Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL205297145M
Compliance #: HL205293605C

Date Concluded: November 1, 2023

Name, Address, and County of Licensee Investigated:
Hillcrest Adams
2229 3rd Avenue East
Hibbing, MN 55746
St. Louis County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Barbara Axness, 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 they failed to have a system was in place to ensure availability of medication refills and staff failed to administer medications as prescribed, after the facility changed pharmacies and medications were not delivered for several days. The resident did not receive medications required to manage her schizophrenia and, as a result, experienced uncontrolled hallucinations and delusions. The resident was hospitalized in a behavioral health unit for seven days.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility had no system in place to ensure medication was available and administered as prescribed. The facility recently switched to a different pharmacy and the resident's medications were not delivered as scheduled. The resident did not receive antipsychotic medications for four days and was not sent to the emergency room until she made the request to be sent in due to hearing voices.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted the resident's case worker. The investigation included review of hospital records, and facility records including assessments, progress notes, the service plan, care plan, and medication administration records. Also, the investigator observed care and services provided in the facility.

The resident resided in an assisted living facility. The resident's diagnoses included schizoaffective disorder, depressive disorder, history of suicidal ideation, behavioral problems, borderline personality disorder, schizophrenia, and panic disorder. The resident's service plan included assistance with behavioral management and medication administration.

The resident was assessed four days before she ran out of medication. The assessment indicated the nurse managed the resident's medications and was responsible for coordinating with the provider and pharmacy, ordering medications as needed, reviewing, and setting up medications, and monitoring for side effects, contraindications, and adverse effects. The assessment indicated the resident was noted to have physical and verbally aggressive behaviors, was at times sexually and socially inappropriate, and showed signs of paranoia, anxiety, delusions, agitation, and depression. The resident was at risk to abuse other vulnerable adults due to her mental health diagnoses, history of suicidal ideation, and paranoid behaviors. Staff were to monitor for any isolating behaviors, increase in behaviors, and mood/behavior changes and directed to complete safety checks on the resident on all shifts. The resident was at risk for self-abuse due to a history of suicidal ideation and staff were to report any escalating behaviors or increase in the resident acting out to the nurse.

The resident's medication administration record indicated the resident missed four days (Friday, Saturday, Sunday, Monday) of medications prescribed to manage her schizophrenia. The medications were scheduled to be given once and/or twice per day.

A progress note indicated on the Friday before a holiday weekend, the pharmacy technician noted the resident's medications were not present during a medication cycle exchange. The pharmacy technician assured facility staff the resident's medications would be delivered by bedtime that day. The following Monday, "nursing arrived to find that medications did not arrive. Nursing contacted [pharmacy] and asked why medications did not arrive as promised. [pharmacy] stated they would need new orders for all medications..." New orders were sent to the pharmacy and "it was conveyed to nursing that the medications would be available first thing Tuesday morning. The medications did not arrive on Tuesday, as it was a holiday.

Review of facility documentation included no evidence of additional attempts to obtain the resident's medication and no additional behavior monitoring or assessment of the resident's condition were completed during the period the medications were not administered.

Resident notes indicated that by Tuesday afternoon, the “resident decompensated from being off of multiple psychiatric medications for a few days and by Tuesday evening, requested to be sent to the hospital for suicidal ideation and hearing voices." The nursing note further included the nurse reported to the pharmacy that this error resulted in the resident being admitted to the mental health unit.

Hospital records indicated the resident admitted “in a manic episode with psychotic features” with suicidal thoughts and was extremely paranoid. The resident was described as “appearing quite fearful and anxious with pressured speech.” The hospital admission assessment indicated the resident arrived at the emergency room after having a “nervous breakdown at her living facility” and reported auditory and visual hallucinations, insomnia, and active thoughts of self-harm and suicide. The resident was noted to have had thoughts of cutting her neck and wrist and had cut her ankle with a razor blade while at the assisted living facility.

Hospital documentation indicated the resident told staff she was seeing people who were not there and hearing voices telling her to harm herself. The resident reported the devil was talking to her and telling her to join him by saying “tell me you are my child, and I will protect you.” A nurse in the emergency room called the facility for additional information on the resident but was told by the facility nurse “she does not know the patient because she works at a different property. She was not able to provide history.” The hospital records indicated the resident “has been quite stable on her medications and living at assisted living for the past few years. The assisted living transferred pharmacies and her insurance apparently is not going to cover her medications through this pharmacy and she has been out of her medications for one week.” The resident was hospitalized for one week in a behavioral health unit and restarted on several medications at lower doses in order to be titrated back up to therapeutic doses.

During an interview, the facility clinical nurse supervisor (CNS) stated the facility recently switched to a pharmacy based out of the Twin Cities metro area and the pharmacy came to the facility on Friday afternoons to switch out medications. The CNS stated when they realized the resident’s medications didn’t come, she assumed the pharmacy would deliver the medications when they said they would, later that day. The CNS stated she called the facility over the weekend to see how the resident was doing. The CNS stated she reached out to the resident’s provider and let them know the medications were out and the provider advised they monitor the resident for behavior changes and send her to the emergency room if changes were noted. The CNS confirmed the facility did not attempt to obtain an emergency refill of medications from a local pharmacy or identify any other ways to obtain medications while the pharmacy worked on getting the medications delivered. The CNS stated she didn’t think it would take as long as it did. The CNS did not view the missed doses as medication errors since the medications were out of stock and they weren’t able to give the medication if they didn’t have it stating “it’s technically not an error if you can’t give it.”

During an interview, the licensed assisted living director (LALD) stated she wasn’t aware at the time that the resident didn’t receive her medications and she felt the facility had done

everything they could to try get the resident's medications. The LALD stated the facility switched back to the local pharmacy after the incident. The LALD confirmed besides changing pharmacies, the facility did not conduct an internal investigation or identify any system breakdowns from the facility that may have contributed to the issue.

During an interview, the resident's case manager stated she was not notified of the facility changing pharmacies or that the medications were not able to be filled. The case manager stated she was not informed by the facility of any issues until after the resident was hospitalized.

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

Action taken by facility:
The facility changed pharmacies and changed medication cycle dates so they would not fall on a Friday.

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
St. Louis County Attorney
Hibbing City Attorney
Hibbing Police Department
Minnesota Board of Nursing
Minnesota Board of Executives for Long Term Services and Supports

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20529	A. BUILDING: _____ B. WING _____	C 10/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST ADAMS	2229 3RD AVENUE EAST HIBBING, MN 55746

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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: #HL205297145M/#HL205293605C On October 23, 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 21 residents receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL205297145M/#HL205293605C, tag identification 0620, 1760, 2360.	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 License 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 144G.31 subd. 1, 2, and 3.	
0 620 SS=D	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma (a) The assisted living facility must comply with	0 620		

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0 620	Continued From page 1 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 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	0 620		

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0 620	Continued From page 2 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 report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment and complete a thorough investigation for one of one resident (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee failed to report suspected	0 620		

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0 620	Continued From page 3 maltreatment after R1 was hospitalized in an inpatient behavioral health unit for a week after she missed four days of medications. The pharmacy failed to send the resident's medications during a routine refill and the resident was not given seven essential antipsychotic medications over four days. The resident requested to be sent to the hospital after she began to hear voices. The licensee failed to complete an internal investigation of the incident. On October 23, 2023, at 12:35 p.m., licensed assisted living director (LALD)-F stated it would have been expected of staff to file a MAARC report related to the incident and staff were reeducated on filing a MAARC report. LALD-F confirmed an internal investigation to identify system breakdowns was not completed and stated, "I don't know there was a whole lot more that we could have done differently, its unfortunate, it was a holiday weekend, they weren't available, the pharmacy wasn't responding and up here it's a lot different, it's harder to get anything done up here than anywhere else." LALD-F stated the facility switched pharmacies after the incident and started working with a local pharmacy "so this doesn't happen again." On October 23, 2023, at 12:55 p.m., executive director (ED)-G confirmed she was the licensed assisted living director of record at the time of the incident. ED-G stated she could not recall if there was any consideration to file a MAARC report and she was not aware the incident had not been reported to MAARC. ED-G stated the nurse would be responsible for but confirmed as the LALD at the time, she should have followed up with the nurse to ensure one was filed. ED-G stated the issue was related to the pharmacy so	0 620		

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0 620	Continued From page 4 the facility had not completed an investigation on system breakdowns or other issues. ED-G stated the issue was related to the pharmacy not delivering medications and thought they had done everything they could to try get the resident's medications. On October 23, 2023, at 1:10 p.m., clinical nurse supervisor (CNS)-A stated she couldn't remember if she did one [report] but when she spoke with the nurses at the hospital, they said they were going to submit a MAARC report and she had asked if she should also complete one and the hospital nurse had told her that "no, one [report] should cover it." On October 26, 2023, at 11:25 a.m., registered nurse (RN)-B stated she was not entirely sure if a MAARC report was filed "because if we call 911, they're getting immediate attention. I think if we weren't to do anything it would potentially be neglect by her not having medications and having a mental breakdown....if we wouldn't have allowed her to go in to get treatment or help, that would be a serious problem." The licensee's 2.44 Vulnerable Adult Maltreatment- Prevention & Reporting policy, revised on July 12, 2023, indicated staff who suspected maltreatment of a resident (abuse, financial exploitation, or neglect) would take immediate action to protect or keep the affected resident safe, call 911 if emergency assistance was needed, contact the clinical nurse supervisor if medical attention was needed, contact the assisted living director, and if the assisted living director or clinical nurse supervisor confirm the suspicion of maltreatment, they would contact the Minnesota Adult Abuse Reporting Center within 24 hours.	0 620		

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0 620	Continued From page 5 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
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 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 record review, the licensee failed to ensure medication was administered as prescribed for one of one residents (R1) and failed to follow-up on medication administration practices when R1's medications were out of stock for four days, resulting in R1 being admitted to an inpatient behavioral health unit. 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	01760		

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01760	Continued From page 6 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). The findings include: R1's diagnoses included schizoaffective disorder, depressive disorder, history of suicidal ideation, behavioral problems, borderline personality disorder, schizophrenia, and panic disorder. R1's service plan, dated July 30, 2021, indicated the resident received services including behavior management and medication administration. R1 was assessed on June 26, 2023, four days before she ran out of medications. The assessment indicated the nurse managed the resident's medications and was responsible for coordinating with the provider and pharmacy, ordering medications as needed, reviewing and setting up medications, and monitoring for side effects, contraindications, and adverse effects. R1 was noted to have physically and verbally aggressive behaviors, was at times sexually and socially inappropriate, and showed signs of paranoia, anxiety, delusions, agitation, and depression. The resident was at risk to abuse other vulnerable adults due to her diagnoses of schizophrenia, borderline personality disorder, post traumatic stress disorder (PTSD), anxiety, panic disorder, mild MR [mental retardation], and a history of suicidial ideation with low self esteem and paranoid behaviors. Staff were to monitor for any isolating, increased behaviors, mood/behavior changes, and complete safety checks on all shifts. The resident was at risk to abuse herself due to a history of suicidial ideation	01760		

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01760	Continued From page 7 and staff were to report escalating behaviors or an increase of acting out to the nurse. R1's June 2023 Medication Administration Record (MAR) indicated the resident did not receive the following medications on June 30, 2023: Levothyroxine (medication for underactive thyroid) 75 micrograms (mcg), take one tablet daily Hydroxyzine Hcl (an anti anxiety medication) 50 mg tablet four times per day Naltrexone (a medication used to manage alcohol use or opioid use disorder) 50 mg tablet daily Benztropine (a medication to treat involuntary movements due to side effects of certain antispychotic drugs) 0.5 mg twice daily Lamotrigine (a medication used to stabilize mood and prevent mood swings) 200 mg tablet twice daily Loxapine (an antipsychotic medication to treat mental/mood disorders) 50 mg tablet twice daily Quetiapine (an antipsychotic medication to treat mental/mood disorders) 500 mg at bedtime Topiramate (a medication to treat epilepsy and prevent migraines) 100 mg tablet twice daily R1's July 2023 MAR indicated the resident did not receive the following medications on July 1, July 2, July 3, and July 4: Levothyroxine (medication for underactive thyroid) 75 micrograms (mcg), take one tablet daily Hydroxyzine Hcl (an anti anxiety medication) 50 mg tablet four times per day Naltrexone (a medication used to manage alcohol use or opioid use disorder) 50 mg tablet daily Benztropine (a medication to treat involuntary movements due to side effects of certain antispychotic drugs) 0.5 mg twice daily	01760		

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01760	Continued From page 8 Lamotrigine (a medication used to stabilize mood and prevent mood swings) 200 mg tablet twice daily Loxapine (an antipsychotic medication to treat mental/mood disorders) 50 mg tablet twice daily Quetiapine (an antipsychotic medication to treat mental/mood disorders) 500 mg at bedtime Topiramate (a medication to treat epilepsy and prevent migraines) 100 mg tablet twice daily A progress note entered by clinical nurse supervisor (CNS)-A on July 7, 2023, indicated on Friday, June 30, 2023, at 4:30 p.m., the pharmacy technician noted that R1's medications were not present during the medication cycle exchange. The pharmacy technician "assured meds would be delivered by bedtime [on June 30, 2023]." On Monday, July 3, 2023, "nursing arrived to find that medications did not arrive. Nursing contacted [pharmacy] and asked why medications did not arrive as promised. [pharmacy] stated they would need new orders for all medications..." New orders were sent to the pharmacy and "it was conveyed to nursing that the medications would be available first thing Tuesday [July 4, 2023] morning. The medications did not arrive on Tuesday, as it was a holiday. By Tuesday afternoon [July 4, 2023], [R1] decompensated from being off of her multiple psych meds for a few days and by Tuesday evening, she requested to be sent to the hospital for suicidal ideation and hearing voices." Hospital records indicated the resident admitted on July 4, 2023, "in a manic episode with psychotic features" with suicidal thoughts and was extremely paranoid. The resident was described as "appearing quite fearful and anxious with pressured speech." The admission assessment indicated the resident arrived to the	01760		

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01760	Continued From page 9 emergency room after having a "nervous breakdown at her living facility" and was reporting auditory and visual hallucinations, insomnia, active thoughts of self-harm and suicide. [R1] was noted to have had thoughts of cutting her neck and wrist and had cut her ankle with a razor blade while at the assisted living facility. Hospital documentation indicated R1 told staff she was seeing people who were not there and hearing voices telling her to harm herself. R1 reported the devil was talking to her and telling her to join him by saying "tell me you are my child and I will protect you." A nurse in the emergency room called the facility for additional information on the resident but was told by the on call nurse (RN)-B "she does not know the patient because she works at a different property. She was not able to provide history." The hospital records indicated R1 "has been quite stable on her medications and living at assisted living for the past few years. The assisted living transferred pharmacies and her insurance apparently is not going to cover her medications through this pharmacy and she has been out of her medications for one week." R1 had to be hospitalized for a week in a behavioral health unit, was restarted on several medications at lower doses and needed to be titrated back up to a therapeutic dose. R1 discharged back to the facility on July 11, 2023. On October 23, 2023, at 12:55 p.m., executive director (ED)-G confirmed she was the licensed assisted living director of record at the time of the incident. ED-G stated she "wasn't aware at the time the resident didn't receive her medications. ED-G confirmed there was no documentation for the medication errors and that the facility did not document or initiate an internal investigation to determine if there were any system breakdowns involving the facility's practices. ED-G stated the	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20529	A. BUILDING: _____ B. WING _____	C 10/23/2023

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01760	Continued From page 10 issue was not a medication error due to the pharmacy not delivering medications and thought they had done everything they could to try get the resident's medications. On October 23, 2023, at 1:10 p.m., clinical nurse supervisor (CNS)-A stated it would not be considered a medication error if the medications weren't given because they were not there. CNS-A stated it was instead "a med out of stock" issue and the nurse was notified the medication was out of stock so "it's technically not an error if you can't give it. It'd be an error if you miss giving it or you give it to the wrong person on the wrong date." CNS-A stated the facility had recently started using a different pharmacy and despite the facility voicing concerns about a Friday medication exchange, they were scheduled for Friday medication exchanges. CNS-A stated they realized on June 30, 2023, at 4:30 p.m. the resident's medications didn't come and before she left for the weekend, the pharmacy tech assured her they'd get them and she assumed they would follow through with that. CNS-A stated she had called the facility over the weekend to see how the resident was doing and she had remained stable so they kept waiting for the medications to be sent. CNS-A stated she had updated the resident's provider about the missing medications and they said to just keep monitoring her and did not say what they should do if the medications didn't arrive by a certain time. On October 26, 2023, at 11:25 a.m., registered nurse (RN)-B stated she was on call from June 30, 2023, through the resident's hospitalization on July 4, 2023. RN-B stated she was not aware the resident was out of medications until staff called about sending her to the emergency room on July 4, 2023.	01760		

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01760	Continued From page 11 The licensee's 7.24 Medication Error policy, last revised July 12, 2023, indicated whenever a medication error occured, the person responsible for the error or the person who caught the error would contact a licensed nurse. The licensed nurse would instruct staff what to do next. The staff involved would complete a medication error report and document in the resident's record progress notes what occurred, the date, and time, who was contacted and what actions were to correct the situation. The licensee's 7.19 Medcations & Supplies-Reordering, last revised July 12, 2023, indicated prior to holidays and weekends, the RN or designated staff would plan ahead for the needs of residents for refills on prescriptions. Nursing staff would assist residents to make sure medications and supplies were ordered and available as needed. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01760		
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 one of one residents reviewed (R1) was free from maltreatment.	02360	No plan of correction is required for this tag.	

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02360	Continued From page 12 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		