STATE LICENSING COMPLIANCE REPORT

Report #: HL394811566C

Date Concluded: March 6, 2025

Name, Address, and County of Facility Investigated:
Norbella of Rogers
21900 South Diamond Lake Road
Rogers, MN 55374
Hennepin County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name: Brooke Anderson, RN
Special Investigator

The Minnesota Department of Health conducted a complaint investigation to determine compliance with state laws and rules governing the provision of care under Minnesota Statutes, 144G. The purpose of this complaint investigation was to review if facility policies and practices comply with applicable laws and rules. No maltreatment under Minnesota Statutes, Chapter 626 was alleged.

To view a copy of the correction orders, if any, please visit: https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html, or call 651-201-4201 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached state form.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39481	A. BUILDING: _____ B. WING _____	C 02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORBELLA OF ROGERS	21900 SOUTH DIAMOND LAKE ROAD ROGERS, MN 55374

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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: #HL394811566C On February 4, 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 14 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL394811566C, tag identification 0430, 0450, 0470, 1650, and 2350.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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0 430	Continued From page 1	0 430		
0 430 SS=F	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a copy of the uniform checklist disclosure of services (UDALSA) with the required content to residents after the licensee updated the UDALSA document. This had to potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic	0 430		

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0 430	Continued From page 2 failure that has affected or has the potential to affect a large portion or all the residents). The findings include: A complaint investigation was initiated at the facility on Februray 4, 2025. The licensee's Uniformed Disclosure of Assisted Living Services and Amenities (UDALSA) dated April 11, 2022, indicated the licensee scheduled four unlicensed staff on day shift, four unlicensed staff on the evening shift and three unlicensed staff on the night shift. The UDALSA indicated the licensee could provide assist of two mechanical lift assistance. The UDALSA did not indicate any limitations for the licensee to provide the two-person transfer. During interview with the regional director of operations (DOO)-E on February 4th, 2025, DOO-E indicated the licensee's April 2022 UDALSA was updated. A copy of the updated UDALSA provided to the investigator was dated October 1, 2024. The licensee's October 1, 2024 UDALSA indicated that the licensee was able to provide assist of 2 staff transfers with a mechancial lift based on RN assessment. The UDALSA indicated two staff were available at the facility during each shift days, evenings, and nights. The USALSA indicated that the memory care unit was a secured unit and wander devices were used at exits. R1 admitted to the facility on September 25, 2024, wth diagnoses that included chronic diastolic heart failure, COPD, chronic kidney disease, hyperlipidemia. R1's assessment dated	0 430		

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0 430	Continued From page 3 November 11, 2024, indicated R1 had a change in condition and required assistance of a full mechanical lift instead of a sara stedy (sit to stand mechanical lift). R1's medical record lacked evidence R1 received the updated October 2022 UDALSA. On February 6, 2025, 2:45 p.m., regional director of operations (DOO)-E stated R1 was given a new UDALSA when it was updated; however, confirmed it could not be found in R1's medical records. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430		
0 450 SS=G	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall: (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced by: Based on observation, interview, and document	0 450		

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0 450	Continued From page 4 review, the licensee failed to utilize person-centered planning and service delivery processes for one of one resident (R1) who required two staff to transfer with a mechanical lift. R1 did not have a diagnosis or cognitive need for the memory care unit and the licensee moved R1's bed and other personal items to the memory care unit to utilize two-assist transfer assistance for toileting and for R1 to sleep in the memory care unit as R1 required the assistance of two staff and a mechanical lift for transfers. 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: A complaint investigation was initiated at the licensee on February 4, 2025. The licensee's unsigned Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) dated April 11, 2022, indicated the licensee could complete two person transfers with mechanical lift. The UDALSA did not indicate any limitations for the licensee to provide the two-person transfer. During interview with the regional director of operations (DOO)-E on February 4th, 2025, DOO-E indicated the licensee's April 2022 UDALSA was updated. A copy of the updated UDALSA provided to the investigator was dated	0 450		

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0 450	Continued From page 5 October 1, 2024. The licensee's October 1, 2024 UDALSA indicated that the licensee was able to provide assist of 2 staff transfers with a mechancial lift based on RN assessment. The UDALSA indicated two staff were available at the facility during each shift days, evenings, and nights. The USALSA indicated that the memory care unit was a secured unit and wander devices were used at exits. During an observation on February 4, 2025, at 10:19 a.m., R1's assisted living apartment was observed to have some personal items but did not have a bed. Observation of the memory care unit of the facility indicated R1 also had an apartment in the memory care unit that was observed to have a bed, a mechanical lift, and toiletries. R1 admitted to the facility on September 25, 2024, due to diagnoses that included chronic diastolic heart failure, COPD, chronic kidney disease, hyperlipidemia. R1's diagnoses lacked evidence of a dementia diagnosis. R1's hospice notes dated November 8, 2024, indicated the licensee wanted to move R1 to the memory care unit. R1 wanted to stay in his assisted living apartment but recognized staffing was an issue. R1's hospice notes indicated R1 needed to move to memory care unit because the licensee did not have enough residents and there wasn't enough staff to provide R1's cares. R1's hospice notes indicated R1 did not have any cognitive issues denoting a need for the memory care unit. R1's licensee completed assessment dated	0 450		

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0 450	Continued From page 6 November 11, 2024, indicated R1 had a change in condition and required assistance of a full mechanical lift instead of a sara stedy (sit to stand mechanical lift). R1's hospice notes dated November 19, 2024, indicated R1 appeared to be depressed. R1's hospice notes dated November 21, 2024, indicated R1 expressed he was not happy with living in the memory care unit each night and hopes staffing will increase so he can move back to the assisted living unit full time. R1's service plan dated December 11, 2024, indicated R1 required assistance with toileting and transfer assist with two staff and a mechanical lift. R1's service plan also indicated R1 used a Sara Stedy to transfer with assist of one staff member. R1's service plan did not indicate R1's bed was located in the memory care or that all two-staff transfers, including toileting, needed to be completed in the memory care unit. During an interview on February 4, 2025, at 10:19 a.m. clinical director (CD)-B stated R1 spent most of his day in the assisted living apartment and unit. At night, R1 would go to the memory care unit. CD-B stated R1 used a urinal during the day and would go back to the memory care unit if needing assistance for a bowel movement due to the need of the two person transfer. CD-B stated R1 had been sleeping in memory care unit since she started working at the licensee in December. During an interview on February 4, 2025, at 10:25 a.m. unlicensed personnel (ULP)-C stated R1 had to move to the memory care unit for the nighttime because the licensee did not have enough staff to complete two person transfers for	0 450		

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0 450	Continued From page 7 R1. During an interview February 4, 2025, at 10:29 a.m. R1 stated he would rather not go to the memory care unit for transfers, but the licensee did not have enough staff. R1 stated every time he had to have a bowel movement, he had to go to memory care unit and staff had to assist him. R1 stated he did not want to use a bed pan to have a bowel movement, but had to because staff don't know how to position the mechanical lift with the commode to allow for him to have a bowel movement so he had to have a bowel movement in bed using the bed pan. During an interview on February 4, 2025, at 11:07 a.m., ULP-D stated R1 could not reside in the assisted living unit full time because the licensee did not have enough staff. ULP-D stated that when staff asked management, staff were told they needed to have more residents to get more staff. During an interview on February 5, 2025, 8:31 a.m., regional director of operations (DOO)-E stated when R1 had a change in condition, facility management had a care conference and told R1 because of the current census there was not enough staff to complete R1's transfers with the mechanical lift. R1 could either move into memory care unit at night or R1 would have to move to a different licensee. During an interview on February 5, 2025, 2:55 p.m., R1's family member (FM)-F stated R1 lived at a different facility and when he needed additional care with the Sara Stedy lift they sought out this licensee. The licensee's management told R1 and FM-F they could provide the care he needed. R1 moved in and within a month, the	0 450		

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0 450	Continued From page 8 licensee told R1 and FM-F that they could no longer provide R1's cares unless they got more residents to move into the building. FM-F stated she expressed concern for R1's mental health to the licensee's management due to having to move his bed to the memory care unit. FM-F stated R1 moved the memory care unit at night three months ago. FM-F stated no timeline was provided from the licensee on when they would have enough staff so R1 could move back to the assisted living unit full time. The licensee's Person-Centered Planning and Services Deliver Process in Assisted Living policy dated June 16, 2021, indicated residents may include preferences for when, how and by whom direct support services are provided. The resident will be able to participate in the community in a manner that enables the person to interact with non-disabled persons to the fullest extent possible. The licensee's Minnesota Bill of Rights for Assisted Living Residents indicated residents have the right to actively participate in the planning, modification, and evaluation of their care and services. The licensee's undated Special Care Status Disclosure for Special Care/Memory Support policy indicated the goal of this special community is to be person centered to provide care that met the changing needs of residents with Alzheimer's disease, or other dementias. Criteria to reside in the special care/memory support unit included medically stable but requires 24-hour intervention due to cognitive impairment. No further information provided.	0 450		

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0 450	Continued From page 9 TIME PERIOD FOR CORRECTION: Seven (7) days	0 450		
0 470 SS=G	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide adequate staffing to meet the needs of one of one resident	0 470		

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0 470	Continued From page 10 (R1) who required a two-person transfer using a mechanical lift resulting in R1 having to move his bed to the memory care unit to sleep and for two-person transfer assistance. 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: The licensee's undated staffing plan indicated the licensee would staff six home health aides per day. The licensee's Uniformed Disclosure of Assisted Living Services and Amenities (UDALSA) dated April 11, 2022, indicated the licensee typically scheduled four unlicensed staff on day shift, four unlicensed staff on the evening shift, and three unlicensed staff on the night shift. The UDALSA indicated the licensee could provide two-staff transfer assistance and mechanical lift assistance. The licensee's updated October 1, 2024 UDALSA indicated that the licensee was able to provide assist of 2 staff transfers with a mechancial lift based on RN assessment. The UDALSA indicated two staff were available at the facility during each shift days, evenings, and nights. The USALSA indicated that the memory care unit was a secured unit and wander devices were used at exits. R1 admitted to the facility on September 25,	0 470		

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0 470	Continued From page 11 2024, due to diagnoses that included chronic diastolic heart failure, COPD and chronic kidney disease. R1's service plan dated December 11, 2024, indicated R1 required assistance with toileting and transfer assist with a mechanical lift. R1's progress notes date November 8, 2024, indicated R1 had a large bruise on his right arm with swelling and pain noted. DON-A and a hospice nurse assessed R1 and believe R1 had a torn tendon in his arm. DON-A noted due to the injury, R1 would need to use a full mechanical lift for transfers and moved to the memory care unit on a temporary basis due to R1's change in status. The licensee's staffing schedule dated November 8, 2024, indicated two unlicensed personnel (ULP) were scheduled to work the 6 a.m. to 2 p.m., two ULPs were scheduled to work 2 p.m. to 10 p.m., (one in memory care and one in assisted living) and three ULPs were scheduled to work 10 p.m. to 6 a.m. Review of the licensee's staff schedules for November 2024, December 2024, and January 2025, indicated the licensee failed to staff the facility as indicated in the licensee's UDALSA. R1's hospice notes dated November 8, 2024, indicated the licensee wanted to move R1 to the memory care unit. R1 wanted to stay in his assisted living apartment but recognized staffing was an issue. R1's hospice notes indicated R1 needed to move to memory care unit because the licensee did not have enough residents and there wasn't enough staff to provide R1's cares. R1's hospice notes indicated R1 did not have any	0 470		

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0 470	Continued From page 12 cognitive issues denoting a need for the memory care unit. R1's licensee completed assessment dated November 11, 2024, indicated R1 had a change in condition and required assistance of a full mechanical lift instead of a sara stedy (sit to stand mechanical lift). R1's hospice notes dated November 19, 2024, indicated R1 appeared to be depressed. R1's hospice notes dated November 21, 2024, indicated R1 expressed he was not happy with living in the memory care unit each night and hopes staffing will increase so he can move back to the assisted living unit full time. R1's service plan dated December 11, 2024, indicated R1 required assistance with toileting and transfer assist with two staff and a mechanical lift. R1's service plan also indicated R1 used a Sara Stedy to transfer with assist of one staff member. R1's service plan did not indicate R1's bed was located in the memory care or that all two-staff transfers, including toileting, needed to be completed in the memory care unit. During an observation on February 4, 2025, at 10:19 a.m., R1 was observed in an apartment in the assisted living unit. The apartment did not have a bed but was furnished as R1's apartment. In the memory care unit, R1's room was observed to have a room with a bed, a mechanical lift, and toiletries. During an interview on February 4, 2025, at 10:19 a.m. clinical director (CD)-B stated R1 spent most of his day in the assisted living unit. At night, R1 would go to the memory care unit. CD-B stated	0 470		

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	39481	A. BUILDING: _____ B. WING _____	C 02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORBELLA OF ROGERS	21900 SOUTH DIAMOND LAKE ROAD ROGERS, MN 55374

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0 470	Continued From page 13 R1 used a urinal during the day and would go back to memory care unit for assistance for a bowel movement and to sleep at night. CD-B stated R1 had been sleeping in memory care unit since she started working at the facility in December. During an interview on February 4, 2025, at 10:25 a.m., unlicensed personnel (ULP)-C stated R1 had to move to memory care unit for night cares because the facility did not have enough staff to complete two person transfers for R1. During an interview on February 4, 2025, at 11:07 a.m., ULP-D stated R1 could not reside in the assisted living unit full time because the licensee did not have enough staff. ULP-D stated that when staff asked management, staff were told they needed to have more residents to get more staff. During an interview on February 5, 2025, 8:31 a.m., regional director of operations (DOO)-E stated when R1 had a change in condition, the facility management had a care conference and told R1 that because of the current census there was not enough staff to complete R1's transfers with the mechanical lift. R1 either had move into the memory care unit at night or would have had to move to a different facility. During an interview on February 5, 2025, 2:55 p.m. R1's family member (FM)-F stated R1 lived at a different facility and when he needed additional care with the Sara Stedy they sought out this licensee. The licensee's management told R1 and FM-F they could provide the care he needed. R1 moved in and within a month the licensee told R1 and FM-F that they could no longer provide the cares unless they got more	0 470		

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0 470	Continued From page 14 residents to move into the licensee. FM-F stated she expressed concern for R1's mental health to the licensee's management about having to move his bed to the memory care unit. FM-F stated R1 moved to memory care unit at night three months ago. FM-F stated no timeline was provided from the licensee on when they would have enough staff so R1 could move back to the assisted living full time. The licensee's Staffing Requirements policy dated August 2022, indicated the staffing purpose was to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his/her individuality. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
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 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;	01650		

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01650	Continued From page 15 (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 observation, interview, and document review, the licensee failed to ensure the service plan of one of one resident (R1) included all required content. 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: The licensee's unsigned Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) dated April 11, 2022, indicated the licensee could complete two person transfers with mechanical lift. The UDALSA did not indicate any limitations for the licensee to provide the	01650		

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01650	Continued From page 16 two-person transfer. During interview with the regional director of operations (DOO)-E on February 4th, 2025, DOO-E indicated the licensee's April 2022 UDALSA was updated. A copy of the updated UDALSA provided to the investigator was dated October 1, 2024. The licensee's October 1, 2024 UDALSA indicated that the licensee was able to provide assist of 2 staff transfers with a mechancial lift based on RN assessment. The UDALSA indicated two staff were available at the facility during each shift days, evenings, and nights. The USALSA indicated that the memory care unit was a secured unit and wander devices were used at exits. During an observation on February 4, 2025, at 10:19 a.m., R1's assisted living apartment was observed to not have a bed. Observation of the memory care unit of the facility inidcated R1 also had an apartment in the memory care unit that was observed to have a bed, a mechanical lift, and toiletries. R1 admitted to the facility on September 25, 2024, due to diagnoses that included chronic diastolic heart failure, COPD, chronic kidney disease, hyperlipidemia. R1's diagnoses lacked evidence R1 had a dementia diagnosis. R1's progress notes date November 8, 2024, indicated R1 had a large bruise on his right arm with swelling and pain noted. DON-A and a hospice nurse assessed R1 and believe R1 had a torn tendon in his arm. DON-A noted due to the injury, R1 would need to use a full mechanical lift for transfers and moved to the memory care unit	01650		

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01650	Continued From page 17 on a temporary basis due to R1's change in status. The change in transfer status was not documented on R1's service plan. R1's assessment dated November 11, 2024, indicated R1 had a change in condition and required assistance of a full mechanical lift instead of a sara stedy (sit to stand mechanical lift). R1's service plan dated October 1, 2024 indicated R1 required the use of a Sara Stand lift and one staff for assistance. R1's service plan indicated R1 resided in a room in the assisted living unit. A care conference summary dated November 11, 2024, indicated that due to injury R1 was unable to use the sara stand lift. The care conference document indicated R1 was currently sleeping in a memory care bed due to needing two people and a mechanical lift for transfers. The summary did not indicate what room R1's bed was located to in the memory care unit. R1's service plan dated December 11, 2024, indicated R1 required assistance with toileting and transfer assist with two staff and a mechanical lift. R1's service plan also indicated under physical assist in dressing that R1 used a Sara Stedy to transfer with assist of one staff member. R1's service plan lacked evidence R1's bed was located in the memory care and that all two staff transfers needed to be completed in the memory care unit. The service plan listed R1's room as a room in the assisted living unit. No room in the memory care was identified on the service plan and the service plan did not direct staff that R1 slept in the memory care unit and did not indicate for memory care staff to provide care to R1 in the memory care unit.	01650		

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01650	Continued From page 18 The licensee's Service Plan policy last revised September 2023 indicated that the facility shall only accept a client if it has staff, sufficient in qualifications, competency, and numbers, to adequately provide the services agreed to in the Service Plan and included the service plan must be revised, if needed, based on the results of required client monitoring and/or reassessments. No further information was provided. Time Period for Correction: Twenty-One (21) Days	01650		
02350 SS=D	144G.91 Subd. 7 Courteous treatment Residents have the right to be treated with courtesy and respect, and to have the resident's property treated with respect This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure one of one resident (R1) and their property was treated with courtesy and respect when R1's bed and personal items were moved to the memory care unit and R1 was required to go to the memory care unit for two-assist transfers and sleep in the memory care unit of the facility in order to accomodate the facility's census and staffing ratio. 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	02350		

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02350	Continued From page 19 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 facility on September 25, 2024, R1's diagnoses lacked evidence R1 had a dementia diagnosis. R1's assessment dated November 11, 2024, indicated R1 had a change in condition and required a full mechanical lift instead of a sara stedy (a non-powered standing aid that helps residents move from a sitting to standing position). R1's December 11, 2024, service plan indicated R1 required assistance with toileting, and transfer assist with two staff and a mechanical lift. R1's service plan also indicated R1 used a Sara Stedy to transfer with assist of one staff member. R1's service plan lacked evidence R1's bed was located in the memory care unit and that all two staff transfers needed to be completed in the memory care unit. R1's individual abuse prevention plan (IAPP) dated November 5, 2024, indicated R1 was at risk for abuse, staff to observe changes in mood, behavior, decline in appetite, or withdrawal from cares or activities. R1's progress notes date November 8, 2024, indicated R1 had a large bruise on his right arm with swelling and pain noted. DON-A and hospice nurse assessed R1 and believe R1 had a torn tendon in his arm. DON-A noted due to the injury R1 would need to use a mechanical lift for transfers and moved to the memory care unit on	02350		

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02350	Continued From page 20 a temporary basis due to R1's change in status. R1's hospice notes dated November 8, 2024, indicated the licensee wanted to move R1 to memory care unit. R1 wanted to stay in his assisted living apartment but recognized staffing was an issue. R1's hospice notes indicated R1 needed to move to memory care unit because the facility did not have enough residents and so there wasn't enough staff for R1's cares. R1's hospice notes indicated R1 did not have any cognitive issues to move to the memory care unit. R1's hospice notes dated November 19, 2024, indicated R1 appeared to be depressed. R1's hospice notes dated November 21, 2024, indicated R1 expressed he was not happy with living in the memory care unit each night and hoped staffing would increase so he can move back to the assisted living full time. During an observation on February 4, 2025, at 10:19 a.m., R1 was in his apartment in the assisted living unit . The apartment did not have a bed but was furnished as R1's apartment. In the memory care unit R1's room was observed with a bed, mechanical lift and toiletries. During an interview on February 4, 2025, at 10:19 a.m. clinical director (CD)-B stated R1 spends most of his day in the assisted living. At night R1 would go to the memory care unit. CD-B stated R1 used a urinal and would go back to memory care unit for assistance for a bowel movement. CD-B stated R1 had been sleeping in memory care unit since she started working at the licensee in December. During an interview on February 4, 2025, at 10:25	02350		

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02350	Continued From page 21 a.m. unlicensed personnel (ULP)-C stated R1 had to move to memory care unit for the night cares because the licensee did not have enough staff to complete the two person transfers for R1. During an interview on February 4, 2025, at 11:07 a.m., ULP-D stated R1 could not be in assisted living full time because the licensee did not have enough staff. ULP-D stated that when staff asked management, staff were told we needed to have more residents to get more staff. During an interview on February 5, 2025, 8:31 a.m., regional director of operations (DOO)-E stated when R1 had a change in condition the facility management had a care conference and told R1 that because of the current census there was not enough staff to complete R1's transfers with the mechanical lift. R1 could either move into memory care unit at night or would have to move to a different licensee. During an interview on February 5, 2025, 2:55 p.m. family member (FM)-F stated R1 lived at a different facility and when he needed additional care with the Sara Stedy they sought out the licensee. The licensee management told R1 and FM-F they could provide the care he needed. R1 moved in and within a month the licensee told R1 and FM-F that they could no longer provide the cares unless they got more residents to move into the licensee. FM-F stated she expressed concern for R1's mental health having to move his bed to the memory care unit. FM-F stated R1 moved to memory care unit at night three months ago. FM-F stated no timeline was provided from the licensee on when they would have enough staff so R1 could move back to the assisted living full time.	02350		

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02350	Continued From page 22 The licensee's undated Special Care Status Disclosure for Special Care/Memory Support policy indicated the goal of this special community is to be person centered to providing care that met the changing needs of residents with Alzheimer's disease, or other dementias. Criteria to reside in the special care/memory support unit included medically stable but requires 24-hour intervention due to cognitive impairment. The Assisted Living Bill of Rights indicated residents have the right to be treated with courtesy and respect, and to have the resident's property treated with respect. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02350		