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

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL321831901M
**Compliance #:** HL321839616C

**Date Concluded:** September 20, 2024

**Name, Address, and County of Licensee Investigated:**
Sunrise View Assisted Living
603 Louisiana Avenue
Adrian, MN 56110
Nobles 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 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 the resident when staff confined the resident in his room and within another area of the memory care unit. Facility staff used furniture to seclude and restrict the resident's movement within the facility after the resident tested positive for a respiratory infection.

**Investigative Findings and Conclusion:**
The Minnesota Department of Health determined abuse was substantiated. The facility was responsible for the maltreatment. Facility staff confined the resident to his room and utilized multiple items of furniture to secure and block off the area to restrict the resident's movement on the unit.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record, hospital records, facility internal investigation documentation, incident reports, personnel files,

staff schedules, and related policies and procedures. Also, the investigator observed staff and resident interactions at the time of the onsite visit.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia and history of physical and verbal aggression. The resident's service plan included assistance with dressing, toileting, behavioral interventions, medication management, and safety checks. The resident's assessment indicated the resident was independent with bed mobility, transfers, and ambulation. The assessment indicated the resident had a history of refusals for toileting assistance and required reminders to complete tasks. The resident was at also at risk for elopement and required safety checks.

The resident's medical record identified nursing and management staff initiated an internal investigation after they were informed of a concern about the resident being confined to his room with the door locked and furniture pushed up against the door as a barricade.

The internal investigation documentation indicated staff utilized furniture to restrict the resident's access on the unit and confine the resident to his room with the door locked after the resident tested positive for a respiratory infection.

Facility video surveillance footage and pictures taken at the time of the incidents were reviewed by the investigator.

One picture displayed a wall-to-wall line of furniture which included a couch, two recliners, two high back chairs, a dining room chair, an end table, and a dresser used to confine the resident to one area of the memory care unit which did not allow for space for the resident to move freely about the unit.

Video footage reviewed matched the picture provided with furniture lined up wall-to-wall of the couch, chairs, end tables and dresser. Video footage displayed the resident was confined to the living room area space with no way to freely exit the area.

A second picture taken the following day, displayed a couch was placed at an angle in front of the resident's room. On one side of the couch there was an end table and behind the couch there was a large dresser. There were no visible gaps to allow the resident to be able to enter or exit his room.

Video surveillance footage matched the second picture of the couch angled in front of the resident's room. The video footage audio indicated that staff questioned if they had permission to barricade the resident before moving the couch, end table, and dresser to block the area outside of the resident's room. Before leaving the area, staff closed the resident's door. There was no visible opening to allow the resident to exit the area. Two hours later, a visitor is seen on camera climbing over the couch and attempting to open the resident's door without success. The visitor climbed back over the couch and returned to the area with staff. Staff told the visitor

they did not know why [the furniture] was there and moved the couch out of the way to unlock the resident's door.

During an interview, administrative staff #1 stated she received a phone call from memory care staff and instructed staff to move furniture to detour the resident from going to the other side of memory care due to his respiratory infection. Administrative staff #1 stated she did not contact the facility nurse about this incident. Administrative staff #1 stated she was contacted by staff the next day about the resident's family being upset that a barricade was placed in front of the resident's door. Administrative staff #1 stated she did not receive a picture of the barricade nor was she involved in the internal investigation.

During an interview, administrative staff #2 stated she was responsible to oversee the facility day to day operations, the employees, and residents. Administrative staff #2 stated there were two separate incidents involving the resident. Administrative staff #2 stated she was not informed of the first incident but went to the memory care unit the next morning and noticed furniture blocking off one area of the wall to the middle of the room. Staff informed her the furniture was set up during the night shift to restrict the resident's movement on the unit due to his recent diagnosis of respiratory infection. Administrative staff #2 stated she instructed staff to put the furniture back and take down the barrier but stated she received a call later that evening from the resident's family stating that the resident was locked in his room with a couch and dresser blocking the door. Administrative staff #2 stated it was never ok to barricade or lock a resident in their room or confine them in an area and that residents should be able to come and go as they please. Administrative staff #2 stated she was embarrassed about the incidents and stated that they should not have happened.

During an interview, facility management staff stated that a barrier in front of the resident's room, or a wall of furniture used to confine a resident was not acceptable.

During an interview, the resident's family stated they went to visit the resident and when they walked into memory care unit there as a sofa with a dresser behind it and the resident's door was locked. The resident's family stated there was no way for the resident to leave his room unless he climbed over the couch. The family stated that the facility tried to tell them there was enough space for the resident to come and go but the couch had to be moved out of the way to enter or exit the resident's room.

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

**Vulnerable Adult interviewed**: No, due to cognition
**Family/Responsible Party interviewed**: Yes
**Alleged Perpetrator interviewed**: Not Applicable

**Action taken by facility:**
The facility completed an internal investigation into the incident.

**Action taken by the Minnesota Department of Health:**

- <u>If substantiated and facility responsibility only</u>:

  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
Nobles County Attorney
Adrian City Attorney
Adrian 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 |
|---|---|---|---|
| | 32183 | A. BUILDING: _____ B. WING _____ | C 07/17/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNRISE VIEW ASSISTED LIVING | 603 LOUISIANA AVENUE ADRIAN, MN 56110 |

| (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 PROVIDER CORRECTION ORDER<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>#HL321839616C/#HL321831901M<br><br>On July 17, 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 26 residents receiving services under the provider's Assisted Living with Dementia Care license.<br><br>The following correction order is issued/orders are issued for ##HL321839616C/#HL321831901M, tag identification 0110, 0330, 0620, 2310, 2360. | 0 000 | | |
| 0 110 SS=F | 144G.10 Subdivision 1a Assisted living director license required<br><br>Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services | 0 110 | | |

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| 0 110 | Continued From page 1<br>and Supports.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure employment of a licensed assisted living director (LALD). This had the potential to affect all 26 residents receiving assisted living services.<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>The licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA), dated May 20, 2021, indicated an Assisted Living Director would be onsite full time.<br><br>The licensee's application for assisted living licensure dated May 25, 2022, indicated the assisted living director was administrative staff (ADM)-C.<br><br>The licensee's staff list identified ADM-C was hired on June 8, 2021, with the title of assisted living director in residence (ALDIR).<br><br>During an interview on July 17, 2024, at 3:15 p.m., ADM-C stated she was the assisted living director in residence and stated her responsibilities were to oversee the the facility, | 0 110 | 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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| 0 110 | Continued From page 2<br><br>employees, residents, and day to day operations of the facility.<br><br>On July 17, 2024, the Minnesota Board of Executives for Long-Term Services and Support (BELTSS) website was reviewed for verification of the licensed assisted living director's licensure. ADM-C was listed as having a residency permit for the licensee that expired on March 29, 2023.<br><br>On July 18, 2024, a member of the licensee's management (LALD)-F sent an email verifying that they held a licensed assisted living director license and acknowledged that the facility did not have a current Director of Record listed on the BELTSS website. LALD-F indicated this would be fixed right away and he would be listed as the Director of Record.<br><br>The licensee lacked a LALD to manage and supervise assisted living services for the 26 residents who received assisted living services.<br><br>A policy was requested but not provided.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: TWO (2) days | 0 110 | | |
| 0 330 SS=F | 144G.30 Subd. 4 Information provided by facility<br><br>(a) The assisted living facility shall provide accurate and truthful information to the department during a survey, investigation, or other licensing activities.<br>(b) Upon request of a surveyor, assisted living facilities shall within a reasonable period of time provide a list of current and past residents and | 0 330 | | |

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| 0 330 | Continued From page 3<br><br>their legal representatives and designated representatives that includes addresses and telephone numbers and any other information requested about the services to residents.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the licensee failed to provide truthful information during the investigation for 1 of 1 resident (R1) reviewed. Licensee administrative staff provided false information about their knowledge of incidents where staff utlized furniture to confine R1 to his room and within another area of the memory care unit; however, video and audio footage confirmed administrative staff were aware of the situation at the time of the incident.<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 resided in memory care with diagnoses including dementia, and a history of verbal and physical aggression.<br><br>R1's undated, unsigned, service plan indicated R1 received assistance with bathing, dressing, toileting, behavior interventions, safety checks, and medication management.<br><br>R1's 90-day assessment dated December 19, 2023, indicated R1 was independent with bed | 0 330 | | |

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| 0 330 | Continued From page 4<br><br>mobility, transfers and ambulation. R1 would refuse toileting and required reminders to complete tasks. R1 was at risk for elopement with 30-minute safety checks.<br><br>R1's progress note dated February 1, 2023, written February 5, 2024, indicated R1's family member (FM) contacted administrative staff stating she went to visit R1 and found a barricade in front of R1's door. The barricade was made from the couch and behind the couch was a dresser. R1's FM attempted to open R1's door and it was locked. The note indicated there was an 18 inch gap between the couch and the wall for R1 to be able to get around it and R1 was not harmed or neglected and re-education was provided to staff to never barricade any doors.<br><br>A review of pictures provided to the MDH investigator taken on February 1, 2024, at 7:00 p.m. identified a couch placed at an angle, with a dresser behind the couch, and an end table at the other end of the couch to block R1 from exiting his room.<br><br>Video and audio footage provided by the licensee dated February 1, 2024, was reviewed and identified the following:<br>- 4:10 p.m., Two unlicensed staff place the barrier in front of R1's room. The barricade consisted of an end table, a couch and a dresser placed behind the couch.<br>- 6:24 p.m., R1's family member (FM) walks into memory care, looks at the barricade takes a picture, climbs over the couch, attempted to open the door and it was locked. R1's FM climbed back over the couch and took another picture on the other side of the couch. R1's FM went to get staff. ULP-I stated, "I don't know why this is here, maybe to prevent the spread of COVID." ULP-I | 0 330 | | |

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| 0 330 | Continued From page 5<br><br>stated here is the walkway and then had to slide the couch out of the way to unlock R1's door. ULP-I stated R1 must have locked the door, "I was just in R1's room five minutes ago at 6:20 to check on him and the door wasn't locked."<br>- 6:41 p.m., R1's FM left R1's room, slid the table back and shut the door. She told ULP-I she put the table back and he thanked her.<br>- 6:41 p.m., to 7:34 p.m., staff did not enter R1's room.<br>- 7:34 p.m., ULP-E walked into memory care and stated, "that's why [R1's FM] is flipping some shift." ULP-E stated last night the barricade was over there and not in front of his room. ULP-E then took a picture of the barricade. ULP-E then was on the phone with administrative staff-A and administrative staff-C. ULP-E informed them she sent them both the picture of the barricade. ULP-E stated, "they put the couch so he can't get out of his door, with the dresser behind to lock him in there." ULP-E stated last night it was not like this he had a little room to walk around.<br>- 7:38 p.m., one administrative staff stated "is the couch up against the wall?" ULP-E replied yes.<br>- 7:41 p.m., one administrative staff directed them to take down the barricade and to never lock the doors.<br>- 7:42 p.m., one administrative staff again asked is the couch touching the wall and is it from corner to corner. ULP-E responded, "yes," ULP-E walked into R1's room and then left right away and shut the door. At that time the barricade was removed.<br><br>On July 17, 2024, at 1:11 p.m., ADM-A stated she was the contact for all staff after hours unless it was a medical concern. She received a call on February 1, 2024, around 7:00 p.m., and told ULP-E to contact administrative staff-C. ADM-A she did not receive a picture of the barricade | 0 330 | | |

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| 0 330 | Continued From page 6<br><br>placed on February 1, 2024, and was not involved in staff interviews for the incident.<br><br>On July 17, 2024, at 3:15 p.m., ADM-C stated she was responsible for oversight of employees, residents, and day to day operations. ADM-C stated during phone conversations staff told her R1 had access to get out of his room and days later ADM-C found out there was not an access point for R1. ADM-C stated she came in that night to ensure the barricade had been removed and to start an internal investigation.<br><br>Video and audio footage from February 1st indicated ADM-A and ADM-C were sent a picture of the furniture used to confine R1 to his room and were informed there was no space available for R1 to enter or exit the area with the way the furniture was arranged in front of R1's door.<br><br>The undated, unsigned, internal investigation documentation indicated ADM-A initially directed staff to use furniture to block off an area to deter R1 from moving about the unit due to a recent diagnosis of Covid.<br><br>On July 23, 2024, at 10:00 a.m., an unlicensed personnel (ULP)-E stated she came to work on February 1, 2024, around 7:00 p.m. and answered the phone. R1's family member was "really, really, super angry" and asked why R1 was barricaded in this room. ULP-E went to to memory care unit and saw the barricade and confirmed they took a picture and sent it to ADM-A. ULP-E stated she understood why the family was upset. ULP-E stated ADM-A and ADM-C were on a group phone call with her. ULP-E then sent the picture to ADM-C. ULP-E stated administrative staff asked her twice if there was a walk way or gap in the barricade and | 0 330 | | |

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| 0 330 | Continued From page 7<br>ULP-E told them there was not. ULP-E said administrative staff told them to take the barricade down and check on R1.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: 2 days | 0 330 | | |
| 0 620 SS=D | 144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma<br><br>(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.<br><br>The requirement in Minnesota Statute section 626.557, Subd. 3 is:<br>(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:<br>(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<br>(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 | 0 620 | | |

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| (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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| 0 620 | Continued From page 8<br><br>(a), clause (4).<br>(b) A person not required to report under the provisions of this section may voluntarily report as described above.<br>(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.<br>(d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.<br>(e) A mandated reporter who knows or has reason to believe that an error under section 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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the licensee was not compliant with the requirements for reporting maltreatment of vulnerable adults when a suspected incident of maltreatment was not reported to the Minnesota Adult Abuse Reporting Center (MARC) within twenty-four hours. The licensee failed to report potential abuse for one of one resident (R1) after staff | 0 620 | | |

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| 0 620 | Continued From page 9<br><br>confined R1 to his room and other areas of the unit by blocking off the area with furniture.<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 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>Findings include:<br><br>R1 resided in memory care with diagnoses including dementia, and a history of verbal and physical aggression.<br><br>R1's undated, unsigned, service plan indicated R1 received assistance with bathing, dressing, toileting, behavior management, and medication management.<br><br>R1's 90-day assessment dated December 19. 2023, indicated R1 was independent with bed mobility, toileting, transfers, and ambulation. R1 would refuse toileting and required reminders to complete tasks. R1 was at risk for elopement with 30-minute safety checks.<br><br>R1's progress note dated February 1, 2024, written February 4, 2024, indicated ULP-E received a call from R1's family member (FM) and found a barricade in front of R1's door. The barricade was made from a couch and behind the couch was a dresser. R1's FM attempted to open R1's door and it was locked. During the investigation it was disclosed there was a gap between the couch and the wall for R1 to be able | 0 620 | | |

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| 0 620 | Continued From page 10<br><br>to get around it and re-education was provided to staff.<br><br>A summary of the licensee's internal investigation undated and unsigned indicated on January 31, 2024, at 10:00 p.m. staff reached out to administrative staff-A to try and find a solution to detour R1 from going into other resident's room. Staff were instructed to set up a barricade made from furniture with the intention of keeping R1 separated from other residents with 1:1 staffing. On February 1, 2024, ADM-A and C went to memory care to speak to staff that were working and instructed the staff to remove the barrier. At around 9:30 a.m., the barricade was taken down. At about 4:15 p.m., two staff moved the couch closer to R1's door without a gap. At approximately 6:15p.m., R1's FM came to visit R1 and noticed the barricade in front R1's door. Residents have the right to come and go freely from their personal spaces. The actions following the idea to isolate R1 from other resident was not communicated effectively for all staff involved.<br><br>A picture taken on January 31, 2024, of the barricade placed to isolate R1 to a certain location in memory care. The barricade included a picture of a couch, two recliners, 2 high back chairs, a dining room chair, end table and a dresser. The barricade went from one side of the wall to another and did not allow for space for R1 to move freely. A picture taken on February 1, 2024, of the barricade in front of R1's room included an end table, a couch put at an angle, and a dresser placed behind the couch.<br><br>Video footage was reviewed and identified facility staff placed the barrier on February 1, 2024, at 4:10 p.m., and removed the barrier at 7:42 p.m. | 0 620 | | |

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| 0 620 | Continued From page 11<br><br>During an interview on July 17, 2024, at 1:10 p.m., ADM-A stated she received a phone call from memory care staff on January 31, 2024, and instructed staff to move furniture to detour R1 from going to the other side of memory care due to Covid. ADM-A stated she was contacted by an unlicensed staff on the evening of February 1, 2024, stating a family member was upset about R1 begin barricaded in his room. ADM-A directed them to call administrative staff-C and did not have any involvement in the investigation.<br><br>During an interview on July 17, 2024, at 2:00 p.m., the facility registered nurse (RN)- B stated she was contacted about the incident that occurred on 1-31-24. RN-B stated ADM-C called her to say R1's FM found him barricaded in his room. RN-B stated ADM-C sent RN-B pictures of what the barricades looked like. The first picture showed the barricade that was placed on January 31, 2024, and the second picture was the barricade placed in front R1's door. RN-B stated she encouraged ADM-C to file a report to the Minnesota Adult Abuse Reporting Center (MAARC) report. RN-B stated upper management informed facility staff the incident did not need to be reported. . RN-B stated facility staff were not able to review the video surveillance. RN-B stated the incident was not reported for four days and stated it should have been reported immediately.<br><br>During an interview on July 17, 2024, at 3:15 p.m., ADM-C stated she was responsible to over see both communities, employees, residents, and day to day operations. She stated there were two separate incidents involving barricades. ADM-C stated she was not notified about the incident on January 31, 2024. On February 1, 2024, when she arrived she noticed a half barricade from one | 0 620 | | |

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| 0 620 | Continued From page 12<br><br>wall to the middle of the room. Staff informed her the barricade was placed during the night shift. ADM-C stated she received a call the evening of February 1, 2024, from R1's FM stating R1 was barricaded in his room with a couch and dresser. . ADM- C stated the incident should have been reported right away, within 24 hours. ADM-C stated it was never ok to barricade or lock a resident in their room or in an area and residents should be able to come and go as they please. ADM-C stated these incidents were "embarrassing" and should not have happened.<br><br>The licensee's Report of Maltreatment of a Vulnerable Adult policy dated August 1, 2021, indicated team members who suspect maltreatment of a resident (abuse, financial exploitation, or neglect), or who has knowledge that a resident sustained a physical injury which is not reasonably explained will: a) Take immediate action to protect, or keep safe, the resident affection, b) call 911 if emergency assist is needed, c) contact the Clinical Nurse Supervisor if medical attention is needed, d) contact the assisted living director, e) The assisted living director or clinical nurse supervisor will determine how to best protect other residents form similar maltreatment in the immediate future, f) if suspicion of maltreatment, they will contact MAARC within 24 hours.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 620 | | |
| 02310 SS=G | 144G.91 Subd. 4 (a) Appropriate care and services | 02310 | | |

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| 02310 | Continued From page 13<br><br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care medical or nursing standards for one of one resident (R1) when staff utilized furniture to create a barricade confine R1 to his room and other areas of the unit, restricting his movement and access to the unit.<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:<br><br>R1 resided in the memory care unit with diagnoses including dementia, and a history of verbal and physical aggression.<br><br>R1's undated, unsigned, service plan indicated R1 received assistance with bathing, dressing, toileting, behavior interventions, and medication management.<br><br>R1's 90-day assessment dated December 19, 2023, indicated R1 was independent with bed | 02310 | | |

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| 02310 | Continued From page 14<br><br>mobility, toileting, transfers and ambulation. R1 would refuse toileting and required reminders to complete tasks. R1 was at risk for elopement and required 30-minute safety checks.<br><br>R1's progress note dated January 29, 2024, indicated R1 tested positive for COVID (respiratory infection).<br><br>R1's progress note dated February 1, 2024, written February 4, 2024, indicated facility staff received a call from R1's family member (FM) when they found a barricade of furniture in front of R1's door. The barricade was made from a couch and behind the couch was a dresser. R1's FM attempted to open R1's door and the door was locked. During the investigation it was disclosed there was a gap between the couch and the wall for R1 to be able to get around it and re-education was provided to staff.<br><br>R1's progress note dated February 1, 2024 written February 5, 2024, indicated the registered nurse (RN) was called at 8:19 p.m., regarding an incident with staff barricading R1 in his room with a dresser and couch.<br><br>R1's progress note dated February 5, 2024, indicated facility staff received a phone call from R1's medical provider team questioning why staff barricaded R1 in his room and why the door was locked.<br><br>R1's medical record did not include an assessment following the incident.<br><br>The undated and unsigned summary of the licensee's internal investigation indicated on January 31, 2024, at 10:00 p.m. staff contacted an administrative staff member (ADM)-A to try | 02310 | | |

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| 02310 | Continued From page 15<br><br>and find a solution to detour R1 from going into other resident's room. ADM-A instructed staff to set up a barricade made from furniture with the intention of keeping R1 separated from other residents with 1:1 staffing. On February 1, 2024, ADM- A and another administrative staff member (ADM)- C went to the memory care unit to speak to staff and instructed the staff to remove the barrier. At around 9:30 a.m., the barricade was taken down. At about 4:15 p.m., two unlicensed staff moved a couch in front of R1's door, to keep R1 from exiting the room. At approximately 6:15p.m., R1's FM came to visit R1 and noticed the couch in front R1's door. The summary indicated there were no pictures taken of the door to show how the furniture was used to block off the door. The invesigation noted that residents have the right to come and go freely from their personal spaces and the actions following the idea to isolate R1 from other resident was not communicated effectively for all staff involved.<br><br>Documentation of the internal investigation did not include documentation of interviews with staff who worked on the evening shift on February 1, 2024.<br><br>A picture provided to the MDH investigator taken January 31, 2024, of the barricade placed to isolate R1 to a certain location in memory care. The barricade included a picture of a couch, two recliners, 2 high back chairs, a dining room chair, an end table, and a dresser. The barricade went from one side of the wall to the other restricting the resident's access to other areas of the unit and did not allow space for R1 to move freely.<br><br>A picture provided to the MDH investigator taken on February 1, 2024, identified a couch placed at an angle in front of R1's room. On one side of the | 02310 | | |

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| 02310 | Continued From page 16<br><br>couch was an end table and behind the couch there was a large dresser blocking R1's ability to ext the room. There were no visible gaps for R1 to be able to enter or exit his room.<br><br>Licensee provided video and audio footage was reviewed and identified the following:<br><br>On January 31, 2024:<br>- 12:01 a.m., furniture was placed from one side of the wall to the other side to create a barrier with a couch, chairs, end tables, to restrict R1's movment throughout the unit. There was no visibile opening available for R1 to exit the living room area.<br><br>On February 1, 2024:<br>- 4:00 p.m., a barricade was in place from one side to the other with a small area to walk through.<br>- 4:02 p.m., an unlicensed personnel (ULP)-I is heard saying "Do we have permission to barricade? How do you want to do this? The only thing is we have to give him an exit because if state walks in we could be fined because it would be considered abuse, I am protecting our butt."<br>- 4:08 p.m., a second unlicensed personnel (ULP)-H stated, "I am going to show you what we are going to do."<br>- 4:10 p.m., ULP-H and ULP-I assisted R1 to his room, ULP-H stated, "We should change him, but not right now. I want to try before we leave. ULP-H stated "I don't want him wandering this whole area. ULP-H and ULP-I moved the couch so it sat from one wall to another and then put a dresser behind it with an end table on the other side to block of the area. There was no visible space that would have allowed R1 to exit the area. ULP-H then told the ULP-I to shut R1's door. | 02310 | | |

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| 02310 | Continued From page 17<br>- 4:10 p.m., to 5:00 p.m., staff did not enter R1's room.<br>- 5:00 p.m., to 6:00 p.m., [MDH investigator was informed by licensee staff that no footage was available for this time period]<br>- 6:00 p.m., to 6:24 p.m., staff did not enter R1's room.<br>- 6:24 p.m., R1's family member (FM) walked into the memory care unit, looked at the barricade and took a picture. FM then climbed over the couch, attempted to open R1's door but it was locked. R1's FM climbed back over the couch and took another picture on the other side of the couch. R1's FM left the area and returned to the area with ULP-I. ULP-I stated, "I don't know why this is here, maybe to prevent the spread of COVID." ULP-I stated, "here is the walkway" and then slid the couch out of the way to unlock R1's door. ULP-I stated R1 must have locked the door, "I was just in R1's room five minutes ago at 6:20 to check on him and the door wasn't locked."<br>- 6:41 p.m., R1's FM left R1's room, slid the table back and shut the door. R1's FM told ULP-I she put the table back and he thanked her.<br>- 6:41 p.m., to 7:34 p.m., staff did not enter R1's room.<br>- 7:34 p.m., a third unlicensed personnel (ULP)-E walked into the memory care unit and stated, "that's why [R1's FM] is flipping some shit." ULP-E stated "last night the barricade was over there and not in front of his room". ULP-E took a picture of the barricade. ULP-E was on the phone with ADM-A and ADM-C. ULP-E informed them she sent them both the picture of the barricade. ULP-E stated, "they put the couch so he can't get out of his door, with the dresser behind to lock him in there." ULP-E stated "last night it was not like this he had a little room to walk around".<br>- 7:38 p.m., one of the administrative staff is heard asking "is the couch up against the wall?" | 02310 | | |

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| 02310 | Continued From page 18<br><br>ULP-E replied yes.<br>- 7:41 p.m., administrative staff directed ULP-E to take down the barricade and to never lock the doors.<br>- 7:42 p.m., one administrative staff again asked "Is the couch touching the wall and is it from corner to corner?" ULP-E responded, "yes," ULP-E walked into R1's room and then left right away and shut the door. At that time the barricade was removed.<br><br>ADM-A was interviewed on July 17, 2024, at 1:10 p.m., ADM- A stated she received a phone call from memory care staff on January 31, 2024, and instructed staff to move furniture to detour R1 from going to the other side of the memory care unit due to his recent diagnosis of Covid. She had directed care staff to not contact her after hours unless it was a medical issue. ADM-A stated she did not contact the RN about this incident. ADM-A stated she was contacted by ULP-E stating R1's family member was upset about R1's barricade in front of his door. ADM-A stated she did not receive a picture of the barricade nor was she involved in the internal investigation of the incident.<br><br>On July 17, 2024, at 2:00 p.m., RN-B was interviewed and stated ADM-C sent her pictures of what the barricades looked like. The first picture showed the barricade that was placed on January 31, 2024, and the second picture was the barricade placed in front of R1's door. RN-B stated she encouraged ADM-C to file a report to the Minnesota Adult Abuse Reporting Center (MAARC) report. RN-B was informed by upper management that the incident did not need to be reported. RN-B stated staff called administrative staff with concerns instead of the RN. RN-B stated facility staff were not able to review the | 02310 | | |

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| 02310 | Continued From page 19<br><br>video surveillance. RN-B stated the incident was not reported for four days but should have been reported immediately. RN-B stated she was not involved in the internal investigation.<br><br>On July 17, 2024, at 3:15 p.m., ADM-C stated she was responsible to over see both of the licensee's communities, employees, residents, and day to day operations. She stated there were two separate incidents involving barricades. The first incident on January 31, 2024, she was not notified of but went to memory care on February 1, 2024, and noticed a half of the barricade was still up from one wall to the middle of the room. Staff informed her this barrier was placed during the night shift so R1 wouldn't get out due to covid. She instructed staff to take it down. ADM-C stated she received a call the evening of February 1, 2024, from R1's FM stating R1 was barricaded in his room with a couch and dresser. When ADM-C came to the facility the furniture had already been moved away from R1's door. ADM-C stated this should have been reported right away and it was never ok to barricade or lock a resident in their room or in any other area as they should be able to come and go as they please. ADM-C stated these incidents were "embarrassing" and should not have happened.<br><br>The licensee's Vulnerable Adults- Maltreatment, Communication, Prevention, and Reporting Plan dated August 1, 2021, indicated the Assisted Living Bill of Rights gives the residents the right to be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment. Staff who suspect maltreatment or who has knowledge that a resident has sustained a physical injury which ins not reasonably explained will: taken immediate action to protect, or keep safe the affected resident; contact the | 02310 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 32183 | A. BUILDING: _____ B. WING _____ | C 07/17/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNRISE VIEW ASSISTED LIVING | 603 LOUISIANA AVENUE ADRIAN, MN 56110 |

| (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 |
|---|---|---|---|---|
| 02310 | Continued From page 20<br><br>clinical nurse supervisor if medical attention is needed; contact 911 if needed; contact the Assisted Living Director; the Assisted Living Director or clinical nurse supervisor will determine how to best protect other residents from similar maltreatment in the immediate future; if suspicion of maltreatment is confirmed they will contact MAAR within 24 hours after the maltreatment was suspected.<br><br>No further information Provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 02310 | | |
| 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 by:<br>The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment.<br><br>Findings include:<br><br>The Minnesota Department of Health (MDH) issued a determination maltreatment occurred for R1, 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 | No plan of correction required for tag 2360. Please refer to the public maltreatment report for details. | |