*Protecting, Maintaining and Improving the Health of All Minnesotans*

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL31747005M
**Compliance #:** HL31747006C

**Date Concluded:** August 29, 2022

**Name, Address, and County of Licensee Investigated:**
2 Caring Hands
18712 Euclid Path
Farmington, MN 55024
Dakota County

**Facility Type: Assisted Living Facility (ALF)**

**Evaluator's Name:** Jennifer Segal, RN, BSN
Special Investigator

**Findings: Inconclusive**
**Substantiated, facility responsibility**

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

**Initial Investigation Allegation(s):**
**Allegation 1**. It is alleged the alleged perpetrator (AP), facility staff, emotionally abused the resident when the AP called the resident fat, and the AP pinched and shook the resident's skin on the resident's stomach.
**Allegation 2**. It is alleged facility staff neglected the resident when staff slept at night and told the resident not to wake them to assist the resident with toileting.

**Investigative Findings and Conclusion:**
The Minnesota Department of Health determined abuse was inconclusive due to conflicting information. The resident reported the AP pinched the resident's stomach and told the resident she was fat. However, the AP denied calling the resident fat or pinching the resident's stomach. There were no witnesses or supporting documentation regarding the allegation. It could not be determined if the allegation occurred.

The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The resident reported unlicensed staff members who worked at night told the resident not to wake them up if the resident needed assistance with cares. Review of recorded video of the facility common area showed multiple staff sleeping during multiple nights for extended periods of time. The facility schedule indicated only one staff was available at night to assist the resident with cares.

The investigations included interviews with facility staff including administrative, nursing, and unlicensed staff. The investigations included review of the resident's facility medical record, incident reports, employee records, facility staffing schedules, and facility policy and procedures. Onsite observations of resident cares and the facility environment were completed**.** In addition, video recording from a two-week period in the facility was reviewed.

The resident resided in an assisted living facility with diagnoses including morbid obesity, and a stroke.

The residents medical record indicated the resident required staff assistance with transfers, mobility, and positioning as needed. The resident required a Hoyer (mechanical) lift for transfers and used a wheelchair for mobility. The resident spent most of the time in bed, and staff were instructed to assist the resident with toileting every two hours, and as needed.

The resident reported to facility staff the AP pinched her stomach and told the resident she was fat.

When interviewed, the AP stated she recently lost weight and the resident asked the AP for weight loss tips. The AP stated she told the resident she lost weight by cutting out sweet foods and candy. The AP stated she never called the resident fat or told the resident she could not eat certain things.

When multiple facility staff were interviewed, they denied ever observing the incident and never heard the AP call the resident fat.

The resident also reported to management she was not getting staff assistance at night with toileting. The resident stated staff told the resident not to wake them up.

Review of the facility staff schedule over a four-month period indicated the facility scheduled one staff to work the 12-hour overnight shift, which was generally 7:00 p.m., to 7:00 a.m. The staff schedules indicated several staff members were scheduled to work twenty-four-hours, forty-eight hours, and occasionally seventy-two hours, shifts at the facility.

Review of recorded video of the facility over a 2-week time period was reviewed. One night a staff member was observed sleeping in the common area on the couch. The staff member went to sleep at 9:00 p.m. 5 ½ hours later the staff member woke up and was observed walking into another resident's bathroom. The staff was in the resident's bathroom for approximately two minutes and returned to the couch in the common area without providing any resident care. The staff went back to sleep and awoke 3 ½ hours later. The staff member was observed sleeping for a total of approximately 9 hours.
The correlating staff schedule indicated the staff member was the only staff member working at the facility during the night. In addition, the staff member was scheduled to work 16 ½ hours.

On another night in the two-week recorded video a staff member was observed sleeping in the common area on the couch. At approximately 9:25p.m. the staff member went into a resident's room and came out in pajamas, laid on the couch in the common area, and went to sleep. 5 ½ hours later the staff woke up and got off the couch to look into another resident's room. The staff did not provide cares and returned to the couch and went to sleep for another 3 ½ hours. The staff member woke up and walked into a resident's room still wearing her pajamas. A few minutes later the staff was observed coming out of the resident's room in daytime clothing. Review of the correlating staff schedule indicated the staff member was the only staff member working at the facility during the night. In addition, the staff member was scheduled to work a 24-hour shift.

The recorded video of a two-week time period showed staff sleeping 13 out of the 14 nights.

When interviewed the resident stated the night shift do not assist the resident with using the bedpan (toileting). The resident stated several of the staff sleep at night and the staff told the resident not to wake them up. During interview the resident was tearful describing difficulty waking staff. The resident stated sometimes all she heard at night was staff snoring on couch. The resident stated feeling ignored or shamed by staff when she requested help with the bedpan. The resident stated one staff told her not to wake the staff member at night because the staff can't get back to sleep and the staff would have a headache from lack of sleep if the resident woke them up to request assistance with cares.

During interview, management staff stated the expectation was for staff to be available and awake twenty-four hours a day, seven days a week, to provide the resident with the required assistance with cares.

Another management staff stated some staff slept during the night on the couch in the common area, however, staff were still expected to provide care to the residents every two

hours during the night and as needed. Management stated staffing was challenging and some staff worked the entire weekend from Friday night to Sunday or Monday, and one staff member regularly worked a twenty-four-hour shift once a week in addition to the weekend. Due to staff shortage, management stated at times there are no other options but to have staff work long shifts.

During interview with a nurse (former employee) she stated she had “grave concern” about the lack of care provided to the residents. The nurse stated some staff slept during the night and staff were present to “babysit” the residents, however, staff did not provide the necessary care to the residents.

When interviewed the residents outside case worker stated the expectation was the resident would receive assistance from awake staff twenty-four hours a day to assist with the resident’s needs. The case worker stated the resident required assistance with toileting every two hours and was able to communicate her needs.

In conclusion, the Minnesota Department of Health determined emotional abuse was inconclusive, and neglect was substantiated.

**Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.**
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

**Abuse: Minnesota Statutes section 626.5572, subdivision 2.**
"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(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

**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**: Yes
**Family/Responsible Party interviewed**: Resident own responsible party
**Alleged Perpetrator interviewed**: Yes

**Action taken by facility:**
No action taken.

**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 651-201-4890 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
Dakota County Attorney
Farmington City Attorney
Farmington Police Department

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 31747 | A. BUILDING: _____ B. WING _____ | C 12/14/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| 2 CARING HANDS INC | 18712 EUCLID PATH FARMINGTON, MN 55024 |

| (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 |
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| 0 000 | Initial Comments<br><br>Initial comments<br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>#HL31747001M #HL31747002C #HL31747003M #HL31747004C #HL31747005M #HL31747006C<br><br>On December 14, 2021, 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 Assisted Living license.<br><br>The following immediate correction order is issued for, #HL31747001M #HL31747002C #HL31747003M #HL31747004C and #HL31747005M #HL31747006C tag identification 0470.<br><br>The following correction order is issued for, #HL31747001M #HL31747002C #HL31747003M | 0 000 | Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3. | |

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| 0 000 | Continued From page 1<br><br>#HL31747004C and #HL31747005M #HL31747006C tag identification, 2360.<br><br>The following correction order is issued for, #HL31747001M #HL31747002C, tag identification 2310. | 0 000 | | |
| 0 470 SS=I | 144G.41 Subdivision 1 Minimum requirements<br><br>(11) develop and implement a staffing plan for determining its staffing level that:<br>(i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility;<br>(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<br>(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;<br>(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:<br>(i) awake;<br>(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;<br>(iii) capable of communicating with residents;<br>(iv) capable of providing or summoning the appropriate assistance; and<br>(v) capable of following directions;<br><br>This MN Requirement is not met as evidenced | 0 470 | | |

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| 0 470 | Continued From page 2<br>by:<br>Based on interview and record review, the licensee failed to ensure they had an awake staff person 24 hours per day seven days per week, who was responsible for providing the health and safety needs of three of three residents (R1, R2, R3) reviewed. Therefore, staff did not provide R1, R2, R3 their required services during the night.<br><br>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a 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).<br><br>The findings include:<br><br>R1's diagnoses included dementia, anxiety, and pressure ulcers. R1's nursing assessment dated July 29, 2020, indicated R1 had a history of a stage 4 (full thickness, bone/muscle exposed) pressure wound on her coccyx.<br><br>R1's service plan dated November 11, 2020, indicated R1 required toileting every two hours, one to two staff for positioning (frequency not indicated), dressing/grooming twice a day, bathing three times a week, eating assistance and medication assistance. A modification to services, undated, indicated post humerous fracture, R1 required a hoyer (total body lift) for transfer, continuous oxygen at two liters per minute, and wound care (frequency illegible). A note dated February 17, 2021, on the modification form indicated behaviors of yelling out. | 0 470 | | |

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| 0 470 | Continued From page 3<br><br>R1's progress note dated May 12, 2021, indicated R1's skin was intact. Progress noted dated June 11, 20221, indicated R1's family member (FM)-C expressed concerns of care to registered nurse (RN)-K and the house manager (licensed assisted living director (LALD)-A). RN-K indicated he was working with the house manager to develop/implement continuity of a care plan.<br><br>R1's progress note dated July 30, 2021, indicated R1's skin was intact. Unlicensed personnel (ULP) progress noted dated August 29, 2021, indicated R1 had both wet and dried feces on her.<br><br>An excel document created by FM-C, indicated on September 17, 2021, FM-C informed LALD-A via text message she would be installing a camera in R1's room due to concerns for safety. On September 24, 2021, FM-C had the camera installed.<br><br>Review of video from R1's camera showed on September 28, 2021, September 29, 2021 and September 30, 2021 staff sleeping through the night shift. The video also showed infrequent repositioning and incontinent care of R1, greater than every two hours.<br><br>FM-C's excel document indicated on October 2, 2021, FM-C showed LALD-A the video footage of inadequate care and sleeping staff.<br><br>R1's ULP progress note dated October 7, 2021, indicated staff sent R1 to the hospital for a change in condition.<br><br>R1's hospital record dated October 9, 2021, titled "Death Summary" indicated R1's final diagnoses included stage 4 coccyx wound and severe | 0 470 | | |

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| 0 470 | Continued From page 4<br>malnutrition in context of chronic illness.<br><br>R2's diagnoses included acute deep vein thrombosis (blood clot in legs), congestive heart failure, morbid obesity, left ankle fracture, major depression<br>R2's service plan dated May 7, 2021, indicated R2 received assistance with medication administration, bathing, grooming/dressing twice a day, incontinence care (frequency not indicated) and transfers.<br><br>R2's RN assessment dated June 6, 2021, indicated R2 was a high fall risk.<br><br>An incident report dated June 24, 2021, indicated at 2:25 a.m. R2 fell while walking back to his room from the bathroom. An incident report on July 12, 2021, (time unclear written "7 p.m. 45 p.m."), indicated R2 slid out of bed and required a lift to pick him up and put him back into bed.<br><br>R2's progress noted dated July 20, 2021, indicated R2 had been walking with physical therapy (PT) and has been going well. RN-K indicated walking had improved. Progress noted dated July 22, 2021, indicated PT will discharge next week. RN-K indicated R2 had improved in lower leg strength and range of motion.<br><br>An incident report dated July 25, 2021, at 3:30 p.m., indicated R2 fell while trying to self change his incontinent product. An incident report dated August 14, 2021, at 4:30 p.m., indicated R2's knee gave out while he was walking on the deck and fell. R2 transported to the hospital. An incident report dated August 15, 2021, at 5:00 p.m., indicated R2 fell from bed trying to stand with walker. | 0 470 | | |

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| 0 470 | Continued From page 5<br><br>R2's progress note on August 17, 2021, indicated R2 had a pre-operative appointment on August 20, 2021, for a left ankle surgery for a fracture on August 23, 2021. On August 20, 2021, transportation failed to arrive to take R2 to appointment. On August 27, 2021, surgery had been rescheduled for August 30, 2021. On August 31, 2021, R2 discharged back to the licensee post surgery with left ankle dressing changes required and to wear a boot.<br><br>R2's progress notes dated September 1, 2021 through December 9, 2021, indicated R2 had several hospitalizations related to blood clots in legs and a suspected stroke. On December 12, 2021, R2 returned to the licensee with stroke not indicated. R2 required total assist with repositioning and toileting with the use of a hoyer lift. R2 had 10/10 pain when attempting to turn.<br><br>R3's diagnoses included hypertension, morbid obesity, history of stroke. R3's service plan dated 12/2/21 indicated R3 received assistance with medication administration, bathing, grooming/dressing twice a day, toileting every two hours, and positioning assistance "as needed".<br><br>R3's RN assessment dated October 17, 2021, indicated R3 had no falls since admission, was unable to walk and required a hoyer lift for transfer, and skin was intact, but reddened in groin and arm pits.<br><br>During an interview on December 14, 2021, at 3:12 p.m., R3 stated ULP-B told her not to wake her up during the night shift for toileting or cares. R3 stated often staff make her wait to use the bedpan or be changed because it the end of their shift or tell her she went recently. R3 stated staff often sleep on their shifts, sometimes they work | 0 470 | | |

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| 0 470 | Continued From page 6<br><br>more that one day straight. R3 said there was no consistent schedule and staff dictated their own schedule. R3 kept a 2015 calendar that was used for year 2021 to log several occasions (more than once) where R3 documented time of bedpan request and either staff denied to help for she had to wait.<br><br>Review of the licensee's staff schedules indicated the following number of 24 hour shifts schedule each month were:<br>August 2021: seven 24 hour shifts<br>September 2021: twelve 24 hour shifts<br>October 2021: eleven 24 hours shifts<br>November 2021: four 24 hours shifts<br>December 2021: seven 24 hour shifts<br>Majority of the 24 hour shifts were schedule to ULP-H.<br><br>During an interview on April 29, 2022, at 10:31 a.m., RN-F stated she was the RN for seven of the different facilities owned by the same licensed owner (LALD-A) with five to six residents in each house in addition to working a separate full time job. RN-F stated the owners were determining admission of residents, so no RN was performing an assessment prior to admission. When asked who trained the staff to provide cares, RN-F stated no one, however she would inform staff of what the resident's care needs were. RN-F stated staff were directed to contact the owners for change of condition and the owners were making nursing decsisions, none of which were nurses. RN-F stated she had concerns with staff not providing incontinence cares when she rounded on residents during visits. RN-F described residents soaked all the way through linen [with urine] and told staff they needed to be cleaned and checked on more frequently. RN-F stated she received a call from LALD-A to assess R1's | 0 470 | | |

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| 0 470 | Continued From page 7<br><br>coccyx around June or July [2020] and RN-F stated she was upset to find R1 had a stage two (partial thickness) wound. RN-F stated she went to the home every day to ensure staff provided care and healed R1's coccyx wound in six months. RN-F stated she instructed staff to assist residents, like R1, who could walk to the restroom, but they did not do so because they were lazy and left residents in bed.<br><br>During an interview on May 5, 2022, at 11:00 a.m., LALD-A stated staff work 12 hour shifts and sometimes on the weekends work 24 hour shifts. When asked how staff stay awake, LALD-A stated she did not know how they did it, but were paid overtime.<br><br>TIME PERIOD FOR CORRECTION: IMMEDIATE | 0 470 | | |
| 02310 SS=J | 144G.91 Subd. 4 Appropriate care and services<br><br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the licensee failed to provide standard Fowler's position (head of bed raised between 45 and 60 degrees) for assisting with eating for one of one residents (R1) reviewed who required total assistance with eating. Staff fed R1 while laying flat in bed liquids and food. R1 died of aspiration pneumonia.<br><br>This practice resulted in a level four violation (a | 02310 | | |

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| | 31747 | A. BUILDING: _____ B. WING _____ | C 12/14/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| 2 CARING HANDS INC | 18712 EUCLID PATH FARMINGTON, MN 55024 |

| (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 8<br><br>violation that results in 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).<br><br>The findings include:<br><br>R1's diagnoses included dementia, anxiety, and pressure ulcers. R1's nursing assessment dated July 29, 2020, indicated R1 had a history of a stage 4 (full thickness, bone/muscle exposed) pressure wound on her coccyx.<br><br>R1's service plan dated November 11, 2020, indicated R1 services included eating assistance. R1 unable to communicate needs or obtain help.<br><br>R1's progress note dated June 11, 20221, indicated R1's family member (FM)-C expressed concerns of care to registered nurse (RN)-K and the house manager (licensed assisted living director (LALD)-A). RN-K indicated he was working with the house manager to develop/implement continuity of a care plan.<br><br>An excel document created by FM-C, indicated on September 17, 2021, FM-C informed LALD-A via text message she would be installing a camera in R1's room due to concerns for safety. On September 24, 2021, FM-C had the camera installed.<br><br>Video from R1's camera recorded from September 24, 2021 through October 7, 2021, showed several occasions (more than once) of staff feeding food and liquids with a straw to R1 laying flat or lower than 45 degrees. | 02310 | | |

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| 02310 | Continued From page 9<br><br>FM-C's excel document indicated on October 2, 2021, FM-C showed LALD-A the video footage of inadequate care and sleeping staff.<br><br>R1's ULP progress note dated October 6, 2021, indicated after dinner R1 had two emesis. ULP staff called the RN and instructed to take vitals and monitor. During the night on October 7, 2021, at 1:35 a.m., staff gave R1 a sip of water because she sounded dry. R1 coughed, had a loose stool and had another emesis. Staff sent R1 to the hospital.<br><br>R1's hospital record dated October 9, 2021, titled "Death Summary" indicated R1's final diagnoses included aspiration pneumonia, stage 4 coccyx wound and severe malnutrition in context of chronic illness.<br><br>R1's death record incident R1 died on October 9, 2021. Primary cause of death was aspiration pneumonia.<br><br>During an interview on April 29, 2022, at 10:31 a.m., RN-F stated she was the RN for seven of the different facilities owned by the same licensed owner (LALD-A) with five to six residents in each house in addition to working a separate full time job. RN-F stated the owners were determining admission of residents, so no RN was performing an assessment prior to admission. When asked who trained the staff to provide cares, RN-F stated no one, however she would inform staff of what the resident's care needs were. RN-F stated staff were directed to contact the owners for change of condition and the owners were making nursing decisions, none of which were nurses. RN-F stated she had concerns with staff not feeding R1 properly. RN-F stated she directed staff to get her up and don't feed her in bed. | 02310 | | |

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| 02310 | Continued From page 10<br>When asked why staff left her in bed to eat, RN-F said because they [staff] were lazy.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) Days | 02310 | | |
| 02360 | 144G.91 Subd. 8 Freedom from maltreatment<br><br>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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interviews, and document review, the facility failed to ensure three of three residents (R1, R2, R3) reviewed were free from maltreatment. R1, R2 and R3 were neglected.<br><br>Findings include:<br><br>On August 31, 2022, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. MDH concluded there was a preponderance of evidence that maltreatment occurred | 02360 | No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag. | |