Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL203817344M
Compliance #: HL203813902C

Date Concluded: December 18, 2023

Name, Address, and County of Licensee Investigated:
Brookdale Edina
3330 Edinborough Way
Edina, MN 55435
Hennepin County

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

Evaluator's Name:
Maerin Renee, RN, Special Investigator

Finding: Substantiated, facility responsibility

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

Initial Investigation Allegation(s):
The facility neglected the resident when staff failed to follow the resident's plan of care and provide necessary care and service including toileting and showering.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility is responsible for the maltreatment. Review of recorded video from the resident's room indicated numerous times when facility staff denied the resident the opportunity to use the toilet. In addition, showers were not provided according to the resident's plan of care.

The investigator conducted interviews with facility staff members, including administrative staff, leadership, and unlicensed staff. The investigation included review of facility policy and procedures, personnel charts, video footage, and resident's medical records. Also, the investigator observed resident cares and staff interactions with residents.

The resident resided in an assisted living facility. The resident's diagnoses included unspecified dementia, lumbago with sciatica, and osteoporosis. The resident's service plan included assistance with medication management, activities of daily living (ADLs) including dressing, grooming, toileting, showering/bathing, mobility, laundry, and cognitive/psychosocial support. The resident's assessment indicated she required an assist of one for most tasks and exhibited cognitive impairment.

Review of the resident's care sheets indicated the resident was scheduled for showers on Tuesdays and Fridays. For the month of April 2023, three of eight showers were not completed, May 2023, six of nine showers were not signed off, and in June 2023, eight of nine showers were not signed off.

The residents' activities of daily living documentation (staff use as a guide to the care the resident requires) contained no direction for staff how often to assist the resident with toileting.

Review of recorded video footage indicated multiple instances where the resident requested to go to the toilet and staff failed to provide the resident assistance. In one instance, the resident told a staff her brief was wet, and she needed to use the bathroom. The staff member was heard telling the resident the bathroom was too small for her wheelchair and she had to change the resident in bed. The staff told the resident, "If you need to go number 2, go in your pants and we will change you."

On another occasion, during morning cares, the resident asked a staff member to go to the bathroom after brushing her teeth. The staff member stated, "No we are not going to the bathroom again. We already did that. Go in your pants." The resident asked, "What?" The staff member again said, "Go in your pants."

A few days later, the recorded video indicated the resident told a staff member she needed to go to the bathroom. The staff member said, "No, you can't because it's not safe. You can fall if you go to the bathroom." The staff member proceeded to change the resident's brief and did not take her to the toilet, despite the resident's request.

One morning, two staff members entered the resident's room and talked about how terrible it smelled in the room. The staff pulled the resident's covers back to check her brief, and then quickly exited the resident's room without providing any assistance with cares. As the staff was walking out the resident cried out, "I'm wet!"

On that same evening, two staff members were in the resident's room as the resident finished brushing her teeth. The resident was in the bathroom and stated to the staff, "I think I need to use that" and pointed to the toilet. The first staff member said, "No you don't, you already used that." The second staff member asked, "Use what?" The first staff member responded, "The toilet." The second staff member said, "She could always go number two." The first staff

member replied, “Yeah, in her pants.” The resident was wheeled out of her room and not taken to the toilet.

When interviewed, staff stated they were short staffed in the past and it was difficult to provide toileting and showers timely to all the residents.

When interviewed, a staff member stated she witnessed other staff members refuse to take the resident to the restroom. The staff member said staff would say things like, “I already took her,” “She already went,” or “She doesn’t do anything.” The staff member said she witnessed this occur two to three times a week. The staff member stated when she would change the residents brief, the brief was, “super, super” wet, as if she had not been changed in the morning, or the resident would have 2 briefs on.

When interviewed, a family member stated there was a lack of staffing, lack of nursing personnel, poor communication, and cares were not being provided. The family eventually put a camera in the resident’s room and witnessed cares were not being provided in accordance with the resident’s service plan. At one point, the recorded video footage indicated the resident went 18 hours and 15 minutes between toileting. The family member stated there were numerous days when the resident was not changed or toileted between morning and bedtime cares. The family member did not feel the resident was safe at the facility and moved her to a different facility.

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

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

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

Vulnerable Adult interviewed: No, unable due to cognition.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not applicable.

Action taken by facility:

No action taken by the facility.

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

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

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

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20381	A. BUILDING: _____ B. WING _____	C 09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EDINA	3330 EDINBOROUGH WAY EDINA, MN 55435

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL203812778C/HL203816844M #HL203814097C/HL203817508M #HL203813902C/HL203817344M On September 19, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 70 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL203814097C/ #HL203817508M, and tag identification 0620, and 2360. The following correction orders are issued for #HL203813902C/ #HL203817344M, tag identifcation 0620 and 2360. The following correction orders are issued for	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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0 000	Continued From page 1 #HL203812778C/ #HL203816844M, tag identification 0620, 1620, 1760, and 2360.	0 000		
0 620 SS=E	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma (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. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of	0 620		

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0 620	Continued From page 2 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 investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment for three of three residents (R1, R2, and R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a	0 620		

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0 620	Continued From page 3 limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). Findings include: R1 R1's diagnoses included Alzheimer's disease with behavioral disturbance. R1's service plan, signed April 4, 2023, indicated R1 received services including medication management, mobility, toileting, daily cares, laundry, and housekeeping. A review of R1's prescriber orders indicated Depakote was prescribed for the resident on June 29, 2023, for the management of agitation, anger, and frustration intolerance. A review of R1's medication administration record (MAR) revealed the Depakote had not been transcribed onto the June 2023 MAR after it was ordered on June 29, 2023. Depakote was transcribed onto R1's July 2023 MAR. The first entry in the MAR was the evening of July 13, 2023. The Depakote was not administered, and the staff member noted "other/see nurse notes." However, nurse notes/progress notes did not address any concerns regarding the resident's Depakote that evening. From the morning of July 14 to the evening of July 17, staff entered the medication as not having been administered with the note "pharmacy action required." The MAR indicated a staff member documented the Depakote was administered to R1 on the morning of July 18, 2023, 19 days after the prescription was originally written. However, from	0 620		

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0 620	Continued From page 4 the evening of July 18 to the morning of July 21, staff again indicated the Depakote was not administered to R1, and pharmacy action was required. Per the MAR, R1 received a dose of Depakote in the evening of July 21, 2023, in the morning and evening of July 22, 2023, and on the morning of July 23, 2023. In the evening of July 23, 2023, a staff-entered code indicated pharmacy action was required. The Depakote was again signed off the morning of July 24, 2023. The evening of July 24, a staff-entered code indicated "other/see nurse notes." Again, nurse notes/progress notes did not address concerns regarding the resident's Depakote. Beginning the morning of July 25, 2023, the MAR indicated R1 received the Depakote as prescribed for the rest of the month. A review of R1's order summary report created by the facility indicated R1's Depakote had been both ordered and initiated on July 13, 2023. No explanation of this discrepancy with the original order date was documented. The delay in initiating the Depakote was not documented or addressed in the resident's progress notes. There were no progress notes or nursing assessments that documented or addressed R1's increased behaviors. A review of the pharmacy shipping summary indicated 60 Depakote capsules were delivered to the facility on June 29, 2023. Another four Depakote capsules were delivered on July 21, 2023. On July 25, 2023, 60 Depakote tablets were again delivered to the facility. All the deliveries were signed off by staff as having been received. On September 26, 2023 at 10:00 a.m., R1's prescriber (APRN)-B said Depakote was	0 620		

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0 620	Continued From page 5 prescribed for R1 on June 29, 2023, to manage paranoia and agitation. APRN-B said the resident was angry during a visit on July 12, 2023 and was more agitated. APRN-B spoke with family members on July 11, 2023, when they verbalized concern about the resident's behaviors. APRN-B said it was after that visit that staff members notified her the resident had not started the Depakote yet. APRN-B said after the resident started the Depakote, he was much calmer with less paranoia, and she received no further reports of behavioral concerns from the resident's family. On November 9, 2023, at 4:10 p.m., nurse (LPN)-Q said a nurse was responsible for reviewing new medication orders and ensuring they were transcribed onto a resident's MAR. LPN-Q did not recall there being problems with obtaining R1's Depakote. LPN-Q said if a staff member documented "pharmacy action required" on a resident's MAR, it usually meant the resident was out of the medication and it needed to be ordered from the pharmacy. On November 10, 2023, at 2:30 p.m., staff member (ULP)-P said only nurses managed any new medications, but nurses and medication technicians were able to manage refills. ULP-P said R1 displayed behaviors prior to starting the Depakote, but after he started taking the Depakote, the behaviors resolved. The facility's policy titled Medications & Treatments-Availability, dated August 2022, indicated all currently ordered medications would be available to residents. No further information was provided. R2	0 620		

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0 620	Continued From page 6 R2's diagnoses included unspecified dementia, psychotic disturbance, mood disturbance, and anxiety. R2's service plan, dated March 23, 2023, indicated R2 received services including medication management, dressing, grooming, toileting, showering/bathing, mobility, laundry, and cognitive/psychosocial support. The service plan indicated R2 was to receive assistance with dressing and grooming in the morning, evening, and overnight ("AM/PM/NOC"). Showering/bathing required an assist of 1 and was to be provided on Tuesday and Friday mornings. Bathroom assistance was to occur in the morning, evening, and overnight, as well as after meals, and every 2-4 hours during the day. Laundry was to occur on shower/bath days (Tuesday and Friday). R2's family provided one month of video footage that revealed the following: On May 14, 2023, at 6:30 a.m., R2 indicated she needed to go to the bathroom. Her caregiver said her brief was clean and did not help her use the bathroom. On May 14, 2023, at 9:00 p.m., R2 asked to go to the bathroom during bedtime cares. The caregiver changed her in bed instead of toileting her. On May 17, 2023, at 8:35 p.m., R2 said her brief was wet and she needed to use the bathroom. A caregiver said R2's bathroom was too small for her wheelchair and she had to change the resident in bed. The caregiver told R2, "If you need to go number two, go in your pants and we will change you." On May 22, 2023, at 5:45 a.m., R2 asked another	0 620		

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0 620	Continued From page 7 caregiver to go to the bathroom after brushing her teeth. The caregiver said "No we are not going to the bathroom again. We already did that. Go in your pants." R2 asked, "What?" The caregiver again said, "Go in your pants." On May 27, 2023, at 5:23 a.m., video footage revealed R2 said she needed to go to the bathroom. A caregiver said, "No, you can't because it's not safe. You can fall if you go to the bathroom." The caregiver proceeded to change R2's diaper and did not take her to the toilet, despite R2's request. Video footage revealed on May 30, 2023, at 3:09 a.m., two caregivers entered R2's room. They talked about how terrible it smelled in the room, pulled R2's covers back to check her brief, and then quickly exited the room after as R2 cried out, "I'm wet!" On May 30, 2023, at 5:55 a.m., two caregivers were in R2's room. Video footage revealed after R2 brushed her teeth in the bathroom she said, "I think I need to use that" and pointed to the toilet. The first caregiver said, "No you don't, you already used that." The second caregiver asked, "Use what?" The first caregiver responded, "The toilet." The second caregiver said, "She could always go number two." The first caregiver replied, "Yeah, in her pants." R2 was wheeled out of her room and not taken to the toilet. On June 2, 2023, at 2:12 p.m., video footage revealed R2 was being assisted in the bathroom by two caregivers. Despite being an assist of one, both caregivers left R2 alone in the bathroom for two minutes, during which R2 fell out of her wheelchair. Staff had re-entered the room just as R2 could be heard falling. R2 could be heard	0 620		

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0 620	Continued From page 8 saying, "Ouch" after the fall. On September 22, 2023, at 9:00 a.m., family member (FAM)-C said she saw a lack of staffing on the floor, a lack of nursing personnel, poor communication, and cares not being provided. Communication with staff was poor, with contradicting information. At one point, via video footage, FAM-C witnessed R2 went 18 hours and 15 minutes between toileting. FAM-C also witnessed, via video footage, there was a time R2 went one month before getting a shower. On October 18, 2023, at 9:15 a.m., registered nurse (RN)-F said the facility never had enough nurses, was always short-staffed, and communication was poor. On November 20, 2023, at 3:00 p.m., unlicensed personnel (ULP)-V said there was no place to document toileting for the residents, so staff went by time and toileted residents every one to two hours, depending on the resident. ULP-V said if a resident was out in the community, staff would often toilet a resident in a community bathroom, rather than take them back to their room to toilet, due to short staffing. ULP-V said, however, not all staff would toilet residents because the facility was short of staff. ULP-V said due to staffing, staff would not always document cares although the expectation was that staff would document all cares provided. In regard to showering, ULP-V said if showering was on a resident's care plan, the expectation was that the resident would receive a shower rather than a bed bath. On December 6, 2023, unlicensed personnel (ULP)-X said care plans were frequently expired, inaccurate, and not updated.	0 620		

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0 620	Continued From page 9 The facility's policy titled Activities of Daily Living (ADL) Care Documentation, dated November 2018, indicated the expectation was that ADL care outlined in a resident's service plan would be delivered to the resident as scheduled. No further information was provided. R3 R3's diagnoses included dementia, mood disturbance, and vertebral compression fracture. R3's service plan, signed May 8, 2023, included assistance with medication management, showering/bathing, bathroom assistance, and service coordination. Review of R3's May and June 2023 progress notes did not indicate physical assessment or pain were documented or addressed before she was hospitalized on June 8, 2023. Review of R3's medication administration record (MAR) from June 2023 indicated R3 was receiving pain medication in the form of a lidocaine patch once a day, lidocaine cream three times a day, acetaminophen three times a day, gabapentin three times a day, and Dilaudid once a day as needed. However, there was no accompanying registered nurse (RN) assessment indicating the effectiveness or ineffectiveness of R3's current regimen. A home health agency received a referral to provide occupational therapy (OT) and physical therapy (PT). On June 5, 2023 PT visited R3 for an intake and was unable to work with R3 due to the level of her pain. On June 6, 2023, OT attempted to work with R3 as well, and was also unable to do so due to the level of R3's pain. Neither PT nor OT were able to find a nurse in	0 620		

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BROOKDALE EDINA	3330 EDINBOROUGH WAY EDINA, MN 55435

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0 620	Continued From page 10 the facility with whom to consult about R3's pain. On June 7, 2023, R3's family coordinated an order for scheduled Dilaudid three times a day. Review of R3's order summary report, dated January 1, 2023-September 22, 2023, indicated a prescription for scheduled Dilaudid was prescribed June 7, 2023. R3 received three doses of the scheduled Dilaudid, but on June 8, 2023, she continued to complain of pain so that OT and PT remained unable to work with her. Due to R3's continued complaints of pain that was not mollified by her current medication regimen, and the addition of scheduled Dilaudid, OT consulted with a community physician who was at the facility. They made the decision to send R3 to the hospital June 8, 2023, for further assessment. Review of R3's hospital records indicated R3 was admitted to the hospital on June 8, 2023 and diagnosed with a lumbar compression fracture. Review of R3's primary care provider's (PCP) notes, (PA)-J, R3 was prescribed a Medrol 4mg dose pack on June 1, 2023 for diagnosis of intervertebral disc disorders with radiculopathy, lumbar region. Directions indicated staff to follow instructions on the packaging, with the following taper instructions noted: Methylprednisolone 4mg PO six times daily on Day 1. Methylprednisolone 4mg PO five times daily on Day 2. Methylprednisolone 4mg PO four times daily on Day 3. Methylprednisolone 4mg PO three times daily on Day 4. Methylprednisolone 4mg PO two times daily on Day 5.	0 620		

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0 620	Continued From page 11 Methylprednisolone 4mg PO one time daily on Day 6. Review of R3's June 2023 MAR indicated the Medrol taper was transcribed onto the MAR as follows: Medrol Oral Tablet 4mg (methylprednisolone) Give 1 tablet by mouth one time only for Six times a day for day 1 related to Intervertebral disc disorders with radiculopathy, lumbar region (M51.16) until 6/10/2023 23:59 Follow packaging instructions -Start Date- 06/03/2023 1615 Hours: One Time Review of R3's June 2023 MAR indicated blank boxes were reserved for one dose of Medrol June 3, 2023 to June 10, 2023. However, the MAR indicated the resident received one dose of Medrol on June 3, 2023 at 8:03 p.m. and, per the MAR, no further doses were administered. Review of R3's June 2023 MAR indicated a prescription for scheduled Dilaudid was transcribed as thus: Dilaudid Oral Tablet 2mg (Hydromorphone HCL) Give 0.5 tablet by mouth three times a day for moderate pain -Start Date- 06/07/2023 1500 -D/C Date- 06/14/2023 1524	0 620		

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0 620	Continued From page 12 Per the MAR, R3 received three doses of Dilaudid before her hospitalization on June 8, 2023. The MAR indicated R3 received Dilaudid as follows: June 7, 2023 at 3:00 p.m. June 7, 2023 at 9:00 p.m. June 8, 2023 at 7:30 a.m. Review of the narcotic log book recording the count of the Dilaudid tablets indicated discrepancies between the log book and R3's MAR. The log book indicated the Dilaudid was received on June 6, 2023 with instructions to take 1/2 tablet by mouth three times daily for severe pain. The log book indicated R3 received a dose of Dilaudid on June 6, 2023 at "630". R3's MAR indicated she received a dose of Dilaudid on June 6, 2023 at 6:21 p.m. However, rather than documenting the resident received 1/2 a tablet of Dilaudid (0.5), staff documented the resident received 0.5mg (the prescription being 1mg, 0.5 of a 2mg tablet). The log book also indicated the resident received "0.5mg" of Dilaudid on June 7, 2023 at 3:00 p.m. and "0.5mg" on June 7, 2023 at "800". The dose of Dilaudid R3 received on June 8, 2023, according to her MAR, was not recorded in the narcotic log book. The resident was admitted to the hospital on June 8, 2023 for further assessment of her pain.Staff failed to report a medication error after R3 did not receive requested pain medication. R3 experienced increased pain and was later diagnosed with a lumbar compression fracture. On September 19, 2023, at 11:30 a.m., family member (FAM)-E said family coordinated with the on-call nurse to obtain a prescription for scheduled Dilaudid to alleviate R3's pain. R3 began receiving the scheduled Dilaudid, but was	0 620		

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0 620	Continued From page 13 admitted to the hospital the next day for unrelieved pain. On October 4, 2023, at 1:00 p.m., executive director (ED)-A said she had a district clinical nurse who was covering at that time but didn't have a physical nurse. ED-A said she had other nurses in the facility but did not recall their names. On October 31, 2023, at 9:45 a.m., physical therapist (PT)-I said upon visiting R3 for an intake assessment, PT-I found R3 crying and in so much pain PT-I was unable to complete her assessment. PT-I was unable to find a nurse in the facility, so she called her supervisor and R3's PCP, (PA)-J, to report R3's pain. PT-I said there might have been a facility nurse available via telephone, but she had no way of knowing who that was. On a return visit, PT-I was able to speak to PA-J in person at the facility and, still unable to locate a facility nurse, PA-J sent R3 to the hospital for further assessment of her pain. PT-I said R3 was then diagnosed with a fracture the facility was unaware of. The facility's policy titled Medication & Treatment-General Guidelines for Medication Administration/Assistance, dated September 2023, indicated a resident change in condition should be communicated to a nurse as soon as possible for follow-up action. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 620		

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01620	Continued From page 14	01620		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure a registered nurse (RN) reassessed one of one resident (R3) for a change in condition with records reviewed. R3 complained of pain that was not well-managed with her current medication regimen. An RN failed to assess R3's pain and medication regimen for its effectiveness and failed to ensure physician orders to relieve the residents pain was administered and implemented. Home health	01620		

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01620	Continued From page 15 staff and a community physician determined R3 required further assessment and sent her to the hospital. R3 was subsequently diagnosed with a vertebral compression fracture. 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). Findings Include: R3's diagnoses included dementia, mood disturbance, and vertebral compression fracture. R3's service plan, signed May 8, 2023, included assistance with medication management, showering/bathing, bathroom assistance, and service coordination. Review of R3's May and June 2023 progress notes did not indicate physical assessment or pain were documented or addressed before she was hospitalized on June 8, 2023. Review of R3's medication administration record (MAR) from June 2023 indicated R3 was receiving pain medication in the form of a lidocaine patch once a day, lidocaine cream three times a day, acetaminophen three times a day, gabapentin three times a day, and Dilaudid once a day as needed. However, there was no accompanying registered nurse (RN) assessment indicating the effectiveness or ineffectiveness of R3's current regimen.	01620		

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01620	Continued From page 16 A home health agency received a referral to provide occupational therapy (OT) and physical therapy (PT). On June 5, 2023 PT visited R3 for an intake and was unable to work with R3 due to the level of her pain. On June 6, 2023, OT attempted to work with R3 as well, and was also unable to do so due to the level of R3's pain. Neither PT nor OT were able to find a nurse in the facility with whom to consult about R3's pain. On June 7, 2023, R3's family coordinated an order for scheduled Dilaudid three times a day. Review of R3's order summary report, dated January 1, 2023-September 22, 2023, indicated a prescription for scheduled Dilaudid was prescribed June 7, 2023. R3 received three doses of the scheduled Dilaudid, but on June 8, 2023, she continued to complain of pain so that OT and PT remained unable to work with her. Due to R3's continued complaints of pain that was not mollified by her current medication regimen, and the addition of scheduled Dilaudid, PT consulted with R3's primary care provider who was visiting the facility that day. The primary care provider evaluated R3's pain and made the decision to send R3 to the hospital June 8, 2023, for further assessment. Review of R3's hospital records indicated R3 was admitted to the hospital on June 8, 2023 and diagnosed with a lumbar compression fracture. On September 19, 2023, at 11:30 a.m., family member (FAM)-E said family coordinated with the on-call nurse to obtain a prescription for scheduled Dilaudid to alleviate R3's pain. R3 began receiving the scheduled Dilaudid, but was admitted to the hospital the next day for unrelieved pain. On October 4, 2023, at 1:00 p.m., executive	01620		

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01620	Continued From page 17 director (ED)-A said she had a district clinical nurse who was covering at that time but didn't have a physical nurse. ED-A said she had other nurses in the facility but did not recall their names. On October 31, 2023, at 9:45 a.m., physical therapist (PT)-I said upon visiting R3 for an intake assessment, PT-I found R3 crying and in so much pain PT-I was unable to complete her assessment. PT-I was unable to find a nurse in the facility, so she called her supervisor and R3's PCP, (PA)-J, to report R3's pain. PT-I said there might have been a facility nurse available via telephone, but she had no way of knowing who that was. On a return visit, PT-I was able to speak to PA-J in person at the facility and, still unable to locate a facility nurse, PA-J sent R3 to the hospital for further assessment of her pain. PT-I said R3 was then diagnosed with a fracture the facility was unaware of. The facility's policy titled Medication & Treatment-General Guidelines for Medication Administration/Assistance, dated September 2023, indicated a resident change in condition should be communicated to a nurse as soon as possible for follow-up action. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01620		
01760 SS=G	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the	01760		

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01760	Continued From page 18 resident'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 resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and document review, facility staff failed to document and administer medication as prescribed for two of three residents (R1 and R3) with records reviewed. R1 missed 22 days of Depakote and experienced behavioral exacerbations. R3 was prescribed a Medrol (steroid) 4 milligram (mg) taper and received only one dose out of 21 doses prescribed. In addition, there were discrepancies between R3's medication administration record (MAR) and narcotic book count in regard to R3's prescribed Dilaudid. R3 experienced increased pain that went unassessed by facility staff, and was eventually diagnosed with a lumbar compression fracture when she was hospitalized. 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).	01760		

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01760	Continued From page 19 The findings include: R1 R1's diagnoses included Alzheimer's disease with behavioral disturbance. R1's service plan, signed April 4, 2023, indicated R1 received services including medication management, mobility, toileting, daily cares, laundry, and housekeeping. A review of R1's prescriber orders indicated Depakote was prescribed for the resident on June 29, 2023, for the management of agitation, anger, and frustration intolerance. A review of R1's medication administration record (MAR) revealed the Depakote had not been transcribed onto the June 2023 MAR after it was ordered on June 29, 2023. Depakote was transcribed onto R1'sJuly 2023 MAR. The first entry in the MAR was the evening of July 13, 2023. The Depakote was not administered, and the staff member noted "other/see nurse notes." However, nurse notes/progress notes did not address any concerns regarding the resident's Depakote that evening. From the morning of July 14 to the evening of July 17, staff entered the medication as not having been administered with the note "pharmacy action required." The MAR indicated a staff member documented the Depakote was administered to R1 on the morning of July 18, 2023, 19 days after the prescription was originally written. However, from the evening of July 18 to the morning of July 21, staff again indicated the Depakote was not administered to R1, and pharmacy action was required. Per the MAR, R1 received a dose of	01760		

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01760	Continued From page 20 Depakote in the evening of July 21, 2023, in the morning and evening of July 22, 2023, and on the morning of July 23, 2023. In the evening of July 23, 2023, a staff-entered code indicated pharmacy action was required. The Depakote was again signed off the morning of July 24, 2023. The evening of July 24, a staff-entered code indicated "other/see nurse notes." Again, nurse notes/progress notes did not address concerns regarding the resident's Depakote. Beginning the morning of July 25, 2023, the MAR indicated R1 received the Depakote as prescribed for the rest of the month. A review of R1's order summary report created by the facility indicated R1's Depakote had been both ordered and initiated on July 13, 2023. No explanation of this discrepancy with the original order date was documented. The delay in initiating the Depakote was not documented or addressed in the resident's progress notes. There were no progress notes or nursing assessments that documented or addressed R1's increased behaviors. A review of the pharmacy shipping summary indicated 60 Depakote capsules were delivered to the facility on June 29, 2023. Another four Depakote capsules were delivered on July 21, 2023. On July 25, 2023, 60 Depakote tablets were again delivered to the facility. All the deliveries were signed off by staff as having been received. On September 26, 2023 at 10:00 a.m., R1's prescriber (APRN)-B said Depakote was prescribed for R1 on June 29, 2023, to manage paranoia and agitation. APRN-B said the resident was angry during a visit on July 12, 2023 and was more agitated. APRN-B spoke with family	01760		

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01760	Continued From page 21 members on July 11, 2023, when they verbalized concern about the resident's behaviors. APRN-B said it was after that visit that staff members notified her the resident had not started the Depakote yet. APRN-B said after the resident started the Depakote, he was much calmer with less paranoia, and she received no further reports of behavioral concerns from the resident's family. On November 9, 2023, at 4:10 p.m., nurse (LPN)-Q said a nurse was responsible for reviewing new medication orders and ensuring they were transcribed onto a resident's MAR. LPN-Q did not recall there being problems with obtaining R1's Depakote. LPN-Q said if a staff member documented "pharmacy action required" on a resident's MAR, it usually meant the resident was out of the medication and it needed to be ordered from the pharmacy. On November 10, 2023, at 2:30 p.m., staff member (ULP)-P said only nurses managed any new medications, but nurses and medication technicians were able to manage refills. ULP-P said R1 displayed behaviors prior to starting the Depakote, but after he started taking the Depakote, the behaviors resolved. The facility's policy titled Medications & Treatments-Availability, dated August 2022, indicated all currently ordered medications would be available to residents. No further information was provided. R3 R3's diagnoses included dementia, mood disturbance, and vertebral compression fracture. R3's service plan, signed May 8, 2023, included	01760		

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01760	Continued From page 22	01760		

assistance with medication management, showering/bathing, bathroom assistance, and service coordination.

Review of R3's primary care provider's (PCP) notes, (PA)-J, R3 was prescribed a Medrol 4mg dose pack on June 1, 2023 for diagnosis of intervertebral disc disorders with radiculopathy, lumbar region. Directions indicated staff to follow instructions on the packaging, with the following taper instructions noted:

Methylprednisolone 4mg PO six times daily on Day 1.
Methylprednisolone 4mg PO five times daily on Day 2.
Methylprednisolone 4mg PO four times daily on Day 3.
Methylprednisolone 4mg PO three times daily on Day 4.
Methylprednisolone 4mg PO two times daily on Day 5.
Methylprednisolone 4mg PO one time daily on Day 6.

Review of R3's June 2023 MAR indicated the Medrol taper was transcribed onto the MAR as follows:

Medrol Oral Tablet 4mg
(methylprednisolone)
Give 1 tablet by mouth one time only for
Six times a day for day 1 related to
Intervertebral disc disorders
with radiculopathy, lumbar
region (M51.16) until 6/10/2023 23:59
Follow packaging instructions
-Start Date-
06/03/2023 1615

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01760	Continued From page 23 Hours: One Time Review of R3's June 2023 MAR indicated blank boxes were reserved for one dose of Medrol June 3, 2023 to June 10, 2023. However, the MAR indicated the resident received one dose of Medrol on June 3, 2023 at 8:03 p.m. and, per the MAR, no further doses were administered. Review of R3's June 2023 MAR indicated a prescription for scheduled Dilaudid was transcribed as thus: Dilaudid Oral Tablet 2mg (Hydromorphone HCL) Give 0.5 tablet by mouth three times a day for moderate pain -Start Date- 06/07/2023 1500 -D/C Date- 06/14/2023 1524 Per the MAR, R3 received three doses of Dilaudid before her hospitaliation on June 8, 2023. The MAR indicated R3 received Dilaudid as follows: June 7, 2023 at 3:00 p.m. June 7, 2023 at 9:00 p.m. June 8, 2023 at 7:30 a.m. Review of the narcotic log book recording the count of the Dilaudid tablets indicated discrepencies between the log book and R3's MAR. The log book indicated the Dilaudid was received on June 6, 2023 with instructions to take 1/2 tablet by mouth three times daily for severe pain. The log book indicated R3 received a dose of Dilaudid on June 6, 2023 at "630". R3's MAR indicated she received a dose of Dilaudid on June	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20381	A. BUILDING: _____ B. WING _____	C 09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EDINA	3330 EDINBOROUGH WAY EDINA, MN 55435

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01760	Continued From page 24 6, 2023 at 6:21 p.m. However, rather than documenting the resident received 1/2 a tablet of Dilaudid (0.5), staff documented the resident received 0.5mg (the prescription being 1mg, 0.5 of a 2mg tablet). The log book also indicated the resident received "0.5mg" of Dilaudid on June 7, 2023 at 3:00 p.m. and "0.5mg" on June 7, 2023 at "800". The dose of Dilaudid R3 received on June 8, 2023, according to her MAR, was not recorded in the narcotic log book. The resident was admitted to the hospital on June 8, 2023 for further assessment of her pain. On October 4, 2023, at 1:00 p.m., executive director (ED)-A said a family member believed the resident needed a medication and had reached out to the resident's prescriber as a result. The staff member was not aware when the medication was started. On November 1, 2023, at 11:39 a.m., physician assistant (PA)-J stated staff did not report issues with the Medrol taper to her, nor was she informed that the resident did not receive the full dose. The facility's policy titled Medications & Treatments-Medication Error, dated July 2023, indicated if a medication error occurred the nurse/designee is responsible for reporting the medication error to the prescribing physician/healthcare provider, the resident, the legally responsible party, and to the state, if applicable. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01760		

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02360	Continued From page 25	02360		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure three of three residents reviewed (R1, R2, and R3) were free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, 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		