MDH Minnesota Department of Health

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:
Circle Drive Manor Assisted Living

Facility Address:
56733 State Highway 56 South

Facility City:
West Concord

State:	ZIP:	County:
Minnesota	55985	Dodge

Report Number:
HL20055002

Time of Visit:
8:30 a.m.- 5:30 p.m.
8:15 a.m. - 10:00 a.m.

Investigator's Name and Title:
Rhylee Gilb, RN
Special Investigator

Date of Visit:
October 20 and 21, 2016

Date Concluded:
January 19, 2017

☒ **Home Care Provider/Assisted Living**

Allegation(s):

It is alleged that a client was neglected when the facility administered an incorrect medication to the client and the client developed severe respiratory distress. The client was hospitalized and needed to be intubated.

☒ State Statutes for Home Care Providers (MN Statutes, section 144A.43 - 144A.483)

☒ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)

☒ State Statutes Chapters 144 and 144A

Conclusion:

Based on a preponderance of evidence, neglect occurred when a client was given the wrong medication by the facility staff. The client required hospitalization and intubation due to receiving the incorrect medication. The facility had a pattern of presetting medications in a manner which made this issue likely to occur, the facility has been informed this practice was not safe, and the facility continued to fail to provide safe medication administration even after this incident.

The client had diagnoses that included chronic obstructive pulmonary disease (COPD). The client required oxygen use to maintain the client's respiratory status. The client received home care services and required assistance with all activities of daily living including medication and oxygen management. The client had a history of respiratory infections and exacerbation of COPD.

The day of the incident, the client was not feeling well and requested to eat in his/her room instead of eating in the dining room. The alleged perpetrator (AP) stated at about 11:00 a.m., s/he prepared another client's medication (gabapentin 600 milligrams), which was due at noon. The AP stated that after setting up the medication, s/he delivered the client his/her lunch tray, but accidentally placed the other client's medication on the tray. The AP continued to serve lunch to other clients in the dining room. At 11:30 a.m., the AP went to the medication cart to administer the gabapentin and found that the medication cup with the pills was no longer there. The AP verified s/he had signed his/her initials on the medication card,

indicating s/he had set up the medication. The AP stated s/he went back to the client's room and noticed an empty medication cup on the client's lunch tray. The client was unresponsive. Immediately, the AP called emergency medical services, and the client was sent to the hospital.

At the hospital, the client was intubated due to compromised respiratory status. The client was extubated the following day and hospitalized for three days. The hospital physician indicated the client would return to previous status with ongoing chronic health issues. Upon discharge, the client returned to the home care provider. The client subsequently declined in health status related to heart and lung diseases. The client died approximately a month later. The client's death record indicated the client died from natural causes.

The client's physician was interviewed and stated it was coincidental that the incident of the medication error occurred a month prior to the client's death. The physician stated the client had a severe heart blockage which ultimately caused his/her death.

During an interview, the AP stated s/he made the medication error on a busy day. The AP stated that because the client was underweight and frail, once s/he realized the error had occurred, s/he called emergency services immediately to treat the client.

During an interview, a nurse who previously worked at the home care provider stated that both before and after this incident, unlicensed staff members would set up medications ahead of time, although they had been trained not to do so. The nurse stated s/he had spoken to the owners of the facility, including the AP, regarding this pattern of unsafe medication administration, and the AP did not change the practice. The nurse's company terminated their contract with the facility due to this practice.

During the investigation, both the AP and another unlicensed staff member were observed setting up medications for multiple clients at the same time. This included an incident where medications, scheduled to be administered at 5:00 p.m. and 8:00 p.m., were placed in medication cups between 3:50 p.m. and 4:20 p.m. These medications were then locked in a tool chest for later administration to the clients.

Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557)

Under the Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557):

☐ Abuse ☒ Neglect ☐ Financial Exploitation

☒ Substantiated ☐ Not Substantiated ☐ Inconclusive based on the following information:

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ☒ Individual(s) and/or ☒ Facility is responsible for the

☐ Abuse ☒ Neglect ☐ Financial Exploitation. This determination was based on the following:

The incident occurred because the AP set up medications but did not immediately administer them, allowing a medication to be inadvertently placed on the client's tray. The AP's role included responsibility to ensure the home care provider had a system of passing medications in accordance with the "six rights" of

medication administration. However, the AP was aware that s/he and other unlicensed personnel were commonly setting up medications hours prior to administration, and placing the medication cups in a rolling tool chest with slots labeled with clients' names. Therefore, both the facility and the AP are responsible.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

Compliance:

State Statutes for Home Care Providers (MN Statutes section 144A.43 - 144A.483) - Compliance Not Met
The requirements under State Statutes for Home Care Providers (MN Statutes, section 144A.43 - 144A.483) were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) - Compliance Not Met
The requirements under State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

State Statutes Chapters 144 & 144A – Compliance Not Met - Compliance Not Met
The requirements under State Statues for Chapters 144 &144A were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

Compliance Notes:

Facility Corrective Action:

The facility took the following corrective action(s):

Definitions:

Minnesota Statutes, section 626.5572, subdivision 17 - Neglect

"Neglect" means:

(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and

(2) which is not the result of an accident or therapeutic conduct.

(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

The Investigation included the following:

Document Review: The following records were reviewed during the investigation:

- [x] Medical Records
- [x] Medication Administration Records
- [x] Assessments
- [x] Physician Orders
- [x] Treatment Sheets
- [x] Physician Progress Notes
- [x] Care Plan Records
- [x] Facility Incident Reports
- [x] Service Plan

Other pertinent medical records:

- [x] Hospital Records
- [x] Death Certificate

Additional facility records:

- [x] Staff Time Sheets, Schedules, etc.
- [x] Facility Internal Investigation Reports
- [x] Personnel Records/Background Check, etc.
- [x] Facility In-service Records
- [x] Facility Policies and Procedures

Number of additional resident(s) reviewed: nine

Were residents selected based on the allegation(s)? ○ Yes ◉ No ○ N/A

Specify: _____

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

○ Yes ○ No ◉ N/A

Specify: _____

Interviews: The following interviews were conducted during the investigation:

Interview with complainant(s) ◉ Yes ○ No ○ N/A

Specify: _____

If unable to contact complainant, attempts were made on:

Date:	Time:	Date:	Time:	Date:	Time:

Interview with family: ◉ Yes ○ No ○ N/A Specify: _____

Did you interview the resident(s) identified in allegation:

○ Yes ○ No ◉ N/A Specify: _____

Did you interview additional residents? ◉ Yes ○ No

Total number of resident interviews: five

Interview with staff: ◉ Yes ○ No ○ N/A Specify: _____

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: five

Physician Interviewed: ◉ Yes ○ No

Nurse Practitioner Interviewed: ○ Yes ◉ No

Physician Assistant Interviewed: ○ Yes ◉ No

Interview with Alleged Perpetrator(s): ◉ Yes ○ No ○ N/A Specify: _____

Attempts to contact:

Date: _____ Time: _____ Date: _____ Time: _____ Date: _____ Time: _____

If unable to contact was subpoena issued: ◯ Yes, date subpoena was issued _____ ◯ No

Were contacts made with any of the following:

☐ Emergency Personnel ☐ Police Officers ☐ Medical Examiner ☐ Other: Specify _____

Observations were conducted related to:

☒ Medication Pass

☒ Cleanliness

☒ Safety Issues

☒ Facility Tour

Was any involved equipment inspected: ◯ Yes ◯ No ◉ N/A

Was equipment being operated in safe manner: ◯ Yes ◯ No ◉ N/A

Were photographs taken: ◉ Yes ◯ No Specify: improvised medication cart

cc:

Health Regulation Division - Home Care & Assisted Living Program

The Office of Ombudsman for Long-Term Care

Dodge County Medical Examiners

West Concord Police Department

Dodge County Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H20055	A. BUILDING: _____ B. WING _____	C 11/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CIRCLE DRIVE MANOR ASSISTED LIVING LLC	56733 STATE HWY 56 SOUTH WEST CONCORD, MN 55985

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0 000	Initial Comments *****ATTENTION****** HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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. INITIAL COMMENTS: On 10/20/16 and 10/21/16, a complaint investigation was initiated to investigate complaint #HL20055002 . At the time of the survey, there were eight clients that were receiving services under the comprehensive license. The following correction orders are issued.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER ' S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144A.474 SUBDIVISION 11 (b)(1)(2)	
0 125 SS=I	144A.43, Subd. 13 Medication Setup Subd. 13. Medication setup. "Medication setup" means arranging medications by a nurse,	0 125		

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0 125	Continued From page 1 pharmacy, or authorized prescriber for later administration by the client or by comprehensive home care staff. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the licensee failed to have a nurse set up medications and unlicensed staff were inappropriately setting up medications prior to administration for eight of ten clients (C2, C3, C4, C5, C6, C8, C9, C10) reviewed. This practice resulted in a level three violation (a violation that harmed a client'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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the clients). The findings include: C2's medical record was reviewed. C2 admitted to the licensee with diagnoses that included Cerebral Palsy. C2's services plan dated 6/1/16 indicated C2 required assistance with medication administration. C3's medical record was reviewed. C3 admitted to the licensee with diagnoses that included mild mental retardation, hypertension and diabetes. C3's service plan dated 8/18/15 indicated C3 required assistance with medication administration, insulin administration and blood glucose monitoring.	0 125		

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0 125	Continued From page 2 C4's medical record was reviewed. C4 admitted to the licensee with diagnoses that included hypertension and type II diabetes. C4's service plan dated 5/17/16 indicated C4 required assistance with medication administration, insulin administration and blood glucose monitoring. C5's medical record was reviewed. C5 admitted to the licensee with diagnoses that included diabetes, Parkinson's disease and hypertension. C5's service plan dated 8/18/15 indicated C5 required assistance with medication administration, except that C5 would administer insulin and monitor blood glucose independently. C6's medical record was reviewed. C6 admitted to the licensee with diagnoses that included encephalitis and hemiparesis of left face and left lower extremity. C6's service plan dated 8/18/15 indicated C6 required assistance with medication administration. C8's medical record was reviewed. C8 admitted to the licensee with diagnoses that included hypertension. C8's service plan dated 8/18/15 indicated C8 required assistance with medication administration. C9's medical record was reviewed. C9 admitted to licensee with diagnoses that included congestive heart failure, stage IV kidney disease and type II diabetes. C9's service plan dated 7/14/16 indicated C9 required assistance with medication administration. C10's medical record was reviewed. C10 admitted to the licensee with diagnoses that included congestive heart failure, renal failure and neuropathy. C10's service plan dated 8/18/15 indicated C10 required assistance with	0 125		

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0 125	Continued From page 3 medication administration. During an on-site visit on 10/20/16 at 11:20 a.m., Owner-B was observed during medication administration. Medications were stored in a locked office inside a locked file cabinet. Each client's medications were separated by dividers with each name. The medication bubble packs were stored in the file cabinets. The medication cart was a rolling tool chest, with one drawer. Inside the door was a wooden divider system, with sections labeled with each client's name and a picture. Within each client's section were three circle holes cut out of the wooden base for a paper medication cup to be placed. Owner-B opened a binder on the tool chest with a medication guide that listed each medication, the dose and the time it was due for each client. Owner-B compared the medication cards with the medication guide and set-up the pills in a paper medication cup and placed the cup in the drawer under each client's name. C4, C5, C8, C9, C10's noon medications were set up by Owner-B. At 11:50 a.m., Owner-B pushed the tool chest down towards the dining room and administered C4, C5, C8, C9 and C10's medications. During a second medication observation on 10/20/16 at 3:50 p.m., unlicensed personnel (ULP)-E, began the same process as Owner-B. ULP-E compared the medication cards with the medication guide and not the MAR. ULP-E set up medications due at 4:00 p.m., 5:00 p.m. and 8:00 p.m. for C2, C3, C4, C5, C6, C8, C9 and C10. For C2, who had both 5:00 p.m. and 8:00 p.m. medications scheduled, ULP-E placed the 8:00 p.m. paper medication cup in the wooden space for C2, and the 5:00 p.m. medications in a paper cup stacked on top of the 8:00 p.m. medications. At 4:20 p.m. when ULP-E was finished setting up	0 125		

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0 125	Continued From page 4 each medication and placing the medication cups with pills in the tool chest, under each client's divider, ULP-E closed the tool chest, locked the drawer, left the office and locked the office door. ULP-E stated she had to prepare supper, therefore she needed to set up the medications in advance because she did not have enough time. ULP-E added that after she serves supper to the clients, she then can pass the 5:00 p.m. medications, and after she begins assisting clients with evening cares, has the 8:00 p.m. medications ready to be administered. ULP-E did not document in the MAR while setting up medications. During an interview with the registered nurse (RN)-A on 10/20/16 at 2:30 p.m., RN-A stated she had not been involved with training staff on medication administration, because the staff were trained by RN-D who was the previous RN. RN-A stated she completed the medication guide for staff to follow. In addition, RN-A stated medications that are dispensed in bottles are set-up weekly by her for each client, whereas medications that are dispensed in bubble packs are administered by the unlicensed staff daily. RN-A stated the medication administration by unlicensed staff could be changed to decrease the risk for medication errors due to staff setting up medications prior to the scheduled time to give, by designating one time frame for administering medications. During an interview with RN-D on 11/23/16 at 12:45 p.m., RN-D stated she discovered during her investigation of a medication error incident on 11/25/16 that staff were not using a MAR during medication pass, and that unlicensed staff were setting up medications for several clients at a time. RN-D stated a meeting was held with	0 125		

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0 125	Continued From page 5 Owner-B and Owner-C, and Owner-B and Owner-C were told the medication administration process was unsafe and needed to be changed. RN-D completed retraining with all of the unlicensed staff in December 2015. RN-D explained that after the medication retraining were completed with staff, she would still discover staff presetting up medication. As a result, the home care agency RN-D was employed by had a meeting with the licensee owners and decided to end their contract for RN service to the licensee, because of the owner's unwillingness to administer medications by the "six rights" of medication administration standard of practice. The licensee policy titled "Administration of Oral Medications" dated 2/4/16 indicated medications previously set up are completed by a nurse or a pharmacist. At the correct time, staff will either administer the medications set up by the nurse or punch out the appropriate bubble on the medication card, watch the client swallow the pills and immediately document in the MAR. TIME PERIOD FOR CORRECTION: Twenty One (21) days	0 125		
0 265 SS=F	144A.44, Subd. 1(2) Up-To-Date Plan/Accepted Standards Practice Subdivision 1. Statement of rights. A person who receives home care services has these rights: (2) the right to receive care and services according to a suitable and up-to-date plan, and subject to accepted health care, medical or nursing standards, to take an active part in developing, modifying, and evaluating the plan and services;	0 265		

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0 265	Continued From page 6 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the licensee failed to administer medications by the nursing standard of six rights of medication administration for nine of ten clients (C1, C2, C3, C4, C5, C6, C8, C9, C10) reviewed. This practice resulted in a level three violation (a violation that harmed a client'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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the clients). The findings include: C1's medical record was reviewed. C1 admitted to the licensee with diagnoses that included congestive heart failure, chronic obstructive pulmonary disease (COPD) and chronic respiratory acidosis. C1's service plan dated 8/19/15 indicated C1 required assistance with medication administration. C2's medical record was reviewed. C2 admitted to the licensee with diagnoses that included Cerebral Palsy. C2's services plan dated 6/1/16 indicated C2 required assistance with medication administration. C3's medical record was reviewed. C3 admitted to the licensee with diagnoses that included mild mental retardation, hypertension and diabetes. C3's service plan dated 8/18/15 indicated C3 required assistance with medication administration, insulin administration and blood	0 265		

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0 265	Continued From page 7 glucose monitoring. C4's medical record was reviewed. C4 admitted to the licensee with diagnoses that included hypertension and type II diabetes. C4's service plan dated 5/17/16 indicated C4 required assistance with medication administration, insulin administration and blood glucose monitoring. C5's medical record was reviewed. C5 admitted to the licensee with diagnoses that included diabetes, Parkinson's disease and hypertension. C5's service plan dated 8/18/15 indicated C5 required assistance with medication administration, except that C5 would administer insulin and monitor blood glucose independently. C6's medical record was reviewed. C6 admitted to the licensee with diagnoses that included encephalitis and hemiparesis of left face and left lower extremity. C6's service plan dated 8/18/15 indicated C6 required assistance with medication administration. C8's medical record was reviewed. C8 admitted to the licensee with diagnoses that included hypertension. C8's service plan dated 8/18/15 indicated C8 required assistance with medication administration. C9's medical record was reviewed. C9 admitted to licensee with diagnoses that included congestive heart failure, stage IV kidney disease and type II diabetes. C9's service plan dated 7/14/16 indicated C9 required assistance with medication administration. C10's medical record was reviewed. C10 admitted to the licensee with diagnoses that included congestive heart failure, renal failure and	0 265		

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0 265	Continued From page 8 neuropathy. C10's service plan dated 8/18/15 indicated C10 required assistance with medication administration. During an on-site visit on 10/20/16 at 11:20 a.m., Owner-B was observed during medication administration. Medications were stored in a locked office inside a locked file cabinet. Each client's medications were separated by dividers with each name. The medication bubble packs were stored in the file cabinets. The medication cart was a rolling tool chest, with one drawer. Inside the door was a wooden divider system, with sections labeled with each client's name and a picture. Within each client's section were three circle holes cut out of the wooden base for a paper medication cup to be placed. Owner-A opened a binder on the tool chest with a medication guide that listed each medication, the dose and the time it was due for each client. Owner-B compared the medication cards with the medication guide and set-up the pills in a paper medication cup and placed the cup in the drawer under each client's name. C4, C5, C8, C9, C10's noon medications were set up by Owner-B. At 11:50 a.m., Owner-A pushed the tool chest down towards the dining room and adminsitered C4, C5, C8, C9 and C10's medications. Owner-A then returned the tool chest to the locked office and was about to leave. When asked if there was anything else, Owner-B stated "no, that is everything." When asked whether the licensee had a medication administration record (MAR), Owner-B then stated "oh yes," and documented in the MAR that each client's medications were given. During a second medication observation on 10/20/16 at 3:50 p.m., unlicensed personnel (ULP)-E began the same process as Owner-B.	0 265		

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0 265	Continued From page 9 ULP-E compared the medication cards with the medication guide and not the MAR. ULP-E set up medications due at 4:00 p.m., 5:00 p.m. and 8:00 p.m. for C2, C3, C4, C5, C6, C8, C9 and C10. For C2, who had both 5:00 p.m. and 8:00 p.m. medications scheduled, ULP-E placed the 8:00 p.m. paper medication cup in the wooden space for C2, and the 5:00 p.m. medications in a paper cup stacked on top of the 8:00 p.m. medications. ULP-E referenced the MAR one time for C9's medication, because the medication guide had the incorrect dose (300 mg) of Wellbutrin (an antidepressant) and was not the same as the medication card which stated 150 mg of Wellbutrin. ULP-E compared the medication card and MAR, which both had the same prescription of "administer 150 mg of Wellbutrin before bed." At 4:20 p.m. when ULP-E was finished setting up each medication and placing the medication cups with pills in the tool chest, under each client's divider, ULP-E closed the tool chest, locked the drawer, left the office and locked the office door. ULP-E stated she had to prepare supper, therefore she needed to set up the medications in advance because she did not have enough time. ULP-E added that after she serves supper to the clients, she then can pass the 5:00 p.m. medications, and after she begins assist clients with evening cares, she has the 8:00 p.m. medications ready to be administered. ULP-E did not document in the MAR while setting up medications. During an interview with the registered nurse (RN)-A on 10/20/16 at 2:30 p.m., RN-A stated she had not been involved with training staff on medication administration, because the staff were trained by RN-D who was the previous RN. RN-A stated she completed the medication guide for staff to follow. In addition, RN-A stated	0 265		

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0 265	Continued From page 10 medications that are dispensed in bottles are set-up weekly by her for each client, whereas medications that are dispensed in bubble packs are administered by the unlicensed staff daily. RN-A stated the medication administration by unlicensed staff could be changed to decrease the risk for medication errors due to staff setting up medications prior to the scheduled time to give, by designating one time frame for administering medications. During an interview with RN-D on 11/23/16 at 12:45 p.m., RN-D stated she discovered during her investigation of a medication error incident on 11/25/16 that staff were not using a MAR during medication pass, and that unlicensed staff were setting up medications for several clients at a time. RN-D stated a meeting was held with Owner-B and Owner-C, and Owner-B and Owner-C were told the medication administration process was unsafe and needed to be changed. RN-D completed retraining with all of the unlicensed staff in December 2015. RN-D explained that after the medication retraining were completed with staff, she would still discover staff presetting up medication. As a result, the home care agency RN-D was employed by had a meeting with the licensee owners and decided to end their contract for RN service to the licensee, because of the owner's unwillingness to administer medications by the "six rights" of medication administration standard of practice. The licensee policy titled "Administration of Medication by Unlicensed Personnel" dated 2/4/16 indicated medications always need to be administered according to the six rights including the right person, right medication, right time, right route, right dose and right documentation.	0 265		

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0 265	Continued From page 11 The licensee policy titled "Administration of Oral Medications" dated 2/4/16 indicated staff will compare the medication with the MAR three times: when picking up the medication, preparing the medication and just prior to administration. At the correct time, staff will follow the instructions for that client for medication administration. The training procedure titled "Administration of Oral Medications" indicated when all medications for one client have been prepared, transport the medication to that client's room carefully, with staff required to have eyes on the medication at all times. Staff are to remain with the client until the medication is swallowed and never leave medication at the patient's bedside. TIME PERIOD FOR CORRECTION: Twenty One (21) days	0 265		
0 325 SS=G	144A.44, Subd. 1(14) Free From Maltreatment Subdivision 1. Statement of rights. A person who receives home care services has these rights: (14) the right to be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act; This MN Requirement is not met as evidenced by: Based on observation, interview and document review the licensee failed to ensure a client was free from maltreatment when a client was given the wrong medication, hospitalized and intubated for respiratory distress for one of ten clients (C1) reviewed.	0 325		

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0 325	Continued From page 12 This practice resulted in a level three violation (a violation that harmed a client'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 clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: C1's medical record was reviewed. C1 admitted to the licensee with diagnoses that included congestive heart failure, chronic obstructive pulmonary disease (COPD) and chronic respiratory acidosis. C1's service plan dated 8/19/15 indicated C1 required assistance with medication administration and central storage of medications. An oxygen prescription dated 10/27/15 showed C1 required one liter per minute of continuous oxygen flow to manage COPD. A medication error report dated 11/25/15 at 11:30 a.m., indicated C1 in error received 600 milligrams (mg) of Gabapentin, which was another resident's medication. The report dictated the medication cup with the Gabapentin was accidentally placed on C1's lunch tray and delivered to C1's room. C1 ingested the medication. C1 became drowsy, weak and unable to get out of bed. Emergency services were called and C1 was hospitalized. C1's hospital report dated 11/25/15 to 11/28/15 indicated C1 required intubation and was transferred to the intensive care unit. On 11/26/15, C1 was extubated and transitioned back to oxygen via nasal cannula. However, C1 now required the use of a BiPAP (Bilevel Positive	0 325		

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0 325	Continued From page 13 Airway Pressure). C1 was able to be weaned back to previous oxygen use of one liter per minute and discharged back to the licensee on 11/28/15. The physician dictated C1 had returned to previous level of functioning with ongoing health problems. C1's progress notes dated 11/28/15 to 1/3/16 depicted concerns with regulating her blood pressure. C1 was hospitalized on 1/3/16 and passed away on 1/4/16. During an on-site visit on 10/20/16 at 11:20 a.m., Owner-B was observed during medication administration. Medications were stored in a locked office inside a locked file cabinet. Each client's medications were separated by dividers with each name. The medication bubble packs were stored in the file cabinets. The medication cart was a rolling tool chest, with one drawer. Inside the door was a wooden divider system, with sections labeled with each client's name and a picture. Within each client's section were three circle holes cut out of the wooden base for a paper medication cup to be placed. Owner-A opened a binder on the tool chest with a medication guide that listed each medication, the dose and the time it was due for each client. Owner-B compared the medication cards with the medication guide and set-up the pills in a paper medication cup and placed the cup in the drawer under each client's name. C4, C5, C8, C9, C10's noon medications were set up by Owner-B. At 11:50 a.m., Owner-A pushed the tool chest down towards the dining room and adminsitered C4, C5, C8, C9 and C10's medications. Owner-A then returned the tool chest to the locked office and was about to leave. When asked if there was anything else, Owner-B stated "no, that is everything." When asked whether the licensee	0 325		

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0 325	Continued From page 14 had a medication administration record (MAR), Owner-B then stated "oh yes," and documented in the MAR that each client's medications were given. During a second medication observation on 10/20/16 at 3:50 p.m., unlicensed personnel (ULP)-E began the same process as Owner-B. ULP-E compared the medication cards with the medication guide and not the MAR. ULP-E set up medications due at 4:00 p.m., 5:00 p.m. and 8:00 p.m. for C2, C3, C4, C5, C6, C8, C9 and C10. For C2, who had both 5:00 p.m. and 8:00 p.m. medications scheduled, ULP-E placed the 8:00 p.m. paper medication cup in the wooden space for C2, and the 5:00 p.m. medications in a paper cup stacked on top of the 8:00 p.m. medications. ULP-E referenced the MAR one time for C9's medication, because the medication guide had the incorrect dose (300 mg) of Wellbutrin (an antidepressant) and was not the same as the medication card which stated 150 mg of Wellbutrin. ULP-E compared the medication card and MAR, which both had the same prescription of "administer 150 mg of Wellbutrin before bed." At 4:20 p.m. when ULP-E was finished setting up each medication and placing the medication cups with pills in the tool chest, under each client's divider, ULP-E closed the tool chest, locked the drawer, left the office and locked the office door. ULP-E stated she had to prepare supper, therefore she needed to set up the medications in advance because she did not have enough time. ULP-E added that after she serves supper to the clients, she then can pass the 5:00 p.m. medications, and after she begins assist clients with evening cares, she has the 8:00 p.m. medications ready to be administered. ULP-E did not document in the MAR while setting up medications.	0 325		

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0 325	Continued From page 15 During an interview with the registered nurse (RN)-A on 10/20/16 at 2:30 p.m., RN-A stated she had not been involved with training staff on medication administration, because the staff were trained by RN-D who was the previous RN. RN-A stated she completed the medication guide for staff to follow. In addition, RN-A stated medications that are dispensed in bottles are set-up weekly by her for each client, whereas medications that are dispensed in bubble packs are administered by the unlicensed staff daily. RN-A also stated she monitors the bubble packs for potential errors weekly. RN-A stated the medication administration by unlicensed staff could be changed to decrease the risk for medication errors due to staff setting up medications prior to the scheduled time to give, by designating one time frame for administering medications. During an interview with Owner-B on 10/20/16 at 4:25 p.m., Owner-B stated he was the unlicensed staff who made the medication error with C1. Owner-B stated on 11/25/15 at approximately 11:00 a.m., he had set up another client's medication that was due at noon (Gabapentin 600 mg). Owner-B stated C1 was not feeling well that day and chose to eat in her room, so Owner-B delivered C1's meal tray to C1's room. He accidentally left the medication cup with the other client's 600 mg of Gabapentin on C1's lunch tray. Then, Owner-B stated he continued to help serve the other clients lunch in the dining room. At 11:30 a.m., Owner-B stated when he was about to pass the other client's medication, the medication cup was not there. Owner-B stated he verified on the medication card he had removed the Gabapentin from the bubble pack, by his initials and date on the card. Owner-B stated the	0 325		

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0 325	Continued From page 16 only other place he went to after removing the medication was C1's room, so he checked C1's room for the missing medication. When he went into C1's room, Owner-B discovered an empty medication cup on C1's lunch tray. Owner-B stated C1 did not have medications due at noon. Owner-B said C1 was found laying in bed and not coherent, and so Owner-B called emergency medical services and the RN immediately. In addition, Owner-B stated after C1 had left the facility, he did go back and administered the Gabapentin 600 mg to the other client. During an interview with RN-D on 11/23/16 at 12:45 p.m., RN-D stated that after the incident occurred with C1, she discovered during her investigation that staff were not using a MAR during medication pass and unlicensed staff were setting up medications. RN-D stated a meeting was held with Owner-B and Owner-C, and Owner-B and Owner-C were told the medication administration process was unsafe and needed to be changed. RN-D completed retraining with all of the unlicensed staff in December 2015. RN-D explained that after the medication retraining were completed with staff, she would still discover staff presetting up medication. As a result, the home care agency RN-D was employed by had a meeting with the licensee owners and decided to end their contract for RN service to the licensee, because of the owner's unwillingness to administer medications by the "six rights" of medication administration standard of practice. The licensee policy titled "Administration of Medication by Unlicensed Personnel" dated 2/4/16 indicated medications always need to be administered according to the six rights, including the right person.	0 325		

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0 325	Continued From page 17 The training procedure titled "Administration of Oral Medications" indicated when all medications for one client have been prepared, transport the medications to that client's room carefully and staff were required to have eyes on the medication at all times. Staff were to remain with the client until the medication was swallowed and never leave medication at the patient's bedside. TIME PERIOD FOR CORRECTION: Twenty One (21) days	0 325		
0 810 SS=F	144A.479, Subd. 6(b) Individual Abuse Prevention Plan (b) Each home care provider must develop and implement an individual abuse prevention plan for each vulnerable minor or adult for whom home care services are provided by a home care provider. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults or minors; the person's risk of abusing other vulnerable adults or minors; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults or minors. For purposes of the abuse prevention plan, the term abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and document review the licensee failed to appropriately assess client's vulnerabilities and implement individualized	0 810		

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0 810	Continued From page 18 interventions of identified vulnerabilities for nine out of ten clients (C1, C2, C3, C4, C5, C6, C8, C9, C10) reviewed. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the clients). The findings include: C1's medical record was reviewed. C1 admitted to the licensee with diagnoses that included congestive heart failure, chronic obstructive pulmonary disease (COPD) and chronic respiratory acidosis. C1's service plan dated 8/19/15 indicated C1 required assistance with medication administration. C1's vulnerable adult (VA) assessment dated 9/1/15 failed to identify oxygen use as an environmental concern. In addition, the VA assessment identified the inability to report maltreatment was a vulnerability but failed to include an intervention for this vulnerability. C2's medical record was reviewed. C2 admitted to the licensee with diagnoses that included Cerebral Palsy. C2's services plan dated 6/1/16 indicated C2 required assistance with medication administration. C2's VA assessment dated 9/1/15 identified the inability to report maltreatment was a vulnerability and failed to include an intervention for prevention. In addition, although C2's need for assist for transfer was identified and the plan was for staff to provide assistance, in error it was identified as not a vulnerability on the VA	0 810		

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0 810	Continued From page 19 assessment. C3's medical record was reviewed. C3 admitted to the licensee with diagnoses that included mild mental retardation, hypertension and diabetes. C3's service plan dated 8/18/15 indicated C3 required assistance with medication administration, insulin administration and blood glucose monitoring. C3's VA assessment dated 9/1/15 failed to identify the following risks as vulnerabilities: dependence on staff for diabetic management, tobacco use, dependence on indwelling catheter management, hearing loss of the left ear and impaired decision making. In addition, the VA assessment identified the inability to report maltreatment was a vulnerability but failed to include an intervention for this vulnerability. C4's medical record was reviewed. C4 admitted to the licensee with diagnoses that included hypertension and type II diabetes. C4's service plan dated 5/17/16 indicated C4 required assistance with medication administration, insulin administration and blood glucose monitoring. C4's VA assessment dated 9/1/15 failed to include the following vulnerabilities: dependence for diabetic management and impaired decision making. In addition, the VA assessment identified the inability to report maltreatment was a vulnerability but failed to include an intervention for this vulnerability. C5's medical record was reviewed. C5 admitted to the licensee with diagnoses that included diabetes, Parkinson's disease and hypertension. C5's service plan dated 8/18/15 indicated C5 required assistance with medication administration, except that C5 would administer insulin and monitor blood glucose independently.	0 810		

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0 810	Continued From page 20 C5's VA assessment dated 5/10/16 failed to include interventions for prevention of the following vulnerabilities: visual difficulties (sees double), inability to follow/ understand instructions and a chronic condition of Parkinson's. C6's medical record was reviewed. C6 admitted to the licensee with diagnoses that included encephalitis and hemiparesis of left face and left lower extremity. C6's service plan dated 8/18/15 indicated C6 required assistance with medication administration. C6's VA assessment dated 5/17/16 failed to include interventions for prevention for the following identified vulnerabilities: non-oriented, environmental safety, visual difficulties, inability to follow/understand instructions, inability to use the telephone and the inability to report maltreatment. C8's medical record was reviewed. C8 admitted to the licensee with diagnoses that included hypertension. C8's service plan dated 8/18/15 indicated C8 required assistance with medication administration. C8's VA assessment dated 9/1/15 failed to include an intervention for prevention of the inability to report maltreatment. C9's medical record was reviewed. C9 admitted to licensee with diagnoses that included congestive heart failure, stage IV kidney disease and type II diabetes. C9's service plan dated 7/14/16 indicated C9 required assistance with medication administration. C9's VA assessment dated 7/14/16 failed to include interventions for prevention of the following identified vulnerabilities: backpain, left eye and left ear impairments and the inability to follow directions consistently. C10's medical record was reviewed. C10	0 810		

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	H20055	A. BUILDING: _____ B. WING _____	C 11/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CIRCLE DRIVE MANOR ASSISTED LIVING LLC	56733 STATE HWY 56 SOUTH WEST CONCORD, MN 55985

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 21 admitted to the licensee with diagnoses that included congestive heart failure, renal failure and neuropathy. C10's service plan dated 8/18/15 indicated C10 required assistance with medication administration. C10's VA assessment dated 9/1/15 failed to identify to following vulnerabilities: neuropathy and history of falls. In addition, the inability to report maltreatment was a vulnerabiltiy but the plan failed to include an intervention for this vulnerability. During an interview with registered nurse (RN)-A on 10/20/16 at 3:45 p.m., RN-A stated she was aware that the previous VA assessments did not properly identify vulnerabilities. RN-A explained she had begun updating all client's VA assessments with a new form that included more details and areas of vulnerability. During an interview with RN-D on 11/23/16 at 12:45 p.m., RN-D stated she was working on correcting the issues the licensee had with unsafe medication administration and had not thought of updating the VA assessments or interventions. RN-D stated the VA form was provided by the licensee for her to use. The licensee policy titled "Initial and On-Going Nursing Assessments of Clients" dated 1/28/16 indicated an initial RN assessment will include an assessment of the client's areas of vulnerability and susceptibility to maltreatment and whether the client poses a risk to other vulnerable adults. The RN will use the assessment to create an individual abuse prevention plan that identifies specific measures to be taken to minimize the risk of maltreatment.	0 810		

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0 810	Continued From page 22 TIME PERIOD FOR CORRECTION: Twenty One (21) days	0 810		
0 840 SS=I	144A.4791, Subd. 4 Acceptance of Clients Subd. 4. Acceptance of clients. No home care provider may accept a person as a client unless the home care provider has staff, sufficient in qualifications, competency, and numbers, to adequately provide the services agreed to in the service plan and that are within the provider's scope of practice. This MN Requirement is not met as evidenced by: Based on interview and document review the licensee failed to provide adequate staffing and supervision of the accepted clients who were receiving services for eight of ten clients (C2, C3, C4, C5, C6, C8, C9, C10) reviewed. This practice resulted in a level three violation (a violation that harmed a client'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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the clients). The findings include: At the time of the on-site investigation on 10/20/16 and 10/21/16, C1 was deceased and C7 was hospitalized. C2's medical record was reviewed. C2 admitted to the licensee with diagnoses that included Cerebral Palsy. C2's services plan dated 6/1/16	0 840		

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0 840	Continued From page 23 indicated C2 required assistance with dressing, grooming, showers, transferring, positioning, continence care, catheter cares and medication administration. C3's medical record was reviewed. C3 admitted to the licensee with diagnoses that included mild mental retardation, hypertension and diabetes. C3's service plan dated 8/18/15 indicated C3 required assistance with showers, continence care, medication administration, insulin administration and blood glucose monitoring. C3's registered nurse (RN) assessment dated 9/27/16 indicated C3 had impaired decision making and confusion and had acquired a groin/buttocks rash. C4's medical record was reviewed. C4 admitted to the licensee with diagnoses that included hypertension and type II diabetes. C4's service plan dated 5/17/16 indicated C4 required assistance with showers, medication administration, insulin administration and blood glucose monitoring. C4's RN assessment dated 9/28/16 indicated C4 had impaired decision making and blood glucose had ranged from 60 mmol/L (millimoles per liter) (low value) to 200 mmol/L. C5's medical record was reviewed. C5 admitted to the licensee with diagnoses that included diabetes, Parkinson's disease and hypertension. C5's service plan dated 8/18/15 indicated C5 required assistance with showering, skin care and medication administration, except that C5 would administer insulin and monitor blood glucose independently. C5's RN assessment dated 8/10/16 indicated C5 had a history of falling from a recliner chair and occasionally required assistance with continence care.	0 840		

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0 840	Continued From page 24 C6's medical record was reviewed. C6 admitted to the licensee with diagnoses that included encephalitis and hemiparesis of left face and left lower extremity. C6's service plan dated 8/18/15 indicated C6 required assistance with dressing, grooming, showering, continence care, transfers, positioning, mobility in the wheelchair, brace wear, oxygen management, CPAP (continuous positive airway pressure) at night and medication administration. C8's medical record was reviewed. C8 admitted to the licensee with diagnoses that included hypertension and heart stents. C8's service plan dated 8/18/15 indicated C8 required assistance with showering and medication administration. C9's medical record was reviewed. C9 admitted to licensee with diagnoses that included congestive heart failure, stage IV kidney disease and type II diabetes. C9's service plan dated 7/14/16 indicated C9 required assistance with showering and medication administration. C9's RN assessment dated 7/14/16 indicated C9 had a history of falls related to decreased vision and experienced short term memory loss. C10's medical record was reviewed. C10 admitted to the licensee with diagnoses that included congestive heart failure, renal failure and neuropathy. C10's service plan dated 8/18/15 indicated C10 required assistance with support stockings, CPAP at night, showering and medication administration. C10's RN assessment dated 10/14/16 indicated C10 had a history of multiple falls and swelling in the right arm. C10 had also chosen to stop taking Coumadin. During an interview with RN-A on 10/20/16 at	0 840		

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0 840	Continued From page 25 2:30 p.m., RN-A stated the owner's residence is close by and clients can use the call system to contact the owners during the night for assistance. RN-A stated there could be room for improvement with client monitoring as some clients have positioning needs and diabetes. During an interview with Owner-B on 10/20/16 at 4:25 p.m., Owner-B stated the owner's residence is about seventy feet away from the facility and about a two minute walk. Owner-B stated Sunday through Thursday there are no staff present in the facility from 8:00 p.m. or 9:00 p.m. until 6:00 a.m., with a maximum of ten hours without any staff physically present in the building. Owner-B explained the call system and fire alarm system are wired to his house, and clients are able to use the call button to request assistance. Owner-B said a message will alert on the computer if a client's pendant battery is low or if there is a malfunction. Owner-B concluded having client's with diabetes, Cerebral Palsy, sleep apnea and mobility impairments he understands things can happen quickly, and a wellness check at night would be a good addition. The licensee admission packet, under the section titled "Contingency Plan for Essential and Non Essential Services" explained there is twenty-four hour supervision because clients are given a call system pendant. The doors to the building are locked from 8:00 p.m. to 6:00 a.m. and there are no awake staff during the overnight shift. If the owner's are on duty (Sunday through Thursday), then they will be located in their home seventy-five feet away from the building. TIME PERIOD FOR CORRECTION: Twenty One (21) days	0 840		

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0 935	Continued From page 26	0 935		
0 935 SS=F	144A.4792, Subd. 8 Documentation of Administration of Medication Subd. 8. Documentation of administration of medications. Each medication administered by comprehensive home care provider staff must be documented in the client's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the client's needs when medication was not administered as prescribed and in compliance with the client's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the licensee staff failed to document medications in the medication administration record (MAR) after administering medications for eight of ten clients (C2, C3, C4, C5, C6, C8, C9, C10) reviewed. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to	0 935		

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0 935	Continued From page 27 cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the clients). The findings include: C2's medical record was reviewed. C2 admitted to the licensee with diagnoses that included Cerebral Palsy. C2's services plan dated 6/1/16 indicated C2 required assistance with medication administration. C3's medical record was reviewed. C3 admitted to the licensee with diagnoses that included mild mental retardation, hypertension and diabetes. C3's service plan dated 8/18/15 indicated C3 required assistance with medication administration, insulin administration and blood glucose monitoring. C4's medical record was reviewed. C4 admitted to the licensee with diagnoses that included hypertension and type II diabetes. C4's service plan dated 5/17/16 indicated C4 required assistance with medication administration, insulin administration and blood glucose monitoring. C5's medical record was reviewed. C5 admitted to the licensee with diagnoses that included diabetes, Parkinson's disease and hypertension. C5's service plan dated 8/18/15 indicated C5 required assistance with medication administration, except that C5 would administer insulin and monitor blood glucose independently. C6's medical record was reviewed. C6 admitted to the licensee with diagnoses that included encephalitis and hemiparesis of left face and left lower extremity. C6's service plan dated 8/18/15	0 935		

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0 935	Continued From page 28 indicated C6 required assistance with medication administration. C8's medical record was reviewed. C8 admitted to the licensee with diagnoses that included hypertension. C8's service plan dated 8/18/15 indicated C8 required assistance with medication administration. C9's medical record was reviewed. C9 admitted to licensee with diagnoses that included congestive heart failure, stage IV kidney disease and type II diabetes. C9's service plan dated 7/14/16 indicated C9 required assistance with medication administration. C10's medical record was reviewed. C10 admitted to the licensee with diagnoses that included congestive heart failure, renal failure and neuropathy. C10's service plan dated 8/18/15 indicated C10 required assistance with medication administration. During an on-site visit on 10/20/16 at 11:20 a.m., Owner-B was observed during medication administration. Owner-B opened a binder on the tool chest with a medication guide (not the MAR) that listed each medication, the dose and the time it was due for each client. Owner-B compared the medication cards with the medication guide and set-up the pills in a paper medication cup and placed the cup in the drawer under each client's name. C4, C5, C8, C9, and C10's noon medications were set up by Owner-B. At 11:50 a.m., Owner-A pushed the tool chest down towards the dining room and adminsitered C4, C5, C8, C9 and C10's medications. Owner-B then returned the tool chest to the locked office and was about to leave. When asked if there was anything else, Owner-B stated "no, that is	0 935		

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0 935	Continued From page 29 everything." When asked whether the licensee had a medication administration record (MAR), Owner-B stated "oh, yes," and then documented in the MAR that each client's medications were given. During a second medication observation on 10/20/16 at 3:50 p.m., unlicensed personnel (ULP)-E began the same process as Owner-B. ULP-E compared the medication cards with the medication guide and not the MAR. ULP-E set up medications due at 4:00 p.m., 5:00 p.m. and 8:00 p.m. for C2, C3, C4, C5, C6, C8, C9 and C10. For C2, who had both 5:00 p.m. and 8:00 p.m. medications scheduled, ULP-E placed the 8:00 p.m. paper medication cup in the wooden space for C2, and the 5:00 p.m. medications in a paper cup stacked on top of the 8:00 p.m. medications. ULP-E referenced the MAR one time for C9's medication, because the medication guide had the incorrect dose (300 mg) of Wellbutrin (an antidepressant) and was not the same as the medication card which stated 150 mg of Wellbutrin. ULP-E compared the medication card and MAR, which both had the same prescription of "administer 150 mg of Wellbutrin before bed." At 4:15 p.m., ULP-E took a pre-filled syringe (six units) of insulin from the medication fridge, compared the dose on the syringe with the medication guide and went to C4's room to administer the insulin via subcutaneous injection. ULP-E returned to the office and did not document in the MAR the insulin administered to C4. At 4:20 p.m., when ULP-E was finished setting up each medication and placing the medication cups with pills in the tool chest, under each client's divider, ULP-E closed the tool chest, locked the drawer, left the office and locked the office door. ULP-E stated she had to prepare supper, therefore she needed to set up the	0 935		

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0 935	Continued From page 30 medications in advance because she did not have enough time. ULP-E added that after she serves supper to the clients, she then can pass the 5:00 p.m. medications and after she begins to assist clients with evening cares, has the 8:00 p.m. medications ready to be administered. ULP-E did not document in the MAR while setting up medications. During an interview with the registered nurse (RN)-A on 10/20/16 at 2:30 p.m., RN-A stated she had not been involved with training staff on medication administration, because the staff were trained by the previous nurse, RN-D. During an interview with RN-D on 11/23/16 at 12:45 p.m., RN-D stated she was employed by a home care agency who contracted with the licensee for RN services. RN-D stated she discovered during her investigation of a medication error incident on 11/25/16 that staff were not using a MAR during medication pass, and that unlicensed staff were setting up medications for several clients at a time. RN-D stated a meeting was held with Owner-B and Owner-C, and Owner-B and Owner-C were told the medication administration process was unsafe and needed to be changed. RN-D completed retraining with all of the unlicensed staff in December 2015. RN-D explained that after the medication retraining were completed with staff, she would still discover staff presetting up medication. As a result, the home care agency RN-D was employed by had a meeting with the licensee owners and decided to end their contract for RN service to the licensee, because of the owner's unwillingness to administer medications by the "six rights" of medication administration standard of practice.	0 935		

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0 935	Continued From page 31 The licensee policy titled "Administration of Medication by Unlicensed Personnel" dated 2/4/16 indicated medications always need to be administered according to the six rights including the right person, right medication, right time, right route, right dose and right documentation. The licensee policy titled "Administration of Oral Medications" dated 2/4/16 indicated the RN will train staff to document immediately after administering medications. TIME PERIOD FOR CORRECTION: Twenty One (21) days	0 935		
02015 SS=D	626.557, Subd. 3 Timing of Report 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,	02015		

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02015	Continued From page 32 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 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 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 agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead 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 document review, the licensee failed to report a serious medication	02015		

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CIRCLE DRIVE MANOR ASSISTED LIVING LLC	56733 STATE HWY 56 SOUTH WEST CONCORD, MN 55985

(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
02015	Continued From page 33 error for one of ten clients (C1) reviewed. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: C1's medical record was reviewed. C1 admitted to the licensee with diagnoses that included congestive heart failure, chronic obstructive pulmonary disease (COPD) and chronic respiratory acidosis. C1's service plan dated 8/19/15 indicated C1 required assistance with medication administration. C1's vulnerable adult (VA) assessment dated 9/1/15 identified the inability to report maltreatment was a vulnerability. A medication error report, dated 11/25/15 at 11:30 a.m., indicated C1 in error received 600 milligrams (mg) of Gabapentin, which was another client's medication. The report indicated the medication cup with the Gabapentin was accidentally placed on C1's lunch tray and delivered to C1's room. C1 ingested the medication. C1 became drowsy, weak and unable to get out of bed. Emergency services were called and C1 was hospitalized. C1's hospital report dated 11/25/15 to 11/28/15 indicated C1 required intubation and was transferred to the intensive care unit. On 11/26/15, C1 was extubated and transitioned back to oxygen via nasal cannula. However, C1	02015		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H20055	A. BUILDING: _____ B. WING _____	C 11/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02015	Continued From page 34 did now require use of a BiPAP (Bilevel Positive Airway Pressure). C1 was able to be weaned back to previous oxygen use of one liter per minute and discharged back to the licensee on 11/28/15. During an interview with Owner-B on 10/20/16 at 4:25 p.m., Owner-B stated a VA report was not submitted by the licensee because they were unaware one needed to be completed. During an interview with registered nurse (RN)-D on 11/23/16 at 12:45 p.m., RN-D stated she was employed by a home care agency who contracted RN services with the licensee. RN-D stated after her investigation of the medication error, she and her supervisor from the home care agency met with Owner-B and Owner-C to discuss the medication error. RN-D explained the home care agency supervisor instructed Owner-B and Owner-C to complete and submit a VA report to the Common Entry Point. RN-D stated Owner-B and Owner-C stated they would. The licensee policy titled "Medication Errors" dated 1/31/16 indicated if a medication error results in injury or harm which reasonably requires the care of a physician, the error must be immediately reported to the Common Entry Point by the RN. TIME PERIOD FOR CORRECTION: Twenty One (21) days	02015		