Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL304502243M

Date Concluded: November 30, 2022

Compliance #: HL304503953C

Name, Address, and County of Licensee Investigated:

Colony Court
200 22nd Ave NE
Waseca, MN 56093
Waseca County

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

Evaluator's Name: Erin Johnson-Crosby, RN
Special Investigator

Finding: Substantiated, facility responsibility

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

Initial Investigation Allegation(s):
The facility neglected the resident when staff failed to assess and provide ordered skin care which resulted in skin breakdown.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to assess and provide necessary cares according to the resident's individual needs. As a result, wound care was not implemented in accordance with the physician's orders and the resident's wounds worsened.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of police and hospital records. Also, the investigator observed staff interactions with residents at the facility.

The resident resided in an assisted living facility. The resident's current diagnoses included dementia, and Chronic Obstructive Pulmonary Disease (COPD). The resident's service plan indicated the resident required assistance with bathing, dressing, and medication administration.

The resident re-admitted to the facility following a stay in a skilled nursing facility (SNF).

Discharge records from the SNF identified the resident was incontinent. The discharge records included a skin assessment which noted a coccyx crease and identified open areas on the bilateral buttocks. Discharge records identified the resident's left buttock open area measured 0.5 cm round, and was superficial (open, affecting only the top layer of skin), with a red tissue base and an epithelizing (healing) ulcer, measuring 1.5 cm x 0.8 cm, was noted on the resident's right buttock by the physician. Physician orders included treatment for Lotrimin (antifungal) cream and barrier cream to be applied to the resident's buttocks twice per day until the open areas were healed. The facility registered nurse (RN) initialed the discharge records, indicating the information was received and reviewed, on the date of the resident's re-admission to the facility.

The facility's re-admission assessment indicated the resident required assistance with bathing, was incontinent of bladder, but did not require assistance with toileting. The assessment also indicated the resident was disoriented, forgetful and required reminders for grooming and hygiene. The section titled "skin", indicated the resident's elbows were treated with application of a cream for treatment of psoriasis. The re-admission assessment did not include or identify the open areas on the resident's buttocks which were included in the discharge records from the SNF. Although an assessment was completed, a new service plan was not created for the resident upon re-admission to the facility to address the resident's needs. The service plan utilized included a date from a previous stay, two years earlier.

Physician visit notes, seven days after the resident's re-admission to the facility, identified the resident had worsening dementia and confusion upon this re-admission to the facility. The notes indicated the resident had been hospitalized for cellulitis (skin infection) of the ankles, lower legs, lower back, and buttocks following a drug reaction. The facility did not update the physician on the resident's buttocks wounds and the physician's note did not address any open areas on the resident's buttocks or treatment for those areas.

The resident's medical record did not identify or include assessment, monitoring, or treatment of the open areas on the resident's buttocks.

A review of services provided to the resident, indicated staff completed personal cares twice throughout the month. The service record included several entries by staff, written in the comment section, that the resident was not available, the services were not applicable, or the resident had refused. The resident's record did not include interventions or follow up to the refusals of care.

Hospital records indicated the resident was sent to the emergency room (ER) with concerns of low oxygen saturation and confusion. The resident was hospitalized for six days with a diagnosis of COVID-19. The records included that upon admission to the ER, the resident had a strong odor of urine and a significant amount of incontinent stool. After incontinent care was provided, staff observed wounds which covered most of resident's buttocks. Hospital records included an assessment and plan for pressure injury(s) to an unspecified site with an unspecified stage but did not include measurements of the wounds.

During an interview, an unlicensed personnel (ULP)#1 stated she had provided care to the resident. ULP#1 stated the resident required assistance with toileting and was incontinent of urine and sometimes stool. ULP#1 stated residents would complain of this resident's smell due to her incontinence. ULP#1 stated the resident often refused toileting and showers. ULP#1 stated she thought she gave the resident a shower a week before her hospitalization but did not recall any areas of skin breakdown. There was no documentation of this service being provided.

During an interview, ULP #2 stated the resident was supposed to have help with toileting and dressing but refused cares 99% of the time. The ULP stated the RN was aware of the resident's refusals. ULP #2 stated the resident often smelled of urine and did not remember if the resident used incontinent products.

During an interview, registered nurse (RN) #1 verified her initials were on the discharge paperwork provided by the SNF facility. She stated the form was confusing and she did not see the skin assessment or the ordered skin treatment. RN #1 stated when the resident returned from the SNF she did not check the resident's buttocks, complete a skin assessment, or implement the treatment as ordered. RN #1 stated the resident initially resided in the locked memory care unit but had to be moved to assisted living due to staffing concerns. RN #1 stated the resident was not appropriate for assisted living. RN#1 also stated she did not know if staff assisted the resident with toileting while the resident was in the memory care unit and stated, "we try not to do toileting schedules in assisted living." RN #1 was aware of the resident's refusals of care and indicated she had informed the family, but this conversation and the refusals were not documented.

During an interview, an emergency room nurse (working at the time of the resident's admission) stated the resident arrived at the ER and was confused, hypoxic (low oxygen saturation) and smelled of urine. The nurse indicated the resident was incontinent of urine and stool and some stool had dried on to the resident's skin. The nurse stated after incontinent care

was provided, ER staff noticed significant damage to the resident's skin. The nurse stated the areas covered most of the resident's buttocks. The nurse stated they applied barrier paste and dressings to the wounds and described the wounds as stage 2 pressure injuries that oozed serosanguinous (clear or red) drainage.

During an interview, the resident's family member (FM) stated she received a call from the ER regarding sores on the resident's buttocks. The resident's family member was not aware, prior to the call, that the resident had skin integrity issues, concerns with incontinence, or consistent refusals of care at the facility.

During an interview, administration identified they were made aware of the resident's skin issues following her admission to the ER, however, they did not report or complete an internal investigation to follow up on this issue.

During an interview, an administrative nurse stated if a resident was admitted with skin concerns, a skin and wound assessment should have been completed and the treatment orders should have been followed. She further stated staff should have monitored the wounds and trained staff on providing wound care. The administrative nurse acknowledged this did not occur upon this resident's re-admission, however stated she was not aware of the resident's wounds or that services were not being provided as directed by the resident's service plan. The administrative nurse stated a Vulnerable Adult (VA) report should have been completed and an in internal investigation should have been conducted by the facility regarding this incident. The administrative nurse further indicated refusals of care should have been documented and interventions implemented to direct staff on how to address the refusals and ensure cares were completed.

In conclusion, neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
Neglect means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: No, cognitively impaired

Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
None

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

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

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

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

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

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Waseca County Attorney
Waseca City Attorney
Waseca Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30450	A. BUILDING: _____ B. WING _____	C 10/12/2022

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COLONY COURT	200 22ND AVENUE NE WASECA, MN 56093

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0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING 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: #HL304503953C/#HL304502243M On October 12, 2022, 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 76 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for #HL304503953C/#HL304502243M, tag identification: 0620, 0730, 2310, 2360 and 3000.	0 000	Assisted Living Provider 144G. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. 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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0 620	Continued From page 1	0 620		
0 620 SS=D	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma 144G.42 Subd. 6. Compliance with requirements for reporting maltreatment of vulnerable adults; abuse prevention plan. (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to timely submit a report to the Minnesota Adult Abuse Reporting Center (MAARC) for one of one resident (R1) reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 resided in memory care at the assisted living until it closed on September 11, 2021. All residents except R1 were moved to another memory care facility and R1 was moved downstairs to the assisted living facility. R1 resided in assisted living with current diagnoses of dementia, and COPD (chronic obstructive pulmonary disease).	0 620		

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0 620	Continued From page 2 R1's service plan dated December 8, 2020, indicated R1 required assistance with bathing, dressing, and medication administration. The MAARC report dated July 20, 2022, indicated R1 had significant odor and upon removing R1's brief a significant amount of stool which had been there for some time and was accompanied by an incredibly strong smell of urine. After providing incontinent care, wounds were noted covering most of R1's buttocks. Police records dated July 21, 2022, indicated the police department received a MAARC report which indicated R1 was brought to the hospital with low oxygen saturation and confusion. When R1 arrived there was an odor and a significant amount of stool and a strong odor of urine. After R1 was cleaned, emergency room (ER) staff noticed wounds covering most of R1's buttocks. The police officer contacted the licensed assisted living director (LALD)-G. LALD-G verified she was aware of the report and indicated R1 normally cared for herself and was starting to need more assistance. LALD-G indicated the licensee was working on setting up training for staff and nurses to recognize someone transitioning from self care to needing care. Licensee records did not include documentation of police notification, a MAARC report, internal investigation or training following this concern. On October 25, 2022, at 12:30 p.m., LALD-G stated she did not remember the police calling her about the incident but did get a call from R1's family member stating the hospital was filing a report for neglect. LALD-G was not aware, did not report the incident or complete an internal investigation. LALD-G stated this should have	0 620		

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0 620	Continued From page 3 been reported by nursing and there was no documentation of training provided after the incident. The licensee's Mandated Reporting Algorithm dated November, 1, 2021, indicated the failure or omission by a caregiver to supply care or services, such as food, clothing, shelter, health care, or supervision, which is not the result of an accident or therapeutic conduct and indicated this should be reported and an internal investigation should be completed. The licensee's policy did not include a time line for reporting. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or	0 730		

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0 730	Continued From page 4 conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included a discharge summary with the required content for one of one discharged resident (R1). 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	0 730		

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0 730	Continued From page 5 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"s record lacked a discharge summary. The licensee's discharged resident list indicated R1 was discharged on June 22, 2022. R1 was admitted to the licensee on November 9, 2020 with diagnoses including dementia, and chronic obstructive pulmonary disease (COPD-a chronic inflammatory lung disease that causes obstructed airflow from the lungs). R1's medical record did not include information related to discharge. On October 10, 2022 at 12:20 p.m,, at 12:10 p.m., Housing Director (HD)-G stated R1 did not have a discharge summary, as that was not the practice at that time, but has since been implemented. HD-G also stated R1 was discharged on July 17, 2022, and later identified the date to be July 18, 2022. Hospital records dated July 20, 2022, were reviewed and indicated July 20, 2022, was R1's date of discharge from the licensee. TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days	0 730		
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services	02310		

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02310	Continued From page 6 (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide care and services based on the resident's needs according to an up-to-date service plan subject to accepted health care standards for one of one resident (R1) with a wound. The resident records lacked documentation of assessment, monitoring and care of the open areas and actions taken to prevent further breakdown and promote healing. 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). Findings include: R1 resided in a memory care unit at the assisted living facility until the memory care closed on September 11, 2021. All residents except R1, were moved to another memory care facility and R1 was moved downstairs to the assisted living. R1 was re-admitted to the assisted living on June 22, 2022, from a long-term care (LTC) facility. R1 resided in assisted living with current	02310		

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02310	Continued From page 7 diagnoses of dementia, and COPD (chronic obstructive pulmonary disease). R1's service plan dated December 8, 2020, indicated R1 required assistance with bathing, dressing, and medication administration. R1's medical record did not include an updated or new service plan completed upon re-admission on June 22, 2022. R1's physician orders sent by the discharging LTC facility dated June 21, 2022, indicated a visit to follow up regarding the drug reaction rash to feet, legs, back and buttocks. All areas were resolved except one area, and ulcer on the right buttock which measured 1.5 cm x 0.8 cm. The orders included discharge back to the licensee and to continue wound barrier cream with anti fungal cream to buttocks wound. R1's Transfer and Referral Record dated June 22, 2022, initialed by registered nurse (RN)-D indicated a skin assessment was completed and noted coccyx crease to bilateral buttocks are open, left buttock 0.5 centimeters (cm) round, superficial, with red base tissue and ruddy red/pink shaded surrounded, right buttock measures 0.3 cm open red base with a treatment order for a mixed after for Lotrimin cream and barrier cream to be applied to the buttocks twice a day until healed. This form also indicated R1 was incontinent of bladder. R1's June and July 2022, medication and treatment administration record(s) did not identify or include orders for open areas on R1's buttocks or monitoring of the open areas. R1's assessment dated June 22, 2022, indicated R1 required assistance with bathing, was	02310		

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02310	Continued From page 8 incontinent of bladder, but did not need help with toileting. The assessment also indicated R1 was disoriented, forgetful and required reminders with grooming and hygiene. The assessment did not include identification of R1's open areas on the buttocks. R1's medical record did not include any update to the physician regarding R1's open areas and treatment plan. R1's physician visit note, dated June 29, 2022, indicated R1 was hospitalized for cellulitis of the ankles, lower legs, lower back and buttocks following a drug reaction. The note also indicated R1 had worsening dementia and confusion since her return to the facility. The note does not include any mention of open areas on R1's buttocks or treatment for those areas. R1's progress notes do not include identification, monitoring or treatment of R1's buttocks wounds. R1's Follow-up Question Report dated June 1, 2022, to July 18, 2022, indicated daily personal care was completed twice within these dates. The comments indicated the resident was not available, not applicable or resident refused. There was no documentation of follow up on R1's availability, why the services were not applicable or R1's refusals. Documentation of bathing services provided was requested and not provided. R1's hospital records dated July 20, 2022, indicated R1 was hospitalized for confusion and COVID-19. When R1 arrived at the emergency room (ER), R1's brief was significantly soiled. The record also indicated pressure ulcers were	02310		

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02310	Continued From page 9 observed on both buttocks, with redness of the skin and crusting of stool that appeared old. R1 also had a soiled urine pad. Police records dated July 21, 2022, indicated the police department received Minnesota Adult Abuse Reporting Center (MAARC) report which indicated R1 was brought to the hospital with low oxygen saturation and confusion. When R1 arrived, there was an odor and a significant amount of stool and a strong odor of urine. After R1 was cleaned, ER staff noticed wounds covering most of R1's buttocks. The police officer contacted the licensed assisted living director (LALD)-G. LALD-G verified to the officer she was aware of the report and indicated R1 normally cared for herself and was starting to need more assistance. LALD-G indicated the licensee was working on setting up training for staff and nurses to recognize someone transitioning from self care to needing care. R1's hospital records from July 21, to July 26, 2022, indicated R1 was initially admitted for increased confusion and inadequate cares and was later admitted with a diagnosis of COVID-19. The assessment and plan indicated pressure injury(s) to unspecified site(s) with an unspecified stage, but did not include measurements. On October 12, 2022, at 12:40 p.m., unlicensed personnel (ULP)-A stated she took care of R1 when R1 resided in memory care. ULP-A indicated R1 required assistance with toileting and was incontinent of urine and sometimes stool. ULP-A stated R1 would not wipe well and other residents would complain of R1's smell due to incontinence. ULP-A stated R1 had episodes of skin break down when she was in memory care. ULP-A stated R1 would refuse toileting and	02310		

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	30450	A. BUILDING: _____ B. WING _____	C 10/12/2022

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02310	Continued From page 10 showers. ULP-A stated she thought she gave R1 a shower one week before her hospitalization but did not recall any areas of skin breakdown. On October 12, 2022, at 2:00 p.m., ULP-C stated R1 was supposed to have help with toileting and dressing, but "refused cares 99% of the time," and stated registered nurse (RN)-D was aware of R1's refusals. ULP-C stated R1 smelled like urine, but did not notice R1's clothing to be soiled. ULP-C did not remember if R1 used incontinent products. On October 12, 2022, at 2:30 p.m., RN-D stated she did not think R1 was appropriate for assisted living and was in memory care for a reason. RN-D stated no services changed when R1 moved from memory care to assisted living. However, RN-D stated she did not know if R1 was assisted with toileting in memory care and said we try not to do toileting schedules in assisted living. RN-D stated upon R1's re-admission on June 22, 2022, she did not check R1's buttocks. RN-D verified her initials were on the transfer form from the discharging facility, but stated that the form was confusing and she did not see the skin assessment which indicated the open areas on R1's buttocks or the treatment for R1's buttocks. RN-D verified she did not complete her own assessment of R1's wounds. RN-D also stated she was aware of R1's refusals of care and updated R1's family on the refusals, but stated that the refusals and the conversation with R1's family were not documented. On October 20, 2022, at 3:50 p.m., RN-F stated R1 arrived at the ER and was confused, hypoxic and had a urine odor. RN-F indicated R1 was incontinent of urine and stool and some of the	02310		

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02310	Continued From page 11 stool was dried on to R1's skin. RN-F stated R1 was cleaned up and observed there was significant damage to R1's skin. RN-F applied barrier paste and dressings over the wounds and described the wounds as stage 2 pressure injuries that oozed serosanguinous (clear or red) drainage, that covered most of R1's buttocks. On October 20, 2022, at 10:00 a.m., family member (FM)-E stated she received a call from the emergency room regarding sores on R1's buttocks. FM-E also stated she was not aware R1 was consistently refusing assistance with bathing and dressing or concerns with wound or incontinent care. On October 25, 2022, at 12:30 p.m., LALD- G stated R1 was moved from the memory care unit to assisted living because she didn't have behaviors requiring a locked unit and did not wander. LALD-G stated staff kept an eye on all resident's toileting and R1 was more independent than others. LALD-G stated R1 was pretty independent with toileting. LALD-G indicated if a resident is admitted from outside of the facility, they tell families they do not provide scheduled toileting services, but if a resident is already admitted and then required assistance with toileting, that the service is provided. LALD-G stated it was an unwritten rule due to staffing, to not accept residents that required every two-hour toileting schedules. LALD-G stated she did not remember the police calling her about the incident with R1 and was not aware of any training completed. LALD-G also stated she did not report the incident or complete an internal investigation. LALD-G stated she was not aware there was not any documentation regarding the open areas on R1's buttocks from June 22, 2022, until discharge.	02310		

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02310	Continued From page 12 On October 28, 2022, at 8:30 a.m., RN-H stated if a resident is admitted with wounds, a skin and wound assessment should be completed. RN-H also stated the wound should be monitored and staff should be trained in regards to wound care. RN-H verified this was not completed upon R1's admission, however RN-H stated she was not aware R1 admitted to the licensee with wounds. RN-H stated a vulnerable adult report and internal investigation should have also been completed regarding R1. The facility policy titled Treatment Management Plan dated October, 2021, indicated staff would provide treatment/therapy services and the RN would obtain an order for treatment/therapies for services provided. The treatment/therapies would be recorded on the treatment record. TIME PERIOD FOR 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 1 of 1 resident (R1) reviewed was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred,	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	

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02360	Continued From page 13 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		
03000 SS=D	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section	03000		

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03000	Continued From page 14 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment for one of one resident (R1) with records 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) 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). Findings include: R1 resided in the memory care unit at the assisted living until it closed on September 11, 2021. All residents except R1, were moved to another memory care facility and R1 was moved	03000		

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03000	Continued From page 15 downstairs to the assisted living. R1 was re-admitted to assisted living on June 22, 2022, from a long term care facility. R1 resided in assisted living with current diagnoses of dementia, and COPD (chronic obstructive pulmonary disease). R1's service plan dated December 8, 2020, indicated R1 required assistance with bathing, dressing, and medication administration. The MAARC report dated July 20, 2022, indicated R1 had significant odor upon removing R1's brief with a significant amount of stool which had been there for some time, and was accompantied by an incredibly strong smell of urine. After cleaning up R1, wounds were noted covering most of R1's buttocks as a result of improper care. Police records dated July 21, 2022, indicated the police department received a MAARC report which indicated R1 was brought to the hospital with low oxygen saturation and confusion. When R1 arrived there was a significant amount of stool and a strong odor of urine. After R1 was cleaned, emergency room (ER) staff noticed wounds covering most of R1's buttocks. The police officer contacted the licensed assisted living director (LALD)-G. LALD-G verified she was aware of the report and indicated R1 normally cared for herself and was starting to need more assistance. LALD-G indicated the licensee was working on setting up training for staff and nurses to recognize someone transitioning from self-care to needing care. Licensee records did not include a MAARC report, internal investigation or training following this concern.	03000		

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03000	Continued From page 16 On October 25, 2022, at 12:30 p.m., LALD-G stated she did not remember the police calling her about the incident but did get a call from R1's family member stating the hospital was filing a report for neglect. LALD-G was not aware of any training completed after the incident and did not report the incident or complete an internal investigation. LALD-G stated nursing should have reported this concern. The licensee's Mandated Reporting Algorithm dated November, 1, 2021, indicated the failure or omission by a caregiver to supply care or services, such as food, clothing, shelter, health care, or supervision, which is not the result of an accident or therapeutic conduct and indicated this should be reported and an internal investigation should be completed. TIME PERIOD FOR CORRECTION: Seven (7) days.	03000		