Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL213872981M
Compliance #: HL213872826C

Date Concluded: November 4, 2024

Name, Address, and County of Licensee Investigated:
Rose Arbor Wildflower Lodge
16500 92nd Avenue North
Maple Grove, MN 55311
Hennepin County

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

Evaluator's Name: Holly German, RN
Special Investigator

Finding: Inconclusive

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 alleged perpetrator (AP) financially exploited the resident when she took the resident's narcotic medication.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was inconclusive. While narcotic medication went missing and the AP was one of the staff members responsible for the medication cart for a shift during the time frame the narcotic medication went missing, the investigation did not reveal it was conclusively the AP who took the medication. The facility failed to ensure proper procedures for monitoring and counting narcotic medication that had been pre-packed for the resident who was planning time away from the facility. Several unlicensed personnel (ULP) had worked the medication cart from the time a ULP pre-packed the resident's medications, including oxycodone (a controlled substance for pain) in the afternoon, until the following morning when a different ULP discovered the oxycodone was replaced with Tylenol (an over-the-counter pain medication).

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted law enforcement. The investigation included review of the resident records, facility internal investigation, facility incident reports, personnel files, staff schedules, law enforcement report, related facility policy and procedures. Also, the investigator observed medication administration while on site.

The resident resided in an assisted living facility. The resident's diagnoses included anxiety and chronic pain. The resident's service plan included assistance with medication administration. The resident's assessment indicated the resident was alert and oriented and was independent with mobility.

The resident's medication administration record indicated the resident received oxycodone routinely three times a day. The resident's narcotic record indicated ULP-1 signed out one tablet of oxycodone at the resident's scheduled time in the afternoon, and the AP signed out one tablet of oxycodone at the resident's scheduled time in the evening. The narcotic record lacked documentation to indicate which staff and what time that staff removed the pre-packaged oxycodone from the medication card. The narcotic log indicated the resident continued to receive her medications as scheduled.

A facility incident report indicated registered nurse (RN)-1 directed ULP-1 to package up the resident's medication at 2:30 p.m. for the next morning because the resident would be leaving the facility to attend an appointment with family. The report indicated ULP-1 dispensed the medications as ordered, placed the medications in labeled envelopes, and placed the envelopes in the medication cart. The packed medications included one oxycodone tablet. ULP-1 reported to the AP, who worked the next shift, there was medications packed for the following morning and directed the AP to pass that information on to the next shift, ULP-2. At the end of her overnight shift, ULP-2 reported to ULP-3 about the need to send the packed medications with the resident that morning before the resident left for her appointment. ULP-3 noted during the morning shift to shift narcotic count, the medication envelope labeled as oxycodone did not appear to contain oxycodone, and instead contained a Tylenol tablet. The staff did not do a narcotic monitoring count or check the oxycodone in the packaged envelope between each shift.

During an interview, ULP-1 stated the facility stored narcotic medications in the medication cart in a separate locked box. ULP-1 stated the staff count the narcotics between each shift by comparing the narcotic logbook to the actual medication card to confirm the amount was right. ULP-1 stated the assigned staff member working the cart was the only person with access to the medications on that shift, aside from the nurses having an extra key. ULP-1 stated the RN-1 asked her to pack up the resident's medications for the next morning. ULP-1 stated she placed all the regular meds in one envelope and the narcotic medication in another envelope. ULP-1 stated she showed the AP the packed medications, including the blue narcotic tablet in the envelope during shift change when the AP was taking over. ULP-1 stated she did not know what

happened to the oxycodone. ULP-1 stated they no longer pre-package medications ahead of time.

During an interview, the AP stated when she took over the cart from ULP-1. She did not count the narcotic in the envelope because the envelope was sealed, and it did not concern her on her shift. The AP stated she gave the resident her oxycodone as scheduled on her shift per usual from the medication card. The AP stated at the end of her shift, she and ULP-2 counted the narcotics on the cards but did not look at the narcotic in the envelope. The AP stated she told ULP-2 there were medications packed in the cart to go with the resident in the morning. The AP denied taking the oxycodone.

During an interview, ULP-2 stated the AP told her about the resident's medications packaged in the medication cart. ULP-2 stated she did not look at them and did not know what medications staff packaged up because it was not something she needed to deal with on her shift. ULP-2 stated her responsibility was to just keep the medications in the cart for the next shift.

During an interview, ULP-3 stated when she came on to her shift to relieve ULP-2, she opened the envelope labeled for the oxycodone to check it since she was responsible for the cart. ULP-3 stated she noticed it was a white pill in the envelope, and she remembered the resident's oxycodone was a blue tablet. ULP-3 stated she confirmed the white tablet in the envelope was in fact a Tylenol tablet, not oxycodone. ULP-3 stated ULP-2 witnessed the discrepancy but stated the AP told her about medications being in the cart, and to pass the information on to ULP-3. ULP-3 stated she did not believe ULP-2 knew what medications were packaged in the envelopes because she was not even aware of what medications the resident was scheduled to receive. ULP-3 did not know what happened to the oxycodone.

During an interview, RN-1 stated she was not aware if anyone else would have access to the medication cart other than the staff assigned to the cart on the shift. RN-1 stated she told ULP-1 to package up the resident's medications for the next morning. RN-1 stated she was not aware of a policy stating a time frame of when staff should prepackage medications for a resident with planned time away from the facility. RN-1 stated she directed ULP-1 to pack the medications at the time she did because that was the time she became aware of the resident's planned time away. RN-1 stated she was not aware the resident's packaged medications would include oxycodone. RN-1 stated if she knew of the narcotic, she would not have directed ULP-1 to package the medications at that time, but rather during the shift the resident was actually leaving on. RN-1 stated the staff should have checked for the oxycodone as part of the shift-to-shift narcotic count. RN-1 stated during the facility investigation, the facility felt the medication when missing during the AP's shift, but they had no way to prove it.

During an investigation, RN-2 stated it was ideal to package medications the day before a resident was leaving the facility for planned time away. RN-2 stated she would prefer staff packed a narcotic in a separate envelope from the other meds that the family then signed for when given to them. RN-2 stated she would prefer the staff to be checking and counting

prepackaged medications during the narcotic count between shifts. RN-2 stated she reviewed the internal investigation RN-1 completed and agreed together they felt the AP took the oxycodone but could not determine where the oxycodone went.

The resident did not return calls for request for interview.

The law enforcement report indicated there was no video or way to see who accessed the medication cart and the staff on site did not know where the pill went. The report indicated the officer directed RN-1 to call him if there was any new information revealed.

In conclusion, the Minnesota Department of Health determined financial exploitation was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

Financial exploitation: Minnesota Statutes, section 626.5572, subdivision 9
"Financial exploitation" means:
(b) In the absence of legal authority a person:
(1) willfully uses, withholds, or disposes of funds or property of a vulnerable adult;

Vulnerable Adult interviewed: No, did not respond to request for interview.
Family/Responsible Party interviewed: No, resident was her own person.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility conducted an internal investigation. The resident continued to receive her mediations. The AP is no longer employed by the facility.

Action taken by the Minnesota Department of Health:
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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21387	A. BUILDING: _____ B. WING _____	C 09/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE ARBOR/WILDFLOWER LODGE	16500 92ND AVENUE NORTH MAPLE GROVE, MN 55311

(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
0 000	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: HL213872826C/HL213872981M HL213873510C/HL213873381M On September 23, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 106 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for HL213872826C/HL213872981M, tag identification 1780. The following correction orders are issued for HL213873510C/HL213873381M, tag identification 630, 990, 1760.	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.	
0 630 SS=G	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21387	A. BUILDING: _____ B. WING _____	C 09/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE ARBOR/WILDFLOWER LODGE	16500 92ND AVENUE NORTH MAPLE GROVE, MN 55311

(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
0 630	Continued From page 1 (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to implement individualized interventions to reduce risk of a resident from harming herself or others for 1 of 1 residents (R2) reviewed. The licensee failed to appropriately reassess R2's new vulnerability of wandering upon re-admission and failed to reassess vulnerabilities for new verbal threats to harm others. Therefore, the licensee failed to implement interventions and provide services to manage behaviors the licensee used as rationale for termination of services. This lack of interventions to address the known vulnerability created a risk of serious harm. 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).	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21387	A. BUILDING: _____ B. WING _____	C 09/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE ARBOR/WILDFLOWER LODGE	16500 92ND AVENUE NORTH MAPLE GROVE, MN 55311

(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
0 630	Continued From page 2 The findings include: R2's individual abuse prevention plan (IAPP) dated December 18, 2023, indicated R2 did not pose a threat to other vulnerable adults, and did not appear to have a risk of maltreatment that required interventions. R2's preadmission assessment dated December 19, 2023 indicated R2 was oriented to person, place, time, situation, and did not have history of disruptive, aggressive or inappropriate behaviors. R2 was independent with mobility. The assessment indicated R2 did not wander. R2 admitted to the licensee on December 27, 2023, with diagnoses that included Parkinson's disease and anxiety disorders. R2's progress notes dated December 27, 2023, through February 6, 2024, was reviewed. On January 9, 2024, R2 had a mild dislocation to her right shoulder and was sent to the emergency department for evaluation. On January 10, 2024, R2 admitted to a transitional care unit (TCU) for therapy. The facility lacked a progress note indicating R2 returned to the facility. R2's TCU discharge care plan dated January 30, 2024, identified R2 had a risk for elopement and required the use of a wanderguard. The vulnerable adult section had interventions that included staff explaining what they are going to do prior to providing care, monitor for signs of emotional distress and behavior changes, and safety monitoring as needed. The careplan identified alteration in cognition and interventions included allowing R2 time to communicate her needs, document changes in orientation, provide	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21387	A. BUILDING: _____ B. WING _____	C 09/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE ARBOR/WILDFLOWER LODGE	16500 92ND AVENUE NORTH MAPLE GROVE, MN 55311

(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
0 630	Continued From page 3 a consistent environment and provide cues, reorientation and supervision as needed. The careplan identified an alteration in mood and behavior related to the adjustment to placement and current health conditions. Interventions included monitoring and documenting mood/behaviors upon occurrences and provided medications as ordered. R2's TCU discharge orders dated February 5, 2024, listed an order for use of a wanderguard and pain monitoring every shift. R2's medication orders for mood and cognition included donepezil 5 milligrams (mg) for Parkinson's and escitalopram 20 mg for anxiety and depression. Additionally, for broken collar bone pain, R2's orders included acetaminophen 1000 mg three times per day as needed and tramadol 25 mg every six hours as needed. R2's change in condition assessment dated February 6, 2024, indicated R2 was oriented to person, place, time, and situation. R2 had occasional disorientation that required some direction and reminding from others. R2 did not have aggressive, verbal or socially inappropriate behaviors. R2 did not wander. R2 required assistance with mobility. R2's progress noted dated February 7, 2024 indicated the facility nurse visited R2 at the TCU and R2 then had a fractured right shoulder. It was the R2's last insurance covered day at the TCU. The progress notes lacked clear documentation of when R2 returned to the licensee. R2's record included therapy discharge orders from the TCU to the licensee with the discharge date February 7, 2024. The licensee failed to update R2's IAPP upon	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21387	A. BUILDING: _____ B. WING _____	C 09/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE ARBOR/WILDFLOWER LODGE	16500 92ND AVENUE NORTH MAPLE GROVE, MN 55311

(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
0 630	Continued From page 4 return from the TCU with newly identified elopement risk and history of needing a wanderguard while at the TCU, therefore failed to implement interventions regarding wander risk. R2's progress note dated February 14, 2024, indicated R2 had a scheduled shoulder surgery and discharged back to the TCU for additional rehabilitation. R2's progress note dated March 13, 2024, indicated the licensee nursing staff (memory care and assisted living) met with R2's family member (FM)-C to discuss R2's return to the facility. Topics discussed included safety, appropriateness for assisted living, as memory care was recommended. The TCU cognitive test indicated R2 displayed poor cognition and required 24 hours care for safety. FM-C agreed to increase level of care for the assisted living and tour the memory care. FM-C hoped as R2 recovered with additional services she could stay in the assisted living. FM-C agreed to memory care if R2 had further decline. R2's progress note dated March 15, 2024, indicated R2 readmitted to the licensee. R2's readmission, change in condition, assessment performed by registered nurse (RN)-D on March 15, 2024, indicated R2's orientation changed to oriented to person and place. R2 required frequent direction and reminders. R2 did not have aggressive, verbal or socially inappropriate behaviors. R2 required extensive assistance with mobility. R2's assessment indicted R2 had no history of elopement and no wandering behavior and failed to indicate the wandering interventions in place at the TCU.	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21387	A. BUILDING: _____ B. WING _____	C 09/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE ARBOR/WILDFLOWER LODGE	16500 92ND AVENUE NORTH MAPLE GROVE, MN 55311

(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
0 630	Continued From page 5 The licensee failed to update R2's IAPP upon return from the TCU with newly identified elopement risk and history of needing a wanderguard while at the TCU, therefore failed to implement interventions regarding wander risk and change in orientation level with need for frequent direction and reminders. R2's service plan dated March 15, 2024, indicated R2 received assistance with medication management and bathing. R2 required two person assist for transfers. R2 required assistance with dressing and grooming. R2 received toileting assistance every two hours. R2 received safety checks two times per day. R2's service plan indicated R2 had no behavior issues, no history of disruptive, aggressive, verbal or socially inappropriate behavior. R2's personal care service record dated March 2024, included assistance with toileting, dressing, grooming, escorts, showers and laundry. R2's service record did not include any services for behavior interventions, wandering or monitoring/safety checks. R2's incident reports in March 2024, included incidents of falls. R2 had no incident reports related to elopement or aggressive behaviors. R2's progress notes from March 15, 2024 through March 31, 2024, lacked any notes indicating R2 had any wandering or aggressive behaviors. R2's progress note dated April 8, 2024, at 12:30 p.m., indicated R2 was frustrated she did not receive her shower in the morning the day before and negotiated a new tie of 5:00 p.m. R2 went to	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21387	A. BUILDING: _____ B. WING _____	C 09/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE ARBOR/WILDFLOWER LODGE	16500 92ND AVENUE NORTH MAPLE GROVE, MN 55311

(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
0 630	Continued From page 6 the front desk after supper to complain the unlicensed personnel (ULP) was not at her apartment. R2 stated she was going to "wring" the ULP's neck. R2 asked a staff member for a gun and stated she wanted to use it on the ULP. RN-D updated law enforcement, FM-C and R2's physician of her verbal threat. The note lacked any interventions provided to R2 or follow up on R2's mood. The Residency Agreement Pre-Termination Meeting Notice dated April 9, 2024, indicated the basis for termination was for R2's welfare and the facility was unable to meet R2's needs. The notice stated a decline in R2's mental status and frequent wandering throughout the facility. R2's progress notes reviewed from April 9, 2024, through May 22, 2024, did not include any other notes regarding verbal threats or aggressive behaviors. Additionally, R2's progress notes did not include any elopement attempts or problems related to wandering. R2's personal care service record dated April 2024, included assistance with toileting, dressing, grooming, escorts, showers and laundry. R2's service record did not include any services for behavior interventions, wandering or monitoring/safety checks. R2's incident reports in April 2024, included incidents of falls. R2 had no incident reports related to elopement or aggressive behaviors. R2's IAPP lacked an update with an assessed vulnerability of R2's verbal threat to determine if it was an isolated occurrence or change in her behavior requiring new interventions.	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21387	A. BUILDING: _____ B. WING _____	C 09/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE ARBOR/WILDFLOWER LODGE	16500 92ND AVENUE NORTH MAPLE GROVE, MN 55311

(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
0 630	Continued From page 7 The Residency Agreement Pre-Termination Meeting Summary dated April 16, 2024, indicated the basis of termination of residency was for R2's welfare and the facility unable to meet R2's needs. Additionally, it indicated R2 engaged in conduct that interfered with the health, safety, peaceful lodging, or quiet enjoyment of others at the facility. The summary indicated R2 required memory care. During an interview on September 26, 2024, at 1:00 p.m., ULP-A stated R2 had behaviors that included threatening to hurt and fight staff. ULP-A stated R2 would wander in the facility looking for her room and family and did not know how to get to her room. During an interview on October 2, 2024, at 1:00 p.m., RN-D stated R2 had behaviors that were related to R2's cognitive decline. RN-D stated staff noted R2 get lost in the facility and R2 had told a staff member she wished she had a gun to shoot her. RN-D stated R2's IAPP and service plan should indicate behaviors. R2's record lacked a vulnerability assessment to evaluate R2's vulnerabilities related to wandering and behaviors, what impact those behaviors had to herself or others and implement interventions to support R2's needs in managing her behaviors. The licensee failed to updated R2's IAPP with wandering, verbal threats and behaviors, and therefore failed to implement interventions regarding the behaviors. R2 was issued a termination notice dated April 23, 2024. R2's 90 day nursing assessment dated May 7,	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21387	A. BUILDING: _____ B. WING _____	C 09/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE ARBOR/WILDFLOWER LODGE	16500 92ND AVENUE NORTH MAPLE GROVE, MN 55311

(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
0 630	Continued From page 8 2024, indicated R2 had no changes to her cognition or behaviors since the assessment date March 15, 2024. R2's orientation status continued to be oriented to person and place. R2 continued to require frequent direction and reminders. R2 did not have aggressive, verbal or socially inappropriate behaviors. R2's assessment indicted R2 had no history of elopement and no wandering behavior. R2's mobility improved to independence with transfers and mobility from extensive assist. R2's progress note dated May 22, 2024, indicated R2 discharged from the licensee. During an interview on September 30, 2024, at 2:00 p.m., FM-C stated R2 was not as accurate with details in the early mornings before she took her meds. FM-C stated the facility stated R2 engaged in activities that disrupted others. FM-C stated staff did not want R2 to wander so they always made her go to her room and did not allow her to move about freely. FM-C stated therefore they paid for escort services to meals. FM-C stated R2 said she felt like she was isolated and not allowed to be with other residents. FM-C stated when they received a termination notice they intended to appeal it because R2 wanted to stay there because she had friends at the facility. FM-C stated she had other care concerns regarding R2 and negotiated a move out date instead of an appeal hearing. The licensee-provided policy titled "ALDC (Assisted Living Dementia Care) Behavioral Symptoms, Interventions and Nonpharmacological Approaches" dated February 28, 2024, indicated the facility will identify behavioral symptoms that negatively impact other residents and evaluate to determine potential	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21387	A. BUILDING: _____ B. WING _____	C 09/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE ARBOR/WILDFLOWER LODGE	16500 92ND AVENUE NORTH MAPLE GROVE, MN 55311

(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
0 630	Continued From page 9 interventions to minimize such behaviors. Interventions will be identified on the care plan or service plan. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 990 SS=D	144G.52 Subd. 2 Prerequisite to termination of a contract (a) Before issuing a notice of termination of an assisted living contract, a facility must schedule and participate in a meeting with the resident and the resident's legal representative and designated representative. The purposes of the meeting are to: (1) explain in detail the reasons for the proposed termination; and (2) identify and offer reasonable accommodations or modifications, interventions, or alternatives to avoid the termination or enable the resident to remain in the facility, including but not limited to securing services from another provider of the resident's choosing that may allow the resident to avoid the termination. A facility is not required to offer accommodations, modifications, interventions, or alternatives that fundamentally alter the nature of the operation of the facility. (b) The meeting must be scheduled to take place at least seven days before a notice of termination is issued. The facility must make reasonable efforts to ensure that the resident, legal representative, and designated representative are able to attend the meeting. (c) The facility must notify the resident that the resident may invite family members, relevant health professionals, a representative of the Office of Ombudsman for Long-Term Care, a representative of the Office of Ombudsman for	0 990		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21387	A. BUILDING: _____ B. WING _____	C 09/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE ARBOR/WILDFLOWER LODGE	16500 92ND AVENUE NORTH MAPLE GROVE, MN 55311

(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
0 990	Continued From page 10 Mental Health and Developmental Disabilities, or other persons of the resident's choosing to participate in the meeting. For residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the facility must notify the resident's case manager of the meeting. (d) In the event of an emergency relocation under subdivision 9, where the facility intends to issue a notice of termination and an in-person meeting is impractical or impossible, the facility must use telephone, video, or other electronic means to conduct and participate in the meeting required under this subdivision and rules within Minnesota Rules, chapter 4659. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to offer reasonable accommodations, modifications, interventions, or alternative to avoid the termination, as required for 1 of 1 residents (R2) reviewed. The licensee offered R2 residency in the memory care unit but did not provide information and tour of the unit as requested by R2 prior to serving a termination letter. The licensee did not allow for R2 to consult with R2's neurology provider for assessment of care needs to determine the appropriateness of a memory care unit prior to serving a termination letter. The licensee did not include a detailed explanation for the basis of the termination as required. 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	0 990		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21387	A. BUILDING: _____ B. WING _____	C 09/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE ARBOR/WILDFLOWER LODGE	16500 92ND AVENUE NORTH MAPLE GROVE, MN 55311

(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
0 990	Continued From page 11 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: R2's diagnosis included Parkinson's disease and anxiety disorders. R2's service plan dated March 15, 2024, indicated R2 received assistance with medication management and bathing. The Residency Agreement Pre-Termination Meeting Notice dated April 9, 2024, indicated the basis for termination was for R2's welfare and the facility was unable to meet R2's needs. The notice stated a decline in R2's mental status and frequent wandering throughout the facility. The Residency Agreement Pre-Termination Meeting Summary dated April 16, 2024, indicated the basis of termination of residency was for R2's welfare and the facility unable to meet R2's needs. Additionally, it indicated R2 engaged in conduct that interfered with the health, safety, peaceful lodging, or quiet enjoyment of others at the facility. The summary indicated the facility required R2 move to the memory care unit and needed to obtain full reports from the neurology provider. The same summary indicated the facility stated R2 refused to move to the memory care unit and did not provide the full reports of the neurology provider. The Termination of Resident Notice dated April 23, 2024, indicated R2's residency agreement would terminate on May 9, 2024, at 12:00 p.m., with the basis of R2's welfare, the facility was unable to meet R2's needs, and R2 engaged in conduct that interfered with the health, safety, peaceful lodging, or quiet enjoyment of others at	0 990		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21387	A. BUILDING: _____ B. WING _____	C 09/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE ARBOR/WILDFLOWER LODGE	16500 92ND AVENUE NORTH MAPLE GROVE, MN 55311

(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
0 990	Continued From page 12 the facility. During an interview on September 30, 2024, at 2:00 p.m., family member (FM)-C stated the facility never provided her with information on increased care in the memory care unit or given a tour of the memory care unit despite asking for it. FM-C stated she felt registered nurse (RN)-D did not like dealing with FM-C, so RN-D took it upon herself to evict R2 so that she would not have to deal with FM-C. During an interview on October 2, 2024, at 1:00 p.m., RN-D indicated the facility staff felt memory care was the safest option for R2, but when R2 stated she wanted a gun to shoot a staff member, staff decided to terminate residency. RN-D was not able to state any specific interventions attempted to avoid termination. RN-D stated she did not know of a completed assessment that determined the facility could not meet R2's needs. During an interview on October 7, 2024, at 1:00 p.m., ombudsman (OM)-E stated the facility was unwilling to negotiate any sort of solution to avoid termination. OM-E stated R2 was in the process of getting some testing done to determine R2's care needs, but the facility would not budge and gave an ultimatum for R2 to move to the memory care unit. OM-E stated the facility did not follow statue by being unwilling to try interventions for a solution and felt the termination was inappropriate. The licensee-provided policy titled "Contract Termination" dated February 28, 2024, indicated the licensee will identify and offer reasonable accommodations or modifications, interventions, or alternatives to avoid the termination or enable	0 990		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21387	A. BUILDING: _____ B. WING _____	C 09/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE ARBOR/WILDFLOWER LODGE	16500 92ND AVENUE NORTH MAPLE GROVE, MN 55311

(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
0 990	Continued From page 13 the resident to remain in the facility, including but not limited to securing services from another provider of the residents choosing that may allow the resident to avoid termination. The policy indicated the pre-termination meeting notice, pre-termination meeting written summary, and contract termination notice would include a detailed explanation of the basis for the termination, including the clinical or other supporting rationale. TIME PERIOD FOR CORRECTION: Seven (7) days	0 990		
01760 SS=D	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 document review the licensee failed to provide medications as ordered, as required for 1 of 1 residents (R2) reviewed. The licensee failed to transcribe a physician order 11 missed doses of an Exelon patch (used to	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21387	A. BUILDING: _____ B. WING _____	C 09/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE ARBOR/WILDFLOWER LODGE	16500 92ND AVENUE NORTH MAPLE GROVE, MN 55311

(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
01760	Continued From page 14 treat dementia related to Parkinson's disease). In addition, the licensee failed to include directions for unlicensed personnel (ULP) to remove old transdermal patches prior to placing a new one. 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: R2's diagnosis included Parkinson's disease and anxiety disorders. R2's service plan dated March 15, 2024, indicated R2 received assistance with medication management and bathing. R2's medical provider's order dated February 15, 2024, indicated an order for an Exelon (used to treat dementia related to Parkinson's disease) 9.5 milligram (mg) 24 hour patch to be placed to R2's skin daily. R2's medication administration record (MAR) dated February 2024, indicated R2 was hospitalized and returned February 8, 2024. The MAR included a transcribed order for Exelon 9.5 mg patch daily. R2 received seven doses and was hospitalized the remainder of the month. R2's progress notes dated February 9, 2024, indicated R2 had a schedule shoulder surgery planned for February 14, 2024. Progress notes dated February 16, 2024, indicated the hospital recommended R2 stay at a transitional care unit	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21387	A. BUILDING: _____ B. WING _____	C 09/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE ARBOR/WILDFLOWER LODGE	16500 92ND AVENUE NORTH MAPLE GROVE, MN 55311

(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
01760	Continued From page 15 for recovery. The licensee evaluated R2's needs from therapy and also agreed R2 required a TCU. R2's progress notes date March 15, 2024, indicated R2 returned to the licensee from the TCU. R2's discharge orders from the TCU did not include an order for Exelon. R2's medical provider's order dated March 22, 2024, indicated an order for an Exelon 4.6 mg 24 hour patch to be placed to R2's skin daily for four weeks then increase to 9.5 mg for four weeks then increase to 13.3 mg daily. R2's MAR dated March 2024, indicated the licensee failed to transcribed the March 22, 2024 Exelon order. Therefore, R2 failed to receive administration of an Exelon patch for 10 days. The Exelon order did not direct staff to remove the previous patch prior to placing a new patch. R2's MAR dated April 2024, included a transcribed order from March 22, 2024, for the Exelon 4.6 mg patch daily and administration started on April 2, 2024. R2 missed 1 dose of the Exelon patch on April 1, 2024. The Exelon order did not direct staff to remove the previous patch prior to placing a new patch. R2's medical provider's order dated April 12, 2024, indicated an order for an Exelon 9.5 mg daily with a provider note indicating dose change, "Patient should NOT be on 4.6 mg patches." R2's April 2024 MAR reflected the transcribed Exelon order from April 12, 2024 and administration began on April 13, 2024, upon return from a leave of absence. The Exelon order	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21387	A. BUILDING: _____ B. WING _____	C 09/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE ARBOR/WILDFLOWER LODGE	16500 92ND AVENUE NORTH MAPLE GROVE, MN 55311

(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
01760	Continued From page 16 did not direct staff to remove the previous patch prior to placing a new patch. During an interview on September 30, 2024, at 2:00 p.m., family member (FM)-C stated there was an ongoing issue of R2 not receiving her Parkinson's medications on time. FM-C stated the facility did not give R2 her Parkinson's patch for two weeks and then gave her the wrong dose. FM-C stated she found multiple patches on R2's back. FM-C stated registered nurse (RN)-D stopped giving R2 her medications near R2's discharge, and RN-D told FM-C she thought FM-C was going to give R2 her medications. During an interview on October 2, 2024, at 1:00 p.m., RN-D stated she did not recall R2 not receiving her medications, that she would look at reports to answer. RN-D stated there should be directive to remove a prior medication patch before placing a new one on the medication order in the MAR. An email communication from RN-D on October 3, 2024, at 2:19 p.m., indicated RN-D acknowledged the missed doses of medications from March 2024 to May 2024. RN-D stated she did not run the report that would have shown medications not administered. The licensee-provided policy titled "Medication and Treatment Orders" dated February 28, 2024, indicated medication orders received must be implemented within 24 hours of receipt. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21387	A. BUILDING: _____ B. WING _____	C 09/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE ARBOR/WILDFLOWER LODGE	16500 92ND AVENUE NORTH MAPLE GROVE, MN 55311

(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
01780	Continued From page 17	01780		
01780 SS=D	144G.71 Subd. 10 Medication management for residents who will (a) An assisted living facility that is providing medication management services to the resident must develop and implement policies and procedures for giving accurate and current medications to residents for planned or unplanned times away from home according to the resident's individualized medication management plan. The policies and procedures must state that: (1) for planned time away, the medications must be obtained from the pharmacy or set up by the licensed nurse according to appropriate state and federal laws and nursing standards of practice; This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to implement policies and procedure for medication management for a resident with planned time away from home, as required for 1 of 1 residents (R1) reviewed. An unlicensed personnel (ULP), not a licensed nurse as required, pre-packaged R1's medications for planned time away a full day prior to the resident leaving the facility. Staff failed to monitor the prepackaged medication between shifts as part of the narcotic medication monitoring. 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).	01780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21387	A. BUILDING: _____ B. WING _____	C 09/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE ARBOR/WILDFLOWER LODGE	16500 92ND AVENUE NORTH MAPLE GROVE, MN 55311

(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
01780	Continued From page 18 The findings include: R1's diagnosis included anxiety and chronic pain. R1's service plan dated October 1, 2024, indicated R1 received medication administration assistance four times daily. The service plan identified R1 as oriented to person, place, time and situation. R1's medication administration record dated March, 2024 indicated all doses of oxycodone were signed as given as ordered. R1's narcotic record lacked documentation of the oxycodone being removed from the medication card ahead of time to be packaged for the following day. The narcotic log indicated the oxycodone was signed for as scheduled. During an interview on September 26, 2024, at 1:00 p.m., ULP-A stated registered nurse (RN)-B told her to pack the medications for R1 for the next morning. ULP-A stated she placed R1's regular medications in one envelope, and R1's blue oxycodone tablet in another envelope. ULP-A stated she showed the packaged medications to ULP-C during shift change when ULP-C was taking over the duties of the medication cart. During an interview on September 26, 2024, at 2:00 p.m., RN-B stated that if she knew R1's medication orders contained oxycodone, she would not have directed ULP-A to prepackage the medication at the time she did. RN-B stated the staff should check and count any prepackaged narcotic medication as part of the shift-to-shift narcotic counts.	01780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21387	A. BUILDING: _____ B. WING _____	C 09/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE ARBOR/WILDFLOWER LODGE	16500 92ND AVENUE NORTH MAPLE GROVE, MN 55311

(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
01780	Continued From page 19 During an interview on September 27, 2024, at 10:00 a.m., ULP-C stated she did not count or see the oxycodone medication when she took over for ULP-A because ULP-A had sealed the envelope, and it did not concern her for her shift. ULP-C stated she and ULP-D did not look at the medication envelopes when ULP-D was taking over duties for her. She told ULP-D they were in the medication cart to pass the information along. During an interview on September 27, 2024, at 11:00 a.m., ULP-D stated she did not look at the packaged medications when she came on her shift because the envelopes were sealed, and they were not something she needed to deal with on her shift. ULP-D stated she did not know what medications were in the envelopes. During an interview on September 27, 2024, at 3:00 p.m., ULP- E stated when she came on to her shift, she opened the medication envelopes during medication count at shift change with ULP-D because she was now responsible for what was in the cart. ULP-E stated that ULP-D was not aware of what medications were supposed to be in the envelopes. During an interview on October 2, 2024, at 10:00 a.m., RN-F stated she preferred the staff prepackage medications a day before the resident is leaving the facility for planned time away. RN-F stated she would prefer the staff to check and count prepackaged medications during the shift-to-shift narcotic counts. The licensee-provided policy titled, "Medication Management-Planned and Unplanned Time Away," dated February 28, 2024, indicated for planned time away, medication must be obtained by the pharmacy or set up by a licensed nurse.	01780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21387	A. BUILDING: _____ B. WING _____	C 09/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE ARBOR/WILDFLOWER LODGE	16500 92ND AVENUE NORTH MAPLE GROVE, MN 55311

(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
01780	Continued From page 20 The policy does not direct staff on procedure for monitoring controlled substances amongst the pre-prepared medications. TIME PERIOD FOR CORRECTION: Seven (7) days	01780		