Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL241025443M
Compliance #: HL241029324C

Date Concluded: December 5, 2023

Name, Address, and County of Licensee Investigated:
Sterling Park Senior Living
114 North 1st Street
Waite Park MN, 56387
Stearns County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Kris Detsch, RN
Special Investigator

Finding: Substantiated, facility responsibility

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 facility neglected a resident when they failed to provided safety checks which resulted in the resident being unresponsive from a suspected suicide attempt. The resident required hospitalization.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. Video footage indicated staff members did not entered the resident's room in 24 hours before they found her unresponsive. Additionally, the resident had a history of drug overdose by hoarding medications from her automatic medication dispense machine system (MD2). The facility allowed the resident to continue to use MD2, and failed to provide supervision for medication administration.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted case managers. The investigation

included review of resident records, hospital reports, and employee files. Also, the investigator toured the facility and observed staff interactions with the residents.

The resident resided in an assisted living facility. The resident's diagnoses included depression, diabetes, personality disorder, identity disorder, and a history of drug abuse. The resident's service plan included assistance with weekly medication set up, insulin administration, dressing, transferring and required scheduled safety checks. Safety checks were scheduled at 12:00 a.m., 4:00 a.m., 8:30 a.m., 11:30 a.m., 4:00 p.m. and 8:00 p.m.

The resident's nursing assessment indicated she was alert and orientated. The assessment indicated the resident required medication set up, but failed to identify she used the MD2 automatic medication dispensing system. The assessment indicated medication services were due to the resident's history of suicide attempts but failed to assess her ability to safely administer medications on her own. The assessment indicated the resident was aware of directions and could follow them "if she chooses."

The resident's progress notes indicated staff sent the resident to the hospital because she barricaded herself in her room. While the resident was in the hospital, she told hospital staff she took baclofen pills (muscle relaxant) to kill herself. Additionally, the resident had methamphetamines in her system, and she had suicidal ideations. The resident returned to the facility after this event and the following day, nurses filled the MD2 system with her medications which included Baclofen.

The facility nursing staff failed to reassess the resident's medication management service upon return from the hospital and complete a self-administration of medications assessment on the resident for continuation to safely administer her own medications after set-up with the MD2 system. The resident's service plan remained unchanged.

The resident's progress notes indicated three months after the resident's first suicide attempt, staff members found the resident in her apartment unresponsive but breathing. The resident was limp and cold to the touch. Staff contacted emergency responders (911) and they took the resident to the hospital. Progress notes indicated staff found two small containers with different kinds of pills hidden in the resident's apartment.

The resident's hospital record indicated the resident was intubated (breathing tube), required mechanical ventilation (life support) and admitted to the intensive care unit. The cause of hospitalization was the resident's intentional ingestion of numerous medications in her room, baclofen and gabapentin (used for diabetic nerve pain).

During an interview, a former manager said nurses placed the resident's medications into the MD2 system and the resident took the medication when the machine dispensed them. The manager said the resident had a history of not taking her medications and hiding them under her bed mattress. The manager said this happened several times and she told nursing staff the

facility should not allow the resident to use the MD2 system and they should give her the medications, but the facility leadership allowed the resident to continue to use the MD2 system. The manager said she observed video footage during the time staff found the resident unresponsive. The manager said she did not observe staff enter the resident's apartment for twenty-four hours prior to the incident. The manager said prior to this incident, the resident complained, multiple times, staff were not providing safety checks and told her she did not feel safe. The manager said she observed video footage because of these complaints and found staff were not providing safety checks. The manager said this occurred several times and the cameras were right outside the resident's door.

During an interview, a former nurse said staff removed insulin from the resident's room because of an alleged suicide attempt but they allowed her to keep the MD2 system. The nurse said she was unaware if staff implemented any further safety measures to ensure the resident took her medications after the machine dispensed them. The nurse said at one of the resident's prior hospital stays, the resident told the hospital she attempted suicide by hoarding medications. However, the nurse said she did not believe the facility staff were aware it because then they would have considered the MD2 system to be unsafe for her to use. The nurse said the facility supervisors and managers were all contracted staff, including the nurses.

During an interview, the resident said she took medications after the MD2 system dispensed them and hid them. The resident said she was depressed and took forty pills of baclofen. The resident said the facility staff found her unresponsive about thirteen hours later. The resident said she did not return to the facility after this incident. The resident said she also overdosed on baclofen three months prior to this incident and required hospital care. The resident said the MD2 system always remained in her room and staff were not present to watch her take medication after the machine dispensed them. The resident said staff did not complete safety checks.

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

"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:
(a) 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: Not Applicable.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
Facility coordinated care with other medical providers.

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.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Stearns County Attorney
Waite Park City Attorney
Waite Park Police Department
The Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24102	A. BUILDING: _____ B. WING _____	C 10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING PARK SENIOR LIVING	114 NORTH 1ST STREET WAITE PARK, MN 56387

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments 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: #HL241029324C/#HL241025443M and HL241023417C/HL241027084M On October 27, 2023, 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 74 residents receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL241029324C/#HL241025443M, tag identification 1700, 2310, 2360. The following correction order is issued for #HL241029324C/#HL241025443M and HL241023417C/HL241027084M, tag identification 1640.	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 License Providers. 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 surveyors' 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 subd. 1, 2, and 3.	
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to	01640		

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01640	Continued From page 1 (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have an accurate service delivery record system for unlicensed personnel (ULP) to implement scheduled services as identified in the service plan for two of two residents (R1, R2) with records reviewed. This deficient practice had the 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	01640		

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01640	Continued From page 2 problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1 admitted to licensee on March 31, 2022. R1's diagnoses included depression, diabetes, personality disorder, dissociative identity disorder, post-traumatic stress disorder, stimulant use, and history of drug abuse. R1's service plan, "Amendment to Addendum A (Section IV-2)," dated May 26, 2022, indicated ULP would provide safety checks to R1 six times per day. R1's Addendum A-Service Agreement dated May 26, 2022, at 3:19 p.m., indicated ULP's would provide safety checks at 4:00 p.m., 8:00 p.m., 8:30 a.m., 11:30 a.m., 12:00 a.m., 4:00 a.m. The agreement indicated the date the service was in effect was May 19, 2022. The agreement indicated R1 received safety checks every two hours prior to May 19, 2022. R1's Service Delivery record dated March 1, 2023, through March 31, 2023, lacked the scheduled service time for when ULP's were to perform the delegated services identified by the services plan. The number of safety check entries filled in the safety check service, which varied by ULP documentation entry. Additionally, the service delivery record identified duplicate entries, one titled, Safety Check, and the other, Safety Checks. R1's Resident Service Usage report dated March 6, 2023, through March 8, 2023, was a detailed report of when ULP's entered documentation of completing services, however it was unclear from	01640		

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01640	Continued From page 3 the record the accurate time ULP's were providing safety check services. Documentation indicated ULP's performed back-to-back safety checks: March 6, 2023, 3:38 p.m., 3:38 p.m., 5:50 p.m., 7:51 p.m., and 7:51 p.m. March 7, 2023, 6:20 p.m., 6:26 p.m., 6:27 p.m., 8:39 p.m., 8:39 p.m., and 10:33 p.m. On December 4, 2023, at 3:50 p.m., registered nurse (RN)-B said, the service addendum for R1 was the licensee's working document at the time. On December 4, 2023, at 4:07 p.m., RN-B provided surveyor R1's Addendum A-Service Agreement form effective date May 26, 2022, at 3:19 p.m. RN-B wrote on the service form, "For informational use only. Amendment to addendum A (Section IV2) was legal document at time of May 26, 2022. " On November 1, 2023, at 3:32 p.m., former housing manager (HM)-A said ULP's were not doing safety checks and R1 told her she did not feel safe. HM-A said she checked video footage several times and discovered ULP's were not providing safety checks. HM-A said ULP's found R1 in her apartment unresponsive on March 8, 2023. HM-A said she observed video footage prior to ULP's finding R1 unresponsive and discovered no ULP's entered R1's room for twenty-four hours prior to the incident. HM-A said R1 required safety checks every two hours and eventually every one hour. HM-A said inaccurate documentation occurred frequently and she observed false charting. HM-A said for an example, she could see ULP's documented services for residents who were not in the building. HM-A said she informed leadership of her findings.	01640		

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01640	Continued From page 4 R2 R2 admitted to licensee on October 23, 2019. R2's diagnoses included multiple sclerosis, hypertension, depression, and osteoporosis. R2's service plan, "Amendment to Addendum A," dated December 5, 2022, indicated ULP's would provide toileting assistance four times daily. R2's Service Plan dated August 9, 2023, identified the times designated for providing toileting assistance. Effective on October 23, 2019, ULP's would provide toileting assistance at 8:00 a.m., 10:00 a.m., 12:00 p.m., 2:00 p.m., 4:00 p.m., 6:00 p.m., and 8:00 p.m. and effective on December 4, 2019, at 2:00 a.m., 5:00 a.m., and 11:00 p.m. R2's Service Delivery record dated June 1 through June 30, 2023, lacked the scheduled service time for when ULP's were to perform the delegated services identified by the services plan. The number of toileting assistance entries filled in the toileting assist service, which varied by ULP documentation entry. R2's Resident Service Usage report dated June 1 through June 30, 2023, lacked documentation unlicensed personnel provided toileting services to R2 as indicated by the service plan. On June 20, 2023, ULP documentation indicated they provide toileting assistance at 5:28 a.m., 10:04 a.m., 8:22 p.m., and 11:30 p.m., but R2 received no documented toileting assistance between 10:04 a.m. through 8:22 p.m. R2's service plan indicated she would receive toileting assistance at 2:00 p.m., 4:00 p.m., and 6:00 p.m. On November 2, 2023, at 10:34 a.m., RN-B said R2 re-admitted to licensee on June 20, 2023, and	01640		

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01640	Continued From page 5 required increased service for toileting assistance and safety checks. R2's record to include an updated service plan to reflect the need for increased toileting assistance and safety checks after R2's return to licensee on June 20, 2023. R2's service report did not indicate staff provided increased toileting service or safety checks to R2 between her return on June 20, 2023, and discharge on June 23, 2023. The licensee's internal investigation dated July 7, 2023, indicated ULP's found R2 soiled with incontinence. R2 had excoriation on her buttocks. RN-B sent R2 to the hospital on June 23, 2022. RN-B observed video footage prior to ULP's finding R2 soiled with incontinence and determined ULP-G did not provide toileting assistance to R2, but documented she provided toileting assistance at 6:11 a.m., and 12:25 a.m. The investigation notes did not indicate when ULP's provided toileting assistance prior to the incident. On December 4, 2023, at 3:28 p.m., RN-B said she increased services for R2, but failed to update the dates on the service agreement to reflect when the changes. On November 8, 2023, at 3:38 p.m., surveyor sent an email to assistant administrator (AA)-D requesting licensee's policy for safety checks. No policy was provided, but AA-D indicated safety checks were provided according to service plans. On November 6, 2023, at 2:01 p.m., director of operations, (OD)-E said most ULP's provide the service and document afterward. OD-E said to verify accuracy of the time ULP's provided a service, you would have to ask them.	01640		

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01640	Continued From page 6 Licensee's Service Plan policy June 1, 2023, indicated licensee would implement and provide all services required by the current service plan. TIME PERIOD OF CORRECTION: Twenty-one (21) Days	01640		
01700 SS=G	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications.	01700		

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01700	Continued From page 7 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted an individualized self-administration of medication assessment to determine if an automatic medication dispensing system (MD2) was a safe option for one of one resident (R1) with records reviewed. As a result, R1 hoarded her medications and had multiple episodes of medication overdose. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 admitted to licensee on March 31, 2022. R1's diagnoses included depression, diabetes, personality disorder, dissociative identity disorder, post-traumatic stress disorder, stimulant use, and history of drug abuse. R1's service plan dated April 11, 2022, indicated the licensee would set up R1's medications weekly. R1's Master Assessment dated August 22, 2022, indicated R1 had a history of recreational drug use. R1 required medication set up. The assessment failed to identify R1 used the MD2 system, but identified R1's history of suicide attempts. The assessment indicated medication services were due to R1's history of suicide attempts and indicated R1 was "aware of	01700		

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01700	Continued From page 8 directions and can follow them if she chooses." R1's progress note dated January 4, 2023, at 7:39 a.m., indicated R1 was at the hospital and required one on one supervision due to suicidal ideations. The note indicated R1 told hospital she, "took baclofen at her apartment to kill herself." R1's change of condition assessment dated January 4, 2023, indicated there were no changes to R1's medication administration plan and the assessment failed to identify MD2 system for use and failed to assess R1's ability to safely self-administer medications after MD2 administered them. R1's progress notes dated January 5, 2023, at 7:03 p.m., indicated R1 returned to licensee at 3:00 p.m. The note indicate nursing provided seven days' worth of medication set up, including baclofen (pain medication). R1's progress notes dated March 8, 2023, at 11:35 a.m., indicated staff found R1 unresponsive, but breathing in her apartment. Staff found R1 in her apartment limp, tongue protruding, moaning, and cold to touch. R1 did not respond to sternal rub. Emergency responders (911) took R1 to the hospital. R1's hospital record dated March 8, 2023, indicated R1 was intubated and sedated in the intensive care unit (ICU). The etiology was mostly likely an intentional ingestion and records indicated a note R1 had access to numerous medications in her room that could result in this clinical picture (baclofen, gabapentin). R1's progress note dated March 24, 2023,	01700		

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01700	Continued From page 9 indicated staff found two small containers in R1's room with different pills. The pills were destroyed in the nursing office. On November 1, 2023, at 3:32 p.m., former housing manager (HM)-A said R1 had an incident when she was on the floor hanging onto the bed frame and staff called 911. During this incident, the mattress was flipped, and staff discovered R1 had been hoarding medication. HM-A said R1 hoarded her medications several times and she told administration and nursing leadership R1 should not use the MD2 system, however they allowed R1 to continue to use it. HM-A said R1 spoke about killing herself. On November 7, 2023, at 10:07 a.m., R1 said she took medications from MD2 once it dispensed them, and saved them. R1 said she ended up taking forty tablets of baclofen. R1 said the MD2 system was in her apartment for her entire stay at licensee. Licensee's Individualized Medication Management Plan policy dated August 1, 2021, indicated licensee would prepare and include in the service plan a written statement of the medication services provided to the resident. The policy indicated the medication management plan would include monitoring and evaluating medication use. TIME PERIOD OF CORRECTION: Seven (7) days	01700		
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24102	A. BUILDING: _____ B. WING _____	C 10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING PARK SENIOR LIVING	114 NORTH 1ST STREET WAITE PARK, MN 56387

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02310	Continued From page 10 living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide safety checks for one of one resident (R1) with records reviewed. R1 had a history of attempted suicide by overdose of medications. Staff failed to provided safety checks for 24 hours prior to R1's second overdose. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 admitted to licensee on March 31, 2022. R1's diagnoses included depression, diabetes, personality disorder, dissociative identity disorder, post-traumatic stress disorder, stimulant use, and history of drug abuse. R1's service plan, "Amendment to Addendum A," dated May 26, 2022, indicated safety checks would be provided six times per day. R1's Addendum A-Service Agreement dated May 26, 2022, at 3:19 p.m., indicated unlicensed personnel (ULP)'s would provide safety checks at 4:00 p.m., 8:00 p.m., 8:30 a.m., 11:30 a.m., 12:00	02310		

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02310	Continued From page 11 a.m., 4:00 a.m. The agreement indicated the date the service was in effect was May 19, 2022. The agreement indicated R1 received safety checks every two hours prior to May 19, 2022. R1's progress notes dated January 4, 2023, at 7:39 a.m., indicated R1 was at the hospital and required one on one supervision due to suicidal ideation. The note indicated R1 told hospital staff she, "took baclofen at her apartment to kill herself." The progress notes indicated R1 was in the hospital December 31, 2022 through January 4, 2023. Progress notes indicated the resident returned to the facility on January 5, 2023. R1's vulnerability assessment dated January 5, 2023, indicated safety checks were provided for R1's suicidal ideation and safety. The assessment failed to identify the frequency of safety check intervention. R1's service plan however, remained unchanged. R1's progress note dated January 17, 2023, at 3:24 p.m., signed by former director of nursing (DON)-C indicated R1 wrote a grievance regarding the lack of safety checks. The note indicated facility management reviewed video footage and provided education for ULP's. R1's Resident Service Usage report dated March 7, 2023 through March 8, 2023, was a more detailed report of when ULP's performed services, however it was unclear from the record the accurate time they were providing the service. On March 7, 2023, ULP's signed safety checks as completed at the following times: 6:20 p.m., 6:26 p.m., 6:27 p.m., 8:39 p.m., 8:39 p.m., and 10:33 p.m. The last documented safety check was on March 7, 2023, at 10:30 p.m.	02310		

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02310	Continued From page 12 R1's progress note dated March 8, 2023, at 11:35 a.m., indicated ULP's found R1 unresponsive, but breathing in her apartment. R1 was in her apartment limp, tongue protruding, moaning, and cold to touch. R1 did not respond to sternal rub. Emergency responders (911) took R1 to the hospital. Facility incident report dated March 8, 2023, at 8:40 a.m., indicated staff found R1 unresponsive by ULP's at 8:40 a.m. R1's hospital record dated March 8, 2023, indicated R1 was intubated and sedated in the intensive care unit (ICU). The etiology was mostly likely an intentional ingestion, dictation included, "She also has access to numerous medications in her room that could result in this clinical picture (baclofen, gabapentin)." Additionally, the record indicated safety checks were not provided and likely led to a more significant incident than R1 may have intended. On November 1, 2023, at 3:32 p.m., former housing manager (HM)-A said ULP's were not doing safety checks and R1 told her she did not feel safe. HM-A said she checked video footage several times and discovered ULP's were not providing safety checks. HM-A said she observed video footage prior to ULP's finding R1 unresponsive and discovered no ULP entered R1's room for twenty-four hours prior to the incident on March 8, 2023. HM-A said R1 required safety checks every two hours and eventually every 1 hour. HM-A said R1 spoke about killing herself. On December 4, 2023, at 3:50 p.m., registered nurse (RN)-B said the service addendum for R1 was the licensee's working document at the time.	02310		

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02310	Continued From page 13 On December 4, 2023, at 4:07 p.m., RN-B provided surveyor R1's, Addendum A-Service Agreement, form effective date May 26, 2022, at 3:19 p.m. RN-B wrote on the service form, "For informational use only. Amendment to addendum A (Section IV2) was legal document at time of May 26, 2022. " On November 9, 2023, at 4:44 p.m., assistant administrator (AA)- D emailed surveyor indication licensee did not have a specific policy on staff performing safety checks. AA-D indicated safety checks would be completed per service plan. Licensee's Service Plans policy dated June 1, 2023, indicated service plans would be revised, if needed, based on the results of required resident's monitoring and/or reassessments. TIME PERIOD OF CORRECTION: Seven (7) days	02310		
02360	144G.91 Subd. 8 Freedom from maltreatment 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. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred,	02360	No plan of correction is required for this tag.	

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02360	Continued From page 14 and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		