Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL239887082M
Compliance #: HL239886682C

Date Concluded: March 20, 2026

Name, Address, and County of Licensee Investigated:
Diamondcrest Senior Living
20600 South Diamond Lake Rd
Rogers, MN 55374
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:
Jana Wegener, RN, Special Investigator

Finding: Inconclusive

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 resident was neglected when the facility failed to provide necessary care and services for a cognitively impaired resident at risk for falls. The resident fell attempting to self-transfer and was sent to the emergency department (ED). The resident died 4 days later.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. Due to conflicting accounts about what the plan of care was for the resident at the time of the fall, there was not a preponderance of evidence to support that the resident's fall occurred because of the action or inaction of the facility staff. When the resident pushed her call pendant for help, staff responded, found the resident on the floor, and contacted 911. The resident was transferred to the hospital for further evaluation and admitted with a diagnosis of heart failure unrelated to the fall and died four days later.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member and law enforcement. The investigation included review of the resident record(s), death record, hospital records, clinic records, facility internal investigation documentation, facility incident reports, staff schedules, law enforcement reports, and related facility policy and procedures. Also, the investigator observed resident's and staff at the facility.

The resident resided in an assisted living facility with diagnoses including moderate dementia without behavioral disturbance and chronic diastolic congestive heart failure. The resident's care plan indicated the resident required toileting assistance, transfer assistance, and meal escorts. The resident's assessment indicated the resident was at a high risk for falls, overestimated or forgot her own limitations, had a weak gait, and had a history of falls. Prior to the fall, the resident had a noted decline in condition and was requiring more assistance; however, continued with the ability to request assistance and toilet and transfer self when able.

The facility incident report the day of the fall indicated staff responded to the resident's call light and found the resident lying face down on her bedroom floor near the door. The resident complained of pain in her left arm, had a black eye, and had broken her glasses. The resident's vital signs were abnormal, the ambulance was called, and the resident was transferred to the ED.

The resident's hospital record indicated the resident sustained a laceration on her elbow requiring sutures and had various bruises and abrasions. The resident had leg edema (swelling), and her chest imaging identified bilateral pleural effusions (excess fluid around the lungs). The resident was admitted to the hospital for exacerbation of congestive heart failure and started on intravenous diuretics (medication to remove excess fluid). Hospice services were initiated the next day following discussion with the family. While hospitalized, the resident became less responsive and died.

Review of the resident's service delivery record indicated the resident was to receive transfer assistance, toileting assistance, reminders and escorts to meals, meal setup, and safety interventions for falls, but on the day of the fall, the service delivery of care record lacked evidence the services were provided.

A facility investigation summary indicated the resident could push her pendant to request help and understood the importance of pushing her pendant to receive assistance for all cares. The resident notified staff when needing assistance but did not push her pendant call light until after falling. Although the facility investigation indicated staff checked on the resident prior to her fall, the resident record failed to indicate this occurred. The resident's assessment, plan of care, and services did not indicate she had to request assistance for care and services to be provided by ringing for staff assistance but rather had scheduled services that were not provided prior to the fall and transfer to the ED.

When interviewed, an unlicensed staff member stated she worked with the resident the day of the fall. The staff member indicated the resident could transfer independently and could toilet herself. If the resident needed assistance, she pressed her pendant for help. The staff member indicated that day the resident pressed her pendant, and when staff responded, they found the resident on the floor, and 911 was notified.

When interviewed, facility leadership stated staff followed the care plan the day of the incident and the resident had experienced a rapid decline prior to the fall. Facility leadership stated after the incident, education was provided to the staff about documenting cares.

When interviewed, the resident's family stated the resident had declined physically and cognitively and was no longer reliable to call staff for assistance when needed. The family stated the fall caused the resident severe pain and suffering, requiring pain medication, which hastened her decline and death.

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

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.

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, deceased
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: N/A

Action taken by facility:
After the resident fell, staff called 911, and the resident was transferred to the ED. The facility investigated the incident and implemented a checklist to ensure resident's who did not attend meals were checked on.

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

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

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

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23988	A. BUILDING: _____ B. WING _____	C 11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMONDCREST SENIOR LIVING	20500 SOUTH DIAMOND LAKE ROAD CORCORAN, MN 55374

(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****** HOME CARE PROVIDER/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: #HL239887082M/#HL239886682C On November 20, 2025, 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 73 residents receiving services under the provider's Assisted Living license. The following correction order is issued/orders are issued for #HL239887082M/#HL239886682C, tag identification 1650, 2310.	0 000		
01650 SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each	01650		

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01650	Continued From page 1 service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included an accurate description of the services to be provided according to the resident's current assessment for one of one resident (R1) reviewed. 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	01650		

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01650	Continued From page 2 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). Findings include: R1 was admitted to the licensee on April 15, 2015, with diagnoses including ischemic cardiomyopathy, moderate dementia without behavioral disturbance, mood disturbance, anxiety, atrial fibrillation, osteoarthritis of left shoulder, right foot drop, chronic diastolic heart failure, dependent edema, and chronic diastolic congestive heart failure. On September 30, 2025, R1's change of condition assessment indicated R1 had requested hospice services for end-of-life care. The assessment indicated R1 required assistance with coordination of medical appointments and hospice services. The assessment identified R1 had impaired cognition and severely impaired decision-making abilities. The assessment indicated R1 was non-ambulatory (unable to walk) bedbound and/or dependent on staff for ambulation needs on a regular basis. The assessment indicated R1 used a walker, transfer belt, and wheelchair and indicated R1 had recently acquired a wheelchair and may take a few steps while performing transfers however was safest not ambulating and should use her wheelchair for mobility. The assessment indicated R1 needed physical assistance from 1 staff with transfers on a regular basis. The assessment indicated R1 was incontinent of bowel and bladder and needed physical assistance with toileting hygiene and incontinence care. The assessment indicated R1 routinely used the toilet at scheduled times upon	01650		

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01650	Continued From page 3 waking, before and after meals and at bedtime and as needed. The assessment identified R1 may resist or say she does not need assistance however required staff assistance with toileting hygiene, transfer assistance, and clothing management. The assessment indicated R1 required escort assistance to meals but was independent with eating after meal set up. The assessment indicated R1 required assistance with ambulation and transfer assistance "on a regular basis" and as a result failed to clearly communicate to staff R1 was not ambulatory and dependent on staff for physical assistance with transfers using a transfer belt and her walker following the change of condition assessment. R1's plan of care was also updated September 30, 2025, but did not reflect the change of condition assessment completed that same day (September 30, 2025). R1's September 30, 2025 care plan indicated R1 needed assistance with ambulation using a 4 wheeled walker on a regular basis and needed physical assistance with transfers on a regular basis. The plan of care failed to clearly communicate to staff R1 was not ambulatory and may only take a few steps with her walker while staff provided physical assistance using a transfer belt and failed to communicate R1 was dependent of staff to provide physical assistance with all transfers not just on "on a regular basis" as indicated on the change of condition assessment completed that same day. The care plan indicated R1 needed assistance with her incontinence product in the morning and as needed (PRN) throughout the day and would be encouraged to request assistance with ambulation to the bathroom and staff should ensure a clear unobstructed path for R1 initiated	01650		

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01650	Continued From page 4 2 years prior to R1's change of condition and remained on the care plan with a revised intervention following the change of condition. The plan of care indicated R1 needed physical assistance with toileting tasks. The plan of care indicated R1 may resist and say she does not need assistance, however required assistance with hygiene, transfers, and clothing management. The plan of care indicated R1 routinely use the toilet upon waking, before/after meals and at bedtime. The plan of care failed to clearly communicate to staff that R1 was incontinent of bowel and bladder, non-ambulatory, and dependent on 1 staff physical assistance for transfers to the toilet using a transfer belt and walker at scheduled times of the day and PRN. R1's October 2025, service delivery of care record for care and service tasks assigned for staff to provide to R1 from October 1, 2025 to October 10, 2025 following the September 30, 2025 change of condition assessment included the following: AMBULATION: R1's services included assistance with ambulation qshift (every shift). The service indicate R1 recently acquired a wheelchair and may take a few steps while performing transfers however was safest not ambulating and using her wheelchair for mobility. The service failed to clearly communicate to staff that R1 was not ambulatory and dependent on a wheelchair for mobility. TRANSFERS: R1's services included assistance from 1 staff with transfers using a transfer belt qshift (every shift) and did not indicate if transfer assistance	01650		

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01650	Continued From page 5 was required for toileting as indicated on the assessment. The record showed staff documented providing transfer assistance 1-2 times per day (not every shfit). GROOMING: R1's services included assistance with grooming and range of motion while in bed 5 times daily scheduled at 7:45 a.m. (during R1's morning cares), and 10:15 p.m. (during R1's bedtime cares). The service was not scheduled 5 times daily for staff to complete, as a result there was no indication staff provided range of motion to R1 5 times per day. On November 20, 2025, at 8:40 a.m. during an interview with licensee leadership RN/ADON-A, Registered Nurse Director of Nursing (RN/DON)-B, and Executive Director (ED)-C, acknowledged R1 had a change of condition with cognitive and physical decline in function which was more rapid in the last month of her stay at the facility. Leadership stated the family was considering hospice and indicated it was more suited for R1 to remain in the assisted living facility rather than go to memory care. Leadership stated R1 required more assistance, required total care and was not ambulatory. Leadership stated R1 had scheduled toileting assistance but could also ring if she needed additional assistance. On December 1, 2025, at 11:53 during email communication ED-C indicated the RN was responsible to complete a change of condition assessment and update to the residents plan of care and tasks if needed. On December 2, 2025, at 9:00 a.m. ULP-J stated if a resident had a change of condition or need it	01650		

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01650	Continued From page 6 would be on the plan of care, assigned tasks for staff to complete, passed on during change of shift report, and posted on the communication board. ULP-J stated R1 did not need assistance with toileting or transfers, and indicated R1 was able to walk using her 4 wheeled walker. ULP-J denied being aware R1 had a change of condition with decline in cognition or physical function. On December 2, 2025, at 2:44 p.m. R1's family member stated R1 had recently had a significant decline in physical and cognitive function and not capable of consistently ringing for assistance. The family member indicated R1's provider had ordered R1 be admitted to memory care because it would be a safer environment, but the facility assured the family they could provide the care and services R1 needed at the assisted living facility. The family member stated if the facility had provided the care and services R1 needed the incident would have been prevented. The family member stated concerns with the facility not providing care and services for R1 was an ongoing concern with the facility. A licensee policy and procedure titled "Resident assessment and Re-Assessment Process" effective February 9, 2023, indicated nursing assessments would be completed by a registered nurse based upon the required assessment scheduled and as needed based upon resident condition. The policy and procedure indicated the RN would complete an comprehensive nursing assessment of the resident's physical, mental, and cognitive needs as required: pre-admission, 14 day assessment, ongoing no less than every 90 days, and with a change in the resident's condition. The assessment would include Risk indicators, fall risk, history of falling, level of assistance needed, including delegated tasks.	01650		

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01650	Continued From page 7 The policy and procedure indicated during a change of condition assessment the RN would review the resident's service plan, communicate any new problems or concerns to the resident's healthcare provider and updated the service plan as necessary based on the resident's needs. An RN may complete ongoing monitoring of a resident who received only one or more services including but not limited to dressing, grooming, toileting, bathing, and stand by assistance. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days.	01650		
02310 SS=D	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 standards. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure care and services were provided based on resident needs and in accordance with an up-to-date service plan for one of one resident (R1) reviewed. 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 an isolated scope (when one or a	02310		

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02310	Continued From page 8 limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings include: R1 was admitted to the licensee on April 15, 2015, with diagnoses including ischemic cardiomyopathy, moderate dementia without behavioral disturbance, mood disturbance, anxiety, atrial fibrillation, osteoarthritis of left shoulder, right foot drop, chronic diastolic heart failure, dependent edema, and chronic diastolic congestive heart failure. A licensee grievance form dated August 28, 2025, indicated R1's morning routine was discussed, the shower scheduled was changed, and the concern was resolved. There was no indication monitoring was implemented to ensure R1's cares and services were provided timely and meals were not missed. On August 29, 2025, R1's change of condition vulnerability assessment indicated R1 lacked orientation to time, place, and was unable to give accurate information consistently. R1 had limited range of motion, poor endurance and strength, impaired vision and hearing. The assessment indicated staff would know R1 limits of range of motion and assist me as needed. R1 had limited range of motion in my shoulders and neck. Please do not rush or push R1 too fast because it increased pain in her neck and shoulders when moved too quickly. When assisting R1 with dressing staff should take their time and go slowly. The assessment failed to identify R1 needed assistance with activities of daily living (ADL)s including incontinence care, toileting, assistance with mobility including transfers and	02310		

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02310	Continued From page 9 ambulation, getting to from meals, and how R1 mobilized. On August 30, 2025, R1's progress note (late entry) for a family care conference indicated R1's family was present to discuss R1's care level and increased weakness, leg swelling, and onset of heart failure diagnosis following a provider visit. The note indicated discussion about R1's recent decline in physical mobility was discussed, increased concern for falls, increased swelling to legs, use of diuretics, and leg wounds were not improved. The note indicated nursing discussed the disease process of heart failure and risk factors of reoccurring swelling and the heart related symptoms related to respiratory symptoms as well. Discussed the goals in care, at that time the family wanted to keep R1 comfortable. R1's fall risk assessment completed September 10, 2025, indicated R1 was at a high risk for falls, overestimated or forgot her own limitations, had a weak gait, and history of falls. A provider's order dated September 18, 2025, included orders for R1 to use a manual wheelchair and recommended R1 transition from assisted living to memory care due to a decline in her physical and mental abilities memory care would be a safer environment for R1. R1's record failed to indicate the facility took action to implement the providers orders for memory care, failed to indicate the licensee communicated with R1's provider or family about transitioning R1 to memory care. On September 23, 2025, email communication from R1's family member to the licensee	02310		

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02310	Continued From page 10 indicated the family reported concerns with finding soiled incontinent clothing and feces in the bathroom area when visiting R1 over the past 10 days. The email outlined specific needs R1 required including use of the wheelchair for mobility, assistance with transfers in and out of the wheelchair, assistance every time R1 needed toileting, and escort assistance to and from meals and activities using a wheelchair for mobility. On September 29, 2025, a licensee grievance form to follow up on concerns reported by the family on September 23, 2205, indicated a care meeting was held with the family to discuss the ongoing needs of R1. R1's record failed to indicate what concerns were reported by the family, and what actions were taken to ensure R1's needs were met including communicating to R1 provider and actions taken to resolve the grievance. There was no indication monitoring to ensure R1's cares and services were provided including assistance with transfers, escorts to meals, and toileting following the change of condition and in response to the concerns reported by family. On September 30, 2025, another provider's order indicated R1 should be admitted to memory care and included orders to arrange a hospice consult. R1's record including progress noted failed to indicate the facility took action to implement the providers orders for memory care or hospice consult. On September 30, 2025, R1's change of condition assessment indicated R1 had requested hospice services for end-of-life care. The assessment indicated R1 required assistance with coordination of medical appointments and hospice services. The	02310		

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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
02310	Continued From page 11 assessment identified R1 had impaired cognition and severely impaired decision-making abilities. The assessment indicated R1 was non-ambulatory (unable to walk) bedbound and/or dependent on staff for ambulation needs on a regular basis. The assessment indicated R1 used a walker, transfer belt, and wheelchair and indicated R1 had recently acquired a wheelchair and may take a few steps while performing transfers however was safest not ambulating and should use her wheelchair for mobility. The assessment indicated R1 needed physical assistance from 1 staff with transfers on a regular basis. The assessment indicated R1 was incontinent of bowel and bladder and needed physical assistance with toileting hygiene and incontinence care. The assessment indicated R1 routinely used the toilet at scheduled times upon waking, before and after meals and at bedtime and as needed. The assessment identified R1 may resist or say she does not need assistance however required staff assistance with toileting hygiene, transfer assistance, and clothing management. The assessment indicated R1 required escort assistance to meals but was independent with eating after meal set up. The assessment indicated R1 required assistance with ambulation and transfer assistance "on a regular basis" but failed to clearly communicate to staff R1 was not ambulatory and dependent on staff for physical assistance with transfers using a transfer belt and her walker following the change of condition assessment. R1's plan of care updated September 30, 2025, did not match the September 30, 2025 assessment. R1's September 30, 2025 plan of care indicated R1 needed assistance with ambulation using a 4	02310		

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	23988	A. BUILDING: _____ B. WING _____	C 11/20/2025

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02310	Continued From page 12 wheeled walker on a regular basis and needed physical assistance with transfers on a regular basis. The plan of care failed to clearly communicate to staff R1 was not ambulatory and may only take a few steps with her walker while staff provided physical assistance using a transfer belt and failed to communicate R1 was dependent of staff to provide physical assistance with all transfers not just on "on a regular basis". The care plan indicated R1 needed assistance with her incontinence product in the morning and as needed (PRN) throughout the day and would be encouraged to request assistance with ambulation to the bathroom and staff should ensure a clear unobstructed path remained on the care plan with a revised intervention. The plan of care indicated R1 needed physical assistance with toileting tasks. The plan of care indicated R1 routinely use the toilet upon waking, before/after meals and at bedtime. The plan of care failed to clearly communicate to staff that R1 was incontinent of bowel and bladder, non-ambulatory, and dependent on 1 staff physical assistance for transfers to the toilet using a transfer belt and walker at scheduled times of the day and PRN. R1's progress notes reviewed from August 21, 2025, to October 13, 2025, failed to indicate the facility received providers orders for a wheelchair, memory care, or hospice consultation. The progress notes failed to include information about R1's medical appointments, condition, status, decline in cognitive and physical function requiring a change of condition, and what additional care and services were needed to ensure R1's needs were met to ensure her safety. The progress notes lacked documentation of concerns reported by the family and what actions were taken to meet R1's needs. The	02310		

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02310	Continued From page 13 progress notes lacked documentation of any refusal of care, failed to indicate why services were not provided to R1, failed to indicate a supervisor, provider, or family was notified of the refusal of care and services and what actions taken to ensure R1's needs were met. On October 8, 2025, licensee care conference form indicated the family acknowledged the decline in R1's condition, increase in heart failure and previous conversations regarding hospice and memory care. The form indicated the family wanted to review the community's recommendation of hospice and remaining in assisted living verses memory care. The form indicated R1 provider had previously noted memory care was not necessary (1 year prior to R1's change of condition) however had not written orders to do so at that point. The form indicated according to Registered Nurse Director of Nurses (RN/DON)-B comments the licensee had received an order for hospice but as of September 30, 2025, the family was still conversing. RNDON-B indicated R1's physical condition as well as cognitive had continued to decline at a steady and more rapid trend with hospice as a resource for comfort it was the licensee's professional opinion would be more detrimental for R1 to move to memory care verses remaining in the familiar assisted living environment. R1's record failed to indicate the licensee had communicated with R1's provider about not admitting R1 to memory care as ordered. On November 20, 2025, at 8:40 a.m. during interview with licensee leadership RN/ADON-A, Registered Nurse Director of Nursing (RN/DON)-B, and Executive Director (ED)-C, acknowledged R1 had a change of condition with	02310		

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02310	Continued From page 14 cognitive and physical decline in function which was more rapid in her last few weeks at the facility. Leadership stated the family was considering hospice and indicated it was more suited for R1 to remain in the assisted living facility rather than go to memory care. Leadership stated R1 required more assistance required total cares and was not ambulatory. Leadership stated R1 had scheduled toileting assistance but could also ring if she needed additional assistance. On November 20, 2025, at 10:40 a.m. unlicensed personnel (ULP)-D stated R1 had declined was more confused, not able to walk, was wheelchair bound, and required stand by assistance with toileting. ULP-D indicated she did not think R1 had scheduled toileting assistance. ULP-D indicated R1 was not good about ringing for assistance when needed, would get confused and thought she was calling her family when she pressed her pendant or would forget the reason she called when staff responded. ULP-D stated R1 was a fall risk and indicated R1's wheelchair was the only fall intervention R1 had and was supposed to remind R1 to call for help when she saw the chair. On November 20, 2025, at 10:30 a.m. ULP-E stated R1 had transitioned to using a wheelchair was not ambulatory at all but was independent and would call for help when needed. ULP-E stated R1 did not have scheduled toileting assistance and was not at a risk for falls. ULP-E stated R1 could not bring herself to meals in her wheelchair. On November 20, 2025, at 10:52 a.m. ULP-F stated R1 did not require much help, once she was up and dressed R1 was independent with	02310		

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02310	Continued From page 15 toileting, transfers, and cares. ULP-F stated sometimes R1 used a wheelchair if her legs were more swollen and indicated she may call for help with an escort if she was using the chair. On December 1, 2025, at 11:53 during email communication ED-C indicated the RN was responsible to complete a change of condition assessment and updated the resident's plan of care and tasks if needed. ED-C indicated nursing was responsible for review and investigation if a task assigned was not completed. On December 2, 2025, at 2:44 p.m. R1's family member stated R1 had recently had a significant decline in physical and cognitive function and not capable of consistently ringing for assistance. The family member indicated R1's provider had ordered R1 be admitted to memory care because it would be a safer environment, but the facility assured the family they could provide the care and services R1 needed at the assisted living facility. The family member stated concerns with the facility not providing care and services for R1 had been an ongoing concern with the facility. An undated licensee policy and procedure titled "Orientation Training, Evaluation and Supervision of Unlicensed Personnel", indicated staff would be trained to document services provided for the resident. The RN must communicate with unlicensed personnel about the individual needs of the resident prior to delegating tasks. The policy indicated the RN would provide supervision of unlicensed team members for services including assistance with dressing, grooming, toileting, and scheduled tasks periodically and annually. Supervision would be completed to assess level of performance and identify problems and solutions related to performance	02310		

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02310	Continued From page 16 concerns if identified. A licensee policy and procedure titled "Resident assessment and Re-Assessment Process" effective February 9, 2023, indicated nursing assessments would be completed by a registered nurse based upon the required assessment scheduled and as needed based upon resident condition. The policy and procedure indicated the RN would complete an comprehensive nursing assessment of the resident's physical, mental, and cognitive needs as required: pre-admission, 14 day assessment, ongoing no less than every 90 days, and with a change in the resident's condition. The assessment would include Risk indicators, fall risk, history of falling, level of assistance needed, including delegated tasks. The policy and procedure indicated during a change of condition assessment the RN would review the resident's service plan, communicate any new problems or concerns to the resident's healthcare provider and updated the service plan as necessary based on the resident's needs. An RN may complete ongoing monitoring of a resident who received only one or more services including but not limited to dressing, grooming, toileting, bathing, and stand by assistance. No additional information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	02310		