DEPARTMENT OF HEALTH

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

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL306215162M
**Compliance #:** HL306216818C

**Date Concluded:** December 10, 2024

**Name, Address, and County of Licensee Investigated:**
Golden Horizons
13631 E. Shore Road
Crosslake, MN 56442
Crow Wing County

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

**Evaluator's Name:**
Katherine Barnhardt RN, Special Investigator
**Revised by:**
Jacci Nickell, Reconsideration Analyst
**Revised on:** July 8, 2025

**Finding:** Allegation 1 Abuse - Not Substantiated
Allegation 2 Neglect - Substantiated

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

**Initial Investigation Allegation(s):**
The facility abused resident #1 when the facility required resident #1's transfer to a memory care unit only because resident #1 required a two-person mechanical sling lift. In addition, the facility neglected resident #2 when they failed to provide supervision and resident #2 eloped from the facility.

**Investigative Findings and Conclusion:**
The Minnesota Department of Health determined ~~abuse and~~ neglect <u>was</u> ~~were~~ substantiated. The facility was responsible for the maltreatment. ~~The facility abused resident #1 by unreasonably confining resident #1 in a secured unit, without a way to exit the unit, when resident #1 did not require a secured unit.~~ The facility neglected resident #2 when the facility

failed to provide interventions and supervision to prevent resident #2's elopements from the facility.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, unlicensed staff, and family members. The investigator contacted a case worker. The investigation included review of the resident records, facility incident reports, personnel files, staff schedules, staff communication logs, related facility policy and procedures. The investigator observed unlicensed staff interact with residents.

Resident #1 resided in an assisted living memory care unit. Resident #1's diagnoses included multiple sclerosis (MS). Resident #1 had a mental health diagnosis but was alert and oriented to person, place, time, and situation. Resident #1's service plan included assistance with safety checks, transfers, and physical tasks. Resident #1's assessment indicated resident #1 required two staff to transfer with a mechanical sling lift, experienced episodes of hypoxia (deprivation of adequate oxygen supply) and was unable to complete activities of daily living (ADLs) without staff assistance.

Resident #1's record indicated a slow progressive deterioration of resident #1's mobility. Mid-summer, resident #1 experienced a hospitalization and returned to the facility. When resident #1 returned from the hospital she required a two-person mechanical sling lift for transfers. The facility did not allow a mechanical sling lift to be used in the non-secured area of the facility because only one staff member was scheduled in that area. Resident #1 was required to move into the secured memory care unit. Resident #1's move into the secured unit limited resident #1's ability to communicate with other residents of similar cognitive status and move freely within the building and grounds. Resident #1's record did not indicate the facility helped with finding alternative placement at the time of resident #1's hospital return.

Resident #1's record indicated resident #1 had utilized a mechanical sling lift for transfers in her assisted living apartment for a month and a half prior to her hospitalization.

During investigative interviews, multiple staff members stated staff were injured during manual transfers when resident #1 resided in the assisted living area because the facility would not allow mechanical sling lifts to be used. Licensed and unlicensed staff stated resident #1 was able to assist with manual transfers on some days and required two to three staff on other days. Licensed and unlicensed staff stated the facility's policy required residents to move into the secured memory care unit if they became a two-person transfer or required a mechanical sling lift, regardless of cognitive status. The facility's memory care unit was the only area of the facility a mechanical sling lift was used. Staff stated resident #1 had "declined a lot" mentally and physically since the facility required resident #1 to transfer into the secured unit.

During an interview, resident #1 stated she was not given a choice when she was moved into the secure memory care unit. Resident #1 stated she was moved to the secured memory care unit because she needed more assistance and a mechanical sling lift for transfers. Resident #1

stated the move was an unhealthy change that caused her to be more depressed, she was unable to communicate with residents in the memory care unit and her ability to move within the facility was limited. Resident #1 stated she felt confined and was concerned with retaliation if she shared her opinions. Resident #1 stated she was required to summon staff to let her out of the secured unit if she chose to go out.

During an interview, resident #1's family member stated when resident #1 was hospitalized, resident #1 experienced a temporary decline in health. The family member stated upon return from the hospital resident #1 required feeding assistance and two staff to transfer with a mechanical sling lift. The family member stated licensed staff told resident #1 and the family the facility could not provide staff assistance for feeding in the assisted living area. The family member stated licensed staff told the family and resident #1 she needed to move to the secured memory care unit or a long-term skilled nursing home because that was the only area of the facility the facility used a mechanical sling lift. The family member stated the staff had used the mechanical sling lift for resident #1 in her assisted living apartment for a month and a half prior to the hospitalization. The family member stated neither the family nor resident #1 was helped in locating an alternative assisted living that accommodated sling lift for transfers. Resident #1 was not given the key-code to freely come and go from the secured unit and was required to request staff's assistance if resident #1 wanted to exit the secured area. The family member stated resident #1's mental and physical health had suffered because of isolation in the secured memory care unit.

Resident #2 resided in an assisted living facility. The resident's diagnoses included dementia without behavioral disturbance. The resident's service plan included safety checks twelve times daily, meal reminders and bathing assist. The resident's assessment indicated staff assisted with peri-care, verbal cueing for hygiene, assistance with meals due to chewing and swallowing difficulties and communication was difficult due to word finding. The resident was vulnerable due to varied orientation and wandering.

A review of resident #2's record indicated during late winter staff were directed to conduct hourly safety checks and staff were to be aware of resident #2's whereabouts "at all times". Resident #2's record indicated she had exited the front door of the facility on numerous occasions and had been redirected back into the building by staff.

A review of resident #2's hourly safety check log indicated staff had signed off multiple hours of safety checks all at one time indicating safety checks were not completed hourly as scheduled. Resident #2's record did not indicate direction was given to unlicensed staff to accompany or supervise resident #2 when she was outside and incident reports were not completed when resident #2 exited the building without staff knowledge.

Resident #2's progress notes indicated dementia behaviors escalated since admission and resident #2 exhibited wandering, confusion, and high levels of anxiety. Resident #2's progress

notes indicated resident #2 cared for a dementia baby doll (a baby doll that emulates a human baby) and required close monitoring of toileting and hygiene cares.

A review of staff communication logs indicated staff did not pass along information from shift to shift or notify licensed staff when resident #2 routinely exited the building without staff knowledge.

During an interview, dietary staff stated one day resident #2 had been found outside by the trash cans when staff took garbage out. Dietary staff stated when found, resident #2 was shaking, unable to clearly communicate and answered "terrible" when asked by dietary staff how she was. Dietary staff stated resident #2 took their hand, walked back into the building and unlicensed staff were notified resident #2 was found standing by the garage. Dietary staff stated resident #2 did not appear to know where to go or how to get back into the building and was outside five to ten minutes.

During an interview, unlicensed staff stated resident #2 liked to be outside and would often go outside unsupervised, but staff "usually found her right away". Staff stated they would know when resident #2 got outside when hourly safety checks were conducted, and the resident was not found in the building. Unlicensed staff stated all the staff were aware resident #2 wandered and at times resident #2 would "sneak past" staff and get outside. Unlicensed staff stated it was difficult to monitor resident #2's whereabouts when staff were assisting other residents. Unlicensed staff stated staffing shortages happened "a lot" on the afternoon shifts and weekends when management was not at the facility.

During an interview, licensed staff stated resident #2 needed placement into the secured memory care unit, however, family was not in agreement. Licensed staff stated the facility did not have a wander guard system that alerted staff to a resident leaving the building and resident #2 left the building through the front doors on average once a week. Licensed staff stated resident #2 had been found on a curb near the road and standing by trash cans next to a garage but had not left the property. Licensed staff stated other residents in the facility would use their call pendants and alert staff when resident #2 went outside. Licensed staff stated the activities department engaged resident #2 during the week with activities, however, the facility did not have the staff to provide one to one staffing. Licensed staff stated staff kept an eye on resident #2, however, were unable to keep eyes on her every second and it took only seconds for resident #2 to get outside. Licensed staff were unsure if resident #2 would know which door to reenter the building through after she got outside.

During an interview, the family member stated resident #2 had dementia and required supervision more than any other cares. The family member stated resident #2 liked being outside but the facility did not have staff to take resident #2 outside. The family member stated the facility and the family compromised and resident #2 would have safety checks every two hours. The family member stated she was notified recently of an elopement that occurred

two weeks prior when resident #2 was found outside by dietary staff. The family member stated they did not feel resident #2 needed a secure memory care unit.

In conclusion, the Minnesota Department of Health determined ~~abuse and~~ 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.

**Abuse: Minnesota Statutes section 626.5572, subdivision 2.**
"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening.

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

**Vulnerable Adult interviewed**: Yes, resident #1.
**Family/Responsible Party interviewed**: Yes.
**Alleged Perpetrator interviewed**: N/A

**Action taken by facility:**
The facility initiated seeking a facility that could meet the needs of resident #1 and held a care conference with resident #2's family.

**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
Crow Wing County Attorney
Crosslake City Attorney
Crosslake Police Department
Minnesota Board of Executives for Long Term Services and Supports

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30621 | A. BUILDING: _____ B. WING _____ | C 08/22/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOLDEN HORIZONS | 13631 E SHORE RD CROSS LAKE, MN 56442 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| 0 000 | Initial Comments<br><br>*****ATTENTION******<br><br>ASSISTED LIVING LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.01 to 144G.95, these correction orders are issued pursuant to a complaint investigation.<br><br>Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.<br><br>INITIAL COMMENTS:<br><br>#HL306215162M/#HL306216818C<br><br>On August 22, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 28 residents receiving services under the assisted living with dementia license.<br><br>The following correction orders are issued for # HL306215162M/#HL306216818C, tag identification 0450, 2340, 2360, and 2370. | 0 000 | Assisted Living Provider 144G.<br><br>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.<br><br>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3. | |

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| 0 450 | Continued From page 1 | 0 450 | | |
| 0 450 SS=G | 144G.41 Subdivision 1 Minimum requirements<br><br>All assisted living facilities shall:<br>(1) distribute to residents the assisted living bill of rights;<br>(2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285;<br>(3) utilize a person-centered planning and service delivery process;<br>(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;<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to provide person-centered care, including using the least restrictive intervention, for one of one resident (R1) reviewed, when the licensee moved R1 into a secured unit to provide transfers with a mechanical lift. The placement in the secured unit did not identify or support R1's preferences, and caused psychosocial harm to R1.<br><br>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).<br><br>The findings include: | 0 450 | | |

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| 0 450 | Continued From page 2<br><br>On August 22, 2024, at 9:50 a.m., the investigator entered R1's room located in a secured memory care unit and observed R1 laying in a hospital bed with a mechanical wheelchair nearby. Unlicensed personal (ULP)-G entered R1's room and provided fluids. The facility included two areas within the building, one area unsecured assisted living, the other area a secured memory care unit that required keypad secure access in and out.<br><br>R1's diagnosis included multiple sclerosis (MS).<br><br>R1's service plan dated June 17, 2024, indicated R1 received services to include medication management, dressing, grooming, transfers, bathing, safety checks, skin care, housekeeping, and laundry assistance.<br><br>R1's hospital return assessment dated July 16, 2024, indicated R1 had returned from a hospitalization and required two staff and a Hoyer (mechanical lift utilizing a body sling) for transfers.<br><br>R1's comprehensive assessment dated July 16, 2024, indicated R1 was not at risk for wandering or elopement.<br><br>R1's Individual Abuse Prevention Plan (IAPP) dated August 22, 2024, indicated R1 required assistance of one staff with transfers as needed, however required two staff when a Hoyer (mechanical lift utilizing a body sling) was needed. The IAPP indicated R1 did not ambulate and was not an elopement or wandering risk.<br><br>On August 22, 2024, at 10:05 a.m., R1 stated she was not given a choice before being moved to a | 0 450 | | |

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| 0 450 | Continued From page 3<br>secured memory care unit upon return from a hospitalization. R1 stated licensed staff told her she was required to move to the secured unit because she needed more assistance and a Hoyer for transfers. Hoyer transfers require two staff. The secured memory care unit scheduled two staff each shift. R1 stated she was told by licensed staff it was the facility rule and if she did not agree to move into the secured memory care unit, she would be moved to a skilled nursing home. R1 was alert and oriented to person, place, time, and situation. R1 was not offered assistance or education on relocating to an assisted living that utilized Hoyers. R1 stated her health was negatively impacted and she was more depressed since she was moved into the secured memory care unit.<br><br>On August 28, 2024. at 1:30 p.m., assisted living director in residency (ALDIR) stated it was facility policy for any resident that required a two-person transfer or a mechanical lift to move into the secured memory care unit because two staff were scheduled in the memory care unit each shift.<br><br>On September 5, 2024, at 4:30 p.m., R1's family member stated licensed staff told R1 and the family members it was facility policy for any resident requiring a two-person transfer or a Hoyer to be moved into the secured memory care unit. R1 was not given a choice and family stated R1's mental and physical health had suffered due to the isolation of the secured unit.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 450 | | |

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| 02340 | Continued From page 4 | 02340 | | |
| 02340 SS=F | 144G.91 Subd. 6 Participation in care and service planning<br><br>Residents have the right to actively participate in the planning, modification, and evaluation of their care and services. This right includes:<br>(1) the opportunity to discuss care, services, treatment, and alternatives with the appropriate caregivers;<br>(2) the right to include the resident's legal and designated representatives and persons of the resident's choosing; and<br>(3) the right to be told in advance of, and take an active part in decisions regarding, any recommended changes in the service plan.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to allow the resident to actively participate in the planning, modification, and evaluation of their care and denied the resident the right to be told in advance of, and take part in decisions regarding recommended changes for one of one resident (R1). This had the potential to affect all residents.<br><br>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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>R1's diagnosis included multiple sclerosis (MS). | 02340 | | |

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| 02340 | Continued From page 5<br><br>R1's service plan dated June 17, 2024, indicated R1 received services to include medication management, dressing, grooming, transfers, bathing, safety checks, skin care, housekeeping and laundry assistance.<br><br>R1's hospital return assessment dated July 16, 2024, indicated R1 had returned from a hospitalization and required two staff and a Hoyer (mechanical lift utilizing a body sling) for transfers.<br><br>On August 22, 2024, at 9:50 a.m., the investigator entered R1's room located in a secured memory care unit and observed R1 laying in a hospital bed with a mechanical wheelchair nearby. Unlicensed personal (ULP)-G entered R1's room and provided fluids.<br><br>On August 22, 2024, at 10:05 a.m., R1 stated she was not given a choice before being moved to a secured memory care unit upon return from a hospitalization. R1 stated licensed staff told her she was required to move to the secured unit because she needed more assistance and a Hoyer for transfers. Hoyer transfers require two staff. The secured memory care unit scheduled two staff each shift. R1 stated she was told by licensed staff it was the facility rule and if she did not agree to move into the secured memory care unit, she would be moved to a skilled nursing home. R1 was alert and orientated to person, place, time and situation, however, R1 feared transfer to a skilled nursing home. R1 was not offered assistance or education on relocating to an assisted living that utilized Hoyers. R1 stated her health was negatively impacted and she was more depressed since she was moved into the secured memory care unit 44 days prior. | 02340 | | |

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| 02340 | Continued From page 6<br><br>On August 28, 2024. at 1:30 p.m., licensed assisted living director in residency (LALDIR) stated it was facility policy for any resident that required a two-person transfer or a mechanical lift to move into the secured memory care unit because two staff were scheduled in the memory care unit each shift.<br><br>On September 5, 2024, at 4:30 p.m., R1's family member stated licensed staff told R1 and the family members it was facility policy for any resident requiring a two-person transfer or a Hoyer to be moved into the secured memory care unit. R1 was not given a choice and family stated R1's mental and physical health had suffered due to the isolation of the secured unit.<br><br>The Minnesota Assisted Living Resident Bill of Rights dated November 8, 2022, indicated residents have the right to actively participate in the planning, modification, and evaluation of their care and services. This right includes the opportunity to discuss care, services, treatment and alternatives with the appropriate caregivers in advance of changes.<br><br>No further information available.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 02340 | | |
| 02360 | 144G.91 Subd. 8 Freedom from maltreatment<br><br>Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act.<br><br>This MN Requirement is not met as evidenced | 02360 | | |

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| 02360 | Continued From page 7<br>by:<br>Based on observations, interviews, and document review, the facility failed to ensure two of two residents reviewed (R1, R2) was free from maltreatment. R1 was emotionally abused, R2 was neglected.<br><br>Findings include:<br><br>On August 22, 2024 , the Minnesota Department of Health (MDH) issued a determination that abuse and neglect occurred, and that the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred. | 02360 | | |
| 02370 SS=E | 144G.91 Subd. 9 Right to come and go freely<br><br>Residents have the right to enter and leave the facility as they choose. This right may be restricted only as allowed by other law and consistent with a resident's service plan.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure one of one resident (R1) had the right to enter and leave the facility as they chose. The facility practice had the potential to affect all residents in the facilty that required a two person mechanical lift transfer.<br><br>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 | 02370 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30621 | A. BUILDING: _____ B. WING _____ | C 08/22/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOLDEN HORIZONS | 13631 E SHORE RD CROSS LAKE, MN 56442 |

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| 02370 | Continued From page 8<br>was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).<br><br>The findings include:<br><br>According to Minnesota Assisted Living: Chapter 144G, 144G.08, Subd. 62, "Secured dementia care unit" means a designated area or setting designed for individuals with dementia that is locked or secured to prevent a resident from exiting, or to limit a resident's ability to exit, the secured setting. A secured dementia care unit is not solely an individual resident's living area.<br><br>R1's diagnosis included multiple sclerosis (MS).<br><br>R1's service plan dated June 17, 2024, indicated R1 received services to include medication management, dressing, grooming, transfers, bathing, safety checks, skin care, housekeeping and laundry assistance.<br><br>R1's hospital return assessment dated July 16, 2024, indicated R1 had returned from a hospitalization and required two staff and a Hoyer (mechanical lift utilizing a body sling) for transfers.<br><br>R1's comprehensive assessment dated July 16, 2024, indicated R1 was not at risk for wandering or elopement.<br><br>R1's Individual Abuse Prevention Plan (IAPP) dated August 22, 2024, indicated R1 required assistance of one staff with transfers as needed, however required two staff when a Hoyer (mechanical lift utilizing a body sling) was | 02370 | | |

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| 02370 | Continued From page 9 | 02370 | | |

needed. The IAPP indicated R1 did not ambulate and was not an elopement or wandering risk.

On August 22, 2024, at 9:50 a.m., the investigator entered R1's room located in a secured memory care unit and observed R1 laying in a hospital bed with a mechanical wheelchair nearby. Unlicensed personnel (ULP)-G entered R1's room and provided fluids. The facility included two areas within the building, one area unsecured assisted living, the other area a secured memory care unit that required keypad secure access in and out.

On August 22, 2024, at 10:05 a.m., R1 stated she was not given a choice before being moved to the secured memory care unit upon return from a hospitalization. R1 stated licensed staff told her she was required to move to the secured unit because she needed more assistance and a Hoyer for transfers. R1 stated she was told by licensed staff it was the facility rule. R1 did not recall receiving a keycode for the secured doors and stated it was impossible for her to go out because it required staff assistance. R1 stated her health had been negatively impacted and she was more depressed since she was moved into the secured memory care unit 44 days prior.

On August 28, 2024. at 1:30 p.m., licensed assisted living director in residency (LALDIR) stated it was facility policy for any resident that required a two-person transfer or a mechanical lift to move into the secured memory care unit because two staff were scheduled in the memory care unit each shift. LALDIR stated it was directed in the facility's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) and a mechanical lift could only be used in the memory care unit. LALDIR stated R1

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| 02370 | Continued From page 10<br>was given the key code when moved into memory care, however, R1 would locate staff and let them know when she wanted to exit the secured memory care area. LALDIR did not recall R1 ever exiting the secure unit independently without staff entering the code.<br><br>The licensee's Protecting Resident Rights policy dated September 1, 2021, indicated it was the policy of the licensee to protect the rights of their residents and [licensee] would not request or require that any resident waive any rights provided at any time for any reason, including as a condition of admission. Prior to, or at the time of admission, all residents would be provided a copy of the Minnesota Assisted Living Bill of Rights.<br><br>The Minnesota Bill of Rights for Assisted Living Residents dated August 2022, under the Right to come and go freely, indicated residents have the right to enter and leave the facility as they choose. This right may be restricted only as allowed by other law and consistent with a resident's service plan.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days. | 02370 | | |