, and delusional disorder. R1 required assistance with medication administration and housekeeping. R1 was	0 630		

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0 630	Continued From page 2 independent with ambulation and was moderately cognitively impaired. R1's individual abuse prevention plan (IAPP) dated August 20, 2023, identified no areas of vulnerabilities that required staff interventions. During an observation on February 6, 2024, at 10:24 a.m., the licensee's downstairs common area was cluttered with miscellaneous items such as boxes, clothes, and random items stacked three to four feet high. Between the wall and the clutter there was a path that led to R1's room. Staff stated the items in the common area belonged to R1. R1's progress notes dated December 1, 2023, through January 31, 2024, included multiple incidents of aggressive behaviors, threatening behaviors of self-harm, threatening others, refusal to take medications, concerns with smoking tobacco, and drinking alcohol on the licensee premises. -December 1, 2023, R1 threw and broke items in the kitchen and yelled at staff. -December 2, 2023, R1 refused to take his medications. -December 3, 2023, R1 threw and broke items in the kitchen and yelled at staff. -December 6, 2023, R1 was verbally aggressive with staff and used racial slurs. -December 14, 2023, R1 was verbally aggressive with staff and used racial slurs. -December 15, 2023, R1 refused to take his medications. -December 20, 2023, R1 became angry and threw plates in the sink and threatened to break items in the house. -December 25, 2023, R1 applied locks to the kitchen cabinets.	0 630		

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0 630	Continued From page 3 -December 27, 2023, R1 refused to take his medications. -December 29, 2023, R1 threw plates in the sink, and threatened to break items in the house. -December 31, 2023, R1 threw plates in the sink, and threatened to break items in the house. -January 2, 2024, R1 refused to his medications. -January 3, 2024, R1 refused to his medications. -January 6, 2024, R1 was verbally aggressive, threatened staff, and threw a phone and broke it. -January 8, 2024, R1 was upset with a receptionist at R1's doctor office and canceled his doctor appointment. -January 15, 2024, R1 was verbal and physically aggressive with staff. R1 threw a TV remote against the wall. R1 also accused staff of stealing personal belongings. -January 16, 2024, R1 refused to take his night medications. -January 17, 2024, R1 refused to take his night medications. -January 18, 2024, R1 had alcohol in the upstairs common area. Staff told R1 to bring the alcohol back down to his room. -January 20, 2024, R1 drank alcohol in the upstairs common area. Staff told R1 to bring the alcohol back to his personal area. R1 was aggressive with staff. Later that day while shopping, R1 was verbally abusive towards staff and other shoppers in the store. -January 21, 2024, R1 threw items around downstairs at the licensee. R1 called the licensed assisted living director (LALD)-F and program manager racial slurs. Later that day, R1 made threatening remarks including breaking items in the house and hurting himself. -January 22, 2024, R1 was outside smoking	0 630		

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0 630	Continued From page 4 a cigarette. Later that day, R1 accused staff of stealing his medications. R1 was verbally aggressive with staff and called staff racial slurs. -January 23, 2024, R1 was outside smoking a cigarette. Later that day, R1 put water on the floor and stated it would stop him from getting shocked by static electricity. R1 then became agitated and threw a TV remote at staff. Staff called the program manager, because of previous incidents involving alcohol and R1's room was checked. Staff found five or six doses of medication that R1 claimed he had taken. During the search of R1's room for alcohol, R1 became physically aggressive with staff. Police were notified of the incident. -January 24, 2024, R1 was outside smoking a cigarette. -January 25, 2024, R1 smoked a cigarette three times. Later that evening, R1 became agitated and threw his drink bottle at the floor and wall. R1 was heard on the phone asking for a gun so he could shoot the owner and staff. -January 27, 2024, R1 became angry with staff over medication; R1 stated he wanted to die. -January 28, 2024, R1 threw items around in his room. When staff asked R1 what was going on, R1 refused to answer. R1 refused his morning medications. -January 29, 2024, R1 became angry with staff when R1 thought someone took his yogurt. -January 31, 2024, R1 was awake for most of the night smoking cigarettes and eating. R1 refused to take his night medications. R1 stated he had not slept for three days and made threatening comments towards staff. An email from the LALD-F to R1's county case manager dated December 27, 2023, indicated the licensee had concerns with R1's escalating behaviors and accusations towards staff of them	0 630		

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0 630	Continued From page 5 stealing his personal items. An email from the LALD-F to R1's county case manager dated January 5, 2024, indicated an increase in R1's mood and behaviors. An email from the LALD-F to the resident's county case manager dated January 10, 2024, indicated R1 canceled his doctor appointment and there was difficulty in finding R1 a new doctor. An email from the licensee program manager to the resident's county case manager dated January 24, 2024, indicated R1 started consuming alcohol. When consuming alcohol, R1 became aggressive and threatened staff. An email from the LALD-F to the resident's county case manager dated February 2, 2024, indicated the evening of February 1, 2024, R1 was naked in a common area and agitated with staff. R1 began calling staff racial slurs and was throwing objects at the staff. R1 began pulling the smoke alarms off the walls, accused staff of stealing personal belongings, and indicated he would starve himself. Furthermore, the email indicated R1's behaviors required careful attention and interventions. During an interview on February 6, 2024, at 11:08 a.m., the program manager (PM)-C stated on January 23, 2024, R1 threw a TV remote at staff member. During this incident, the PM-C suspected R1 had alcohol in his room. The PM-C stated during a search of R1's room, a locked safe was found. The PM-C stated R1 refused to open the safe to show staff. The PM-C also stated R1 refused to open the safe for the police. The PM-C stated the licensee was concerned	0 630		

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0 630	Continued From page 6 with R1's hoarding tendencies and aggressive behaviors. The PM-C stated R1 was a fall risk due to the clutter and hoarding in his room. The PM-C stated during this incident, R1 tripped over the clutter in his room, and fell backwards onto his bed. During an interview on February 6, 2024, at 11:39 a.m., the LALD-F and registered nurse (RN)-E stated they were aware of R1's behaviors. The LALD-F and RN-E stated they had concerns with R1 smoking cigarettes. The LALD-F and RN-E stated with R1 smoking, they had concerns about R1 smoking in his room because of R1's behaviors and the potential fire hazard because of the hoarding of items R1 kept in the basement and R1's bedroom. During an interview, on February 7, 2024, at 11:36 a.m., an unlicensed personnel (ULP)-G stated R1 had good days and bad days. The ULP-G stated when R1 was angry, interventions included one on one conversations, outings in the community or finding something R1 liked. During an interview, on February 7, 2024, at 11:57 a.m., registered nurse (RN)-E stated R1's IAPP was not updated after any of the incidents involving R1 and the IAPP did not reflect R1's noted behaviors. During an interview on February 13, 2024, at 3:27 p.m., the LALD-F stated R1 would not allow staff to enter his room. The LALD-F stated R1 had added a hinge lock to the inside of his door to prevent staff from entering. The LALD-F stated the licensee staff could open the door a few inches, however, R1 would need to get up and unlock the door to allow staff access to R1's room.	0 630		

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0 630	Continued From page 7 The licensee policy titled Vulnerable Adult, dated April 18, 2023, indicated the licensee was to individually assess the residents to determine vulnerability to abuse and neglect and develop a specific plan to minimize the risk of abuse to that resident. Abuse included self abuse and neglect. An individual abuse prevention plan shall be established for each resident. The plan should include susceptibility to abuse, contain risk of abusing others, specific measurements to be taken to minimize the risk of abuse and be implemented immediately. The licensee policy titled Unsafe Assisted Living Situations, dated April 18, 2023, indicated the licensee had responsibility to assess the safety of the resident. The policy further indicated if the RN determined the assisted living situation is unsafe for the resident, staff or other residents, a report to the Minnesota Adult Abuse Reporting (MAARC) would be made and the process for the discharge policy would be followed. No additional information was provided. TIME PERIOD OF CORRECTION: Two (2) Days.	0 630		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.	0 800		

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0 800	Continued From page 8 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 admitted to the licensee on August 17, 2023, for diagnoses that included attention deficit disorder, bipolar disorder, and delusional disorder. R1 required assistance with medication administration and housekeeping. R1 was independent with ambulation and was moderately cognitively impaired. During an observation on February 6, 2024, at 10:24 a.m., the licensee's downstairs common area was cluttered with miscellaneous items such as boxes, clothes, and random items stacked three to four feet high. The items were observed to be stacked from wall to wall. Between a wall and the clutter there was a path that led to R1's room. Staff stated the items in the common area belonged to R1.	0 800		

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(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
0 800	Continued From page 9 During an observation and an attempted interview on February 6, 2024, at 12:18 p.m., the investigator knocked on R1's door and attempted to enter R1's room. R1's door to his room was locked. R1 spoke through the shut door, stated he was fine, did not open the door, and declined to interview with the investigator. During an interview on February 6, 2024, at 11:08 a.m., the program manager (PM)-C stated R1's room is full of clutter. The PM-C stated staff had explained to R1 the risk of falling due to clutter. The PM-C stated during an incident on January 23, 2024, R1 tripped over his own clutter in his room and fell backwards onto his bed. During an interview on February 6, 2024, at 11:39 a.m., the registered nurse (RN)-E stated R1 hoarded items, including disposable bowls and other garbage. The RN-E stated R1 will not let staff dispose of the items. The RN-E stated the cluttered increased R1's risk for falls. The RN-E stated R1 did not let staff enter his room. During an interview on February 13, 2024, at 3:27 p.m., The LALD-F stated R1 would not allow staff to enter his room. The LALD-F stated R1 had added a hinge lock to the inside of his door to prevent staff from entering. The LALD-F stated staff could open the door a few inches, however, R1 would need to get up and unlock the door to allow staff access to R1's room. No additional information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39903	A. BUILDING: _____ B. WING _____	C 02/06/2024

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01620	Continued From page 10	01620		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure an assessment was completed for safe smoking for one of one resident (R1) reviewed. This practice had the potential to affect residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01620		

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01620	Continued From page 11 cause serious injury, impairment, or death) 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). The findings include: R1 admitted to the licensee on August 17, 2023, for diagnoses that included attention deficit disorder, bipolar disorder, and delusional disorder. R1 required assistance with medication administration and housekeeping. R1 was independent with ambulation and was moderately cognitively impaired. R1's individual abuse prevention plan (IAPP) dated August 20, 2023, indicated R1 did not have any vulnerabilities. The IAPP indicated "false" for vulnerabilities for safe smoking. The IAPP had pre-designed interventions to choose from with instructions to check the interventions that applied to R1. None of the interventions had check marks, indicating no plan was developed to provide for R1's safe smoking. R1's assessment dated December 5, 2023, indicated R1 did not smoke. R1's progress notes dated January 21, 2024, through January 31, 2024, indicated multiple occasions R1 was smoking. -January 21, 2024, R1 was outside smoking a cigarette. -January 22, 2024, R1 was outside smoking a cigarette. -January 23, 2024, R1 was outside smoking a cigarette. -January 24, 2024, R1 was outside smoking a cigarette.	01620		

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01620	Continued From page 12 -January 25, 2024, R1 smoked a cigarette outside three times. -January 31, 2024, R1 was awake for most of the night smoking cigarettes and eating. R1 refused to take his night medications. R1 stated he had not slept for three days and made threatening comments towards staff. During an interview on February 6, 2024, at 11:39 a.m., the licensed assisted living director (LALD)-F and registered nurse (RN)-E stated they had concerns with R1 smoking cigarettes. LALD-F and RN-E stated with R1 smoking, they had concerns about R1 smoking in his room because of R1's behaviors and the potential fire hazard because of R1 hoarding items in the basement and bedroom. During an interview, on February 7, 2024, at 11:57 a.m., (RN)-E stated R1's IAPP was not updated, and no smoking assessment was completed. During an interview on February 13, 2024, at 3:27 p.m., the LALD-F stated R1 would not allow staff to enter his room. The LALD-F stated R1 had added a hinge lock to the inside of his door to prevent staff from entering. LALD-F stated the licensee staff could open the door a few inches, however, R1 had to unlock the door to allow staff access to R1's room. The licensee policy titled Unsafe Assisted Living Situations, dated April 18, 2023, indicated the licensee had responsibility to assess the safety of the resident. The policy further indicated if the RN determined the assisted living situation is unsafe for the resident, staff or other residents, a report to the Minnesota Adult Abuse Reporting (MAARC) would be made and the process for the discharge	01620		

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01620	Continued From page 13 policy would be followed. No additional information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01620		