Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL370044785M
Compliance #: HL370046320C

Date Concluded: December 23, 2024

Name, Address, and County of Licensee Investigated:
New Life Home LLC
15300 Dundee Court
Apple Valley, MN 55124
Dakota County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Kris Detsch, RN
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) abused a resident when he restrained her hands during an altercation.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. Although video footage showed the AP hold the resident's hands and body, the resident attempted to stab the AP with a scissors. Through audio footage, the resident told the AP she was going to stab him. The AP sustained minor skin injuries and no harm occurred to the resident. Law enforcement responded to the incident and also restrained the resident due to her aggressive behavior.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement and a family member. The investigation included review of the resident records, hospital records, facility

incident reports, personnel files, law enforcement report, related facility policy and procedures. Also, the investigator toured the facility and observed medication administration, documentation systems, and staff interactions with residents.

The resident resided in an assisted living facility. The resident's diagnoses included bipolar disorder, schizoaffective disorder, anxiety, and depression. The resident's service plan included assistance with behavior management such as anxiety, elopement, and physical aggression. The resident's nursing assessment indicated the resident's memory was intact, but she had poor judgement. She walked independently. The facility administered the resident's medications.

The resident's progress notes indicated the resident appeared to be under the influence of substances. At one point the AP and the resident were outside the facility because the resident wanted the AP to open the car. The resident "rushed" the AP and attempted to get into his pocket to get his car keys. The AP held the resident's hand to prevent her from getting the car keys. The resident and AP went into the facility and the resident screamed at the AP. The resident went to the kitchen and grabbed scissors. The resident told the AP to give her the keys or she would stab him. The AP held the resident's hand in self-defense. The resident pointed the scissors at the AP several times attempting to stab him. The AP was able to get the scissors away from the resident and called law enforcement.

Video footage showed the resident come down the upper-level stairs, while the AP was at a table in the common area. Through audio footage, the resident asked the AP to come outside with her. Video footage then showed the AP and the resident in the common area just inside the front door. The AP had his right hand inside his right pant pocket and the resident was holding onto his pants with her left hand, while attempting to reach into his pants with her right hand. The AP took his left hand and grabbed the resident's left arm, while continuing to keep his right hand inside his pocket. Video footage showed the resident enter the kitchen area and open a drawer. The resident grabbed an object (scissors), the AP was behind her, then wrapped his arms around her body and a struggle occurred. The resident told the AP to give her his car keys or she would stab him (audio footage). The resident attempted to stab the AP and kicked him, while he held onto her attempting to get the scissors. While the AP was holding onto the resident, he attempted to get the phone. The AP was able to get the scissors during this time and he walked backward from the resident, however the resident continued to go toward him and made continued attempts to grab him as he walked back from her. The resident eventually sat on the counter, away from the AP. Video footage then showed the resident leaving the facility while the AP was on the phone with law enforcement.

Law enforcement records indicated the resident was not cooperative with officers when they arrived, so they also had to restrain her. Law enforcement records indicated the AP had sustained a cut to his finger. Law enforcement took the resident to the hospital.

Hospital records indicated the resident was delusional, disorganized, and was becoming more aggressive. The records indicated the resident used methamphetamine (“meth”) three days prior to arrival to the hospital which lab results confirmed. The hospital records indicated the resident required inpatient hospitalization for approximately two months.

During an interview, the AP said he took the resident to her medical appointments and to her chemical dependency treatment programs. The AP said there were times the resident left the medical and treatment programs and refused to comply with the programming. The AP said the resident appeared to be under the influence of a substance prior to the incident and her behavior was erratic. The AP asked the resident if she wanted to go to the hospital, but she declined. The AP also offered the resident medications, but she refused. The AP said he had to hold the resident’s hands to prevent her from getting the car keys. The AP said he had to grab the resident (from behind) to protect himself from getting stabbed and protect other residents.

The resident was hospitalized at the time of the investigation and unable to interview.

In conclusion, the Minnesota Department of Health determined abuse 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;

(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult; and
(4) use of any aversive or deprivation procedures for persons with developmental disabilities or related conditions not authorized under section 245.825.
(c) Any sexual contact or penetration as defined in section 609.341, between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.
(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

Vulnerable Adult interviewed: No. Hospitalization.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility took the resident to her medical and treatment appointments and coordinated her care with medical providers.

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
	37004	A. BUILDING: _____ B. WING _____	C 12/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW LIFE HOME	15300 DUNDEE COURT APPLE VALLEY, MN 55124

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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: HL370046320C/HL370044785M On December 3, 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 were four residents receiving services under the provider's Assisted Living license. The following correction orders are issued for HL370046320C/HL370044785M, tag identification 630, 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.	
0 630 SS=G	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (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	0 630		

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0 630	Continued From page 1 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 ensure the individualized abuse prevention plan (IAPP) accurately reflected the resident's vulnerabilities including her mental health diagnoses, behaviors, and court order for commitment and Jarvis (court order to take psychotropic medication) for one of one resident (R1) with record reviewed. Additionally, R1 had changes in her abilities to keep herself safe and increased illicit drug (fentanyl and methamphetamine) use and alcohol abuse leading to an overdose with cardiac arrest (heart stopped) and a engaging in a violent act towards a staff member requiring an updated assessment of R1's vulnerabilities with implementation of individualized interventions to reduce the risk of self harm. 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:	0 630		

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0 630	Continued From page 2 R1 admitted to the licensee on April 19, 2024, for diagnoses including bipolar disorder, schizoaffective disorder, anxiety, post-traumatic stress syndrome (PTSD), and depression. R1's assessment dated April 30, 2024, indicated assistance R1 required included assistance with choosing clothing, medication administration, appointments and arranging transportation, and monitoring for changes in behavior. The assessment indicated R1 was independent with her finances. R1's IAPP dated April 30, 2024, indicated R1 went on walks, informed staff and was not at risk for elopement. The IAPP indicated R1 was not at risk to abuse others. The IAPP indicated R1 was at risk for self abuse and had impaired judgement. Interventions directed staff were to monitor her for changes in her behavior and report them to the supervisor. The IAPP indicated R1 required staff members to administer medications, however failed to identify R1 had a Jarvis. R1's care plan indicated dated April 30, 2024, indicated R1 had "no behaviors of concern." The care plan in accurately indicated R1 had no history of mental illness. R1's progress notes: R1's progress notes dated April 24, 2024 through July 15, 2024, indicated R1's behavior and agitation progressed along with her increased use of alcohol and substances, ultimately resulting in violent behavior toward a staff member. The following examples include: April 24, 2024, at 6:36 a.m., indicated R1 was up	0 630		

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0 630	Continued From page 3 all night, and "coming and going", she looked anxious and stressed, but declined as needed (PRN) medications. April 26, 2024, at 6:35 p.m., indicated staff saw a vodka (Smirnoff) cap on R1's nightstand, and then found five more small bottles of vodka in her backpack. April 28, 2024, at 7:57 a.m., R1 was begging for money. April 29, 2024, at 2:51 p.m., indicated staff found five empty 100 milliliters (ml) bottles in R1's trash and an empty 375 ml bottle of fireball cinnamon whiskey. The progress notes indicated the resident had an appointment at a "treatment center." April 30, 2024, at 11:09 a.m., R1 asked staff for money. Staff told her, "No", but then R1 left the licensee and they found her down the street. The progress notes indicated R1 did not notify staff before leaving. The progress notes indicated R1 asked other residents for money. May 1, 2024, at 9:53 p.m., R1 left without telling staff. R1 went to a school bus stop and asked adults for money. May 5, 2024, at 4:49 p.m., owner (OW)-A brought R1 to treatment center at 10:00 a.m. The progress notes indicated when OW-A arrived to pick her up at 4:00 p.m., the treatment center staff informed him they found R1 unresponsive in the bathroom and they suspected R1 used drugs, possibly fentanyl. The treatment center staff informed OW-A they gave R1 cardiopulmonary resuscitation (CPR).	0 630		

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0 630	Continued From page 4 R1's progress notes failed to identify when R1 returned to the licensee. May 15, 2024, at 5:41 p.m., indicated R1 was at the licensee and staff administered her medications. June 3, 3034, at 4:58 p.m., indicated R1 asked other residents for money. June 3, 3034, at 10:52 p.m., R1 returned to the licensee at 10:20 p.m., with blood on her hand and nose. R1 said her nose was bleeding. R1 declined medical attention. June 6, 2024, at 3:17 p.m., R1 asked staff if there was a "meth" doctor she could go to. R1 asked staff to get her some "meth." R1 also asked staff to get her Vicodin or Percocet (opioids). June 7, 2024, at 2:25 p.m., R1 was "pulling out her loose hair" and leaving it in the bathroom. June 10, 2024, at 5:37 p.m., R1 called staff for help, and they found her in the bathroom. R1 seemed "out of it." Her eyes were red and "glazed over." R1 told staff something was "stuck" in her vagina. R1 declined medical intervention. July 1, 2024, at 5:37 p.m., R1 received money, left the licensee and returned intoxicated. July 3, 2024, at 9:43 a.m., R1 went to her treatment center and staff members found an empty 1.75-liter bottle of vodka in her room. July 8, 2024, at 8:06 p.m., R1 had sores all over her face, and bleeding pimples. R1 declined medical intervention.	0 630		

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0 630	Continued From page 5 July 9, 2024, at 5:02 p.m., indicated the licensee's nurse gave R1 a "shot." Initially R1 refused, however the nurse told R1 she was required to take the "shot" because it was part of R1's commitment. R1 then agreed to accept the "shot." July 11, 2024, at 10:18 a.m., R1's treatment facility called the licensee and informed them R1 was smoking "meth" and drinking alcohol on their premises. The treatment center told the licensee R1 needed to be picked up and taken to "detox." The treatment center told the licensee R1 required a high level of care. The progress notes indicated the licensee went to get R1, however R1 returned to the licensee because she declined to go to "detox." July 14, 2024, at 6:58 a.m., R1 "looked drunk" and intoxicated. R1 did not listen to staff and ran outside to elope. R1 was "out of control" and seeing things. R1's record failed to include an updated IAPP after April 30, 2024. The licensee failed to update the IAPP and implement individualized interventions to reduce risk of self harm related to illicit drug use and overdose, alcohol abuse, financial management leading to beg others for money, refusing medical concerns including bleeding, changes in her skin and having something "stuck" in her vagina. R1's progress note dated July 15, 2024, 6:10 p.m., indicated R1 attempted to stab OW-A with a scissor. Law enforcement responded. Law enforcement records dated July 15, 2024, indicated officers responded to the licensee	0 630		

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0 630	Continued From page 6 because R1 stabbed OW-A with a knife. Officers restrained R1 because she was not compliant. Officers took R1 to the hospital. R1's hospital medical record dated July 15, 2024, through September 4, 2024, indicated law enforcement brought R1 to the hospital after an altercation with a staff member. R1 was delusional, disorganized, more aggressive, and required inpatient hospitalization. The records indicated R1 used methamphetamine three days prior. (Laboratory findings confirmed R1 used methamphetamine.) The hospital records indicated R1's medical diagnoses included paranoid schizophrenia. R1 had a history of cardiac arrest after an opiate (fentanyl) overdose (May 2024) and used polysubstance drugs. Hospital records indicated R1 had a "active" commitment and Jarvis court order valid September 9, 2023, through September 8, 2024. The Jarvis order included the following antipsychotic medications: Zyprexa, Invega, Ability, Clozaril, Prolixin, and Risperdal. R1's service plan dated November 21, 2024, indicated R1 required assistance with behavior management including anxiety, physical aggression, and self-injurious behavior. The service plan indicated R1 was an elopement risk. The service plan indicated the licensee would provide assistance with these behaviors three times per day. R1's record lacked an updated IAPP since April 30, 2024 and failed to include individualized interventions for staff to implement to support the service plan assistance with managing R1's anxiety, physical aggression, elopement risk and self-injurious behaviors.	0 630		

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0 630	Continued From page 7 On December 3, 2024, at 2:44 p.m., OW-A said he communicated with RN-B and she was aware of R1's behaviors. OW-A said RN-B told him to make appointments for R1 to see her physicians. OW-A said the licensee uses a computer system for care plans and services and staff members have access to see the care plans. OW-A said he took R1 to her medical appointments, and to her treatment facility appointments. On December 5, 2024, at 9:47 a.m., RN-B said she goes to the licensee every other week, or whenever they need her. RN-B said she was the only nurse on call (24/7). RN-B said she really does not do much because OW-A is good at providing care to the residents, and he talks to the resident's physicians, and takes the residents to their medical appointments. RN-B said staff members communicate with her though the computer system using a message delivery system called "snap message", and she can see the message automatically. RN-B said R1 received treatment for substance use, and R1 required services from the methadone clinic, however RN-B was unsure how often. RN-B said she only saw R1 three times. RN-B said when R1 admitted to the licensee she was quite and calm. RN-B assessed R1 approximately 14 days later and said R1 seemed "ok." RN-B said she remembered hearing from staff members about R1 having alcohol in her room, however said past interactions with the Minnesota department of Health (MDH), indicated she could not remove alcohol from resident's rooms because it was their right to have it. RN-B said she instructed staff members to keep monitoring and documenting it, because that's all you can do about it. RN-B said the care plan is where staff members would find interventions to manage R1's behavior. RN-B said she usually does not	0 630		

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0 630	Continued From page 8 see resident progress notes unless a staff member sends her a "snap message". RN-B said was aware R1 was unresponsive while at a treatment facility (May 7, 2024), however she was not aware when she returned to the licensee, and she never saw her after she returned. The licensee's policy titled, Vulnerable Adult, dated February 22, 2024, indicated the licensee would complete individualized assessments of the residents susceptibility to abuse other individuals, and the residents susceptibility to abuse from others. The IAPP would include specific measures the licensee would take to minimize the risk of abuse. The licensee would evaluate the IAPP with each supervisory visit, or more frequently if necessary. Time period for correction: Seven (7) days	0 630		
01620 SS=D	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	01620		

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01620	Continued From page 9 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 complete change of condition registered nurse (RN) assessments and post hospital assessments one of one resident (R1) with record 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 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 April 19, 2024, for diagnoses including bipolar disorder, schizoaffective disorder, anxiety, post-traumatic stress syndrome (PTSD), and depression. R1's admission assessment dated April 19, 2024, indicated she required staff assistance to administer medications. The assessment failed to identify R1 had an active court order for Jarvis. The assessment indicated R1 was not at risk for elopement. R1 was not at risk to abuse other	01620		

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	37004	A. BUILDING: _____ B. WING _____	C 12/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW LIFE HOME	15300 DUNDEE COURT APPLE VALLEY, MN 55124

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01620	Continued From page 10 vulnerable adults. The assessment indicated R1 was vulnerable to abuse from others, but failed to identify the vulnerability or interventions to minimize the risk of harm. The assessment indicated R1 had impaired judgement. The assessment indicated R1 was independent with her finances. The assessment indicated R1 had no behavior concerns, or history of mental illness. R1's clinical update assessment (14-day assessment) dated April 30, 2024, indicated there were no further change to R1's vulnerabilities (risk) and staff would monitor for signs of abuse and report abuse/changes in behavior to a supervisor. The assessment indicated R1 had no behavior concerns, and no history of metal illness. The assessment indicated R1 did not wander. R1's progress notes dated April 24, 2024 through July 15, 2024, were reviewed. R1 experienced the following changes in behavior requiring an assessment. ELOPEMENT and FINANCIAL CONCERN R1's progress note dated April 30, 2024, at 11:09 a.m., indicated R1 asked staff for money. Staff told her, "No," but then R1 left the licensee and they found her down the street. The progress notes indicated R1 did not notify staff before leaving. The progress notes indicated R1 asked other residents for money. R1's progress note dated May 1, 2024, at 9:53 p.m., indicated R1 left without telling staff. R1 went to a school bus stop and asked adults for money. R1's record lacked a focused RN assessment addressing a change from R1 telling staff when	01620		

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01620	Continued From page 11 she'd leave and to assess her continued ability to manage her own finances. DRUG and ALCOHOL USE R1's progress note dated May 5, 2024, at 4:49 p.m., owner (OW)-A brought R1 to treatment center at 10:00 a.m. The progress notes indicated when OW-A arrived to pick her up at 4:00 p.m., the treatment center staff informed him they found R1 unresponsive in the bathroom and they suspected R1 used drugs, possibly fentanyl. The treatment center staff informed OW-A they gave R1 cardiopulmonary resuscitation (CPR). R1's progress notes failed to identify when R1 returned to the licensee. R1's record failed to include an assessment after R1's overdose and hospital stay. R1's progress note dated June 3, 3034, at 10:52 p.m., indicated R1 returned to the licensee at 10:20 p.m., with blood on her hand and nose. R1 said her nose was bleeding. R1 declined medical attention. R1's progress note dated June 6, 2024, at 3:17 p.m., indicated R1 asked staff if there was a "meth" doctor she could go to. R1 asked staff to get her some "meth." R1 also asked staff to get her Vicodin or Percocet (opioids). R1's progress note dated June 7, 2024, at 2:25 p.m., indicated R1 was "pulling out her loose hair" and leaving it in the bathroom. R1's progress note dated June 10, 2024, at 5:37 p.m., indicated R1 called staff for help, and they found her in the bathroom. R1 seemed "out of it." Her eyes were red and "glazed over." R1 told	01620		

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01620	Continued From page 12 staff something was "stuck" in her vagina. R1 declined medical intervention. R1's progress note dated July 1, 2024, at 5:37 p.m., indicated R1 received money and left the licensee and returned intoxicated. R1's progress note dated July 3, 2024, at 9:43 a.m., indicated R1 went to her treatment center and staff members found an empty 1.75-liter bottle of vodka in her room. R1's progress note dated July 8, 2024, at 8:06 p.m., indicated R1 had sores all over her face, and bleeding pimples. R1 declined medical intervention. R1's progress note dated July 11, 2024, at 10:18 a.m., indicated R1's treatment facility called the licensee and informed them R1 was smoking "meth" and drinking alcohol on their premises. The treatment center told the licensee R1 needed to be picked up and taken to "detox." The treatment center told the licensee R1 required a high level of care. The progress notes indicated the licensee went to get R1, however R1 returned to the licensee because she declined to go to "detox." R1's progress note dated July 14, 2024, at 6:58 a.m., indicated R1 "looked drunk" and intoxicated. R1 did not listen to staff and ran outside to elope. R1 was "out of control" and seeing things. R1's record lacked an assessment following continued illicit drug use and alcohol abuse resulting in changes in her skin condition, the treatment center requiring her to leave and go to detox, and intoxications leaving her "out of control", seeing things and feeling like something	01620		

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01620	Continued From page 13 was "stuck" in her vagina. R1's progress note dated July 15, 2024, 6:10 p.m., indicated R1 attempted to stab owner (OW)-A with a scissor. Law enforcement responded. R1's hospital medical record dated, July 15, 2024, through September 4, 2024, indicated law enforcement brought R1 to the hospital after an altercation with a staff member. R1 was delusional, disorganized, more aggressive, and required inpatient hospitalization. The records indicated R1 used methamphetamine three days prior. (Laboratory findings confirmed R1 used methamphetamine.) The hospital records indicated R1's medical diagnoses included paranoid schizophrenia. R1 had a history of cardiac arrest after an opiate (fentanyl) overdose (May 2024) and used polysubstance drugs. Hospital records indicated R1 had a "active" commitment and Jarvis court order valid September 9, 2023, through September 8, 2024. The Jarvis order included the following antipsychotic medications: Zyprexa, Invega, Ability, Clozaril, Prolixin, and Risperdal. R1 discharged from the hospital on September 4, 2024, to an intensive residential treatment service (IRTS) facility. R1's record lacked a nursing assessment following R1's readmission to the facility after hospitalization with intensive residential treatment service and lacked a required 90 day assessment. R1's service plan dated November 21, 2024, indicated R1 required assistance with behavior management including anxiety, physical aggression, and self-injurious behavior. The	01620		

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01620	Continued From page 14 service plan indicated R1 was an elopement threat. The service plan indicated the licensee would provide assistance with these behaviors three times per day. R1's record failed to include an new nursing assessment to support changes to R1's services on her service plan dated November 21, 2024, R1's record had no further nursing assessments completed after the nursing assessment dated April 30, 2024. On December 3, 2024, at 2:44 p.m., OW-A said the licensee has RN-B goes to the licensee twice weekly and as needed. RN-B is "on call" 24 hours per day, 7 days a week. OW-A said the licensee has a "back up" RN who is available when RN-B is not available. OW-A said it was RN-B's responsibility to complete nursing assessments. OW-A said RN-B was involved in the admission process and determination of accepting R1 as a resident into the licensee. OW-A said he communicated with RN-B and she was aware of R1's behaviors. On December 5, 2024, at 8:02 a.m., the surveyor emailed owner OW-A to request/clarify R1's nursing assessments. At 9:23 a.m., OW-A responded and said the licensee did not complete any further nursing assessments after April 30, 2024. On December 5, 2024, at 9:47 a.m., RN-B said she goes to the licensee every other week, or whenever they need her. RN-B said she was the only nurse on call (24/7). RN-B said she completes nursing assessments, orders/ensures medications are available, and gives injections. RN-B said staff members communicate with her though the computer system using a message	01620		

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01620	Continued From page 15 delivery system called "snap message", and she can see the message automatically. RN-B said she was not involved in R1's admission process until after she admitted. RN-B said R1 came to the licensee from a treatment center. RN-B said she only saw R1 three times, one being when she moved in, and the other approximately fourteen days later. RN-B said when she was at the licensee, R1 was not there, so she would just ask staff members how R1 was doing. RN-B said when R1 admitted to the licensee she was quite and calm. RN-B assessed R1 approximately 14 days later and said R1 seemed "ok." RN-B said she saw R1 only as she was leaving for various appointments and she never "sat down" with her again. RN-B said she remembered hearing from staff members about R1 having alcohol in her room. RN-B said she usually does not see resident progress notes unless a staff member sends her a "snap message." RN-B said was aware R1 was unresponsive while at a treatment facility (May 7, 2024), however she was not aware when she returned to the licensee, and she never saw her after she returned. The licensee's policy titled, Assessment and Reassessment, dated February 22, 2024, indicated a registered nurse (RN) would complete ongoing assessments based on changes in the needs of the resident. The policy indicated the RN would then develop a service plan to reflect person-centered planning and care delivery. Time period for correction: Seven (7) days.	01620		