Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL246751542M, HL246753726M, and HL246753725M

Date Concluded: November 23, 2022

Compliance #: HL246752937C, HL246756114C, and HL246756113C

Name, Address, and County of Licensee Investigated:
West Bloomington Residence
10441 Johnson Ave S
Minneapolis, MN 55437-2819
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Lena Gangestad, RN
Special Investigator

Finding: Substantiated, individual responsibility

Nature of Visit:
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), who worked as an unlicensed person providing cares for residents including medication administration, financially exploited resident #1, resident #2, and resident #3 when the AP diverted controlled substances from each resident.

Investigative Findings and Conclusion:

Regarding resident #1 and resident #2 the Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment. The AP diverted controlled substances from resident #1 and resident #2.

Regarding resident #3, the Minnesota Department of Health determined financial exploitation was inconclusive. While the AP documented administration of resident #3's controlled

substances after his death, there is a lack of information of what occurred from then until resident #3's medications were destroyed.

The investigation included interviews with facility staff members, including nursing staff, unlicensed staff, and residents. The investigation included a review of facility incident reports, the facility narcotic book, the resident's record, and the records of other residents who were prescribed narcotic medication in the past year.

Resident #1

Resident #1 resided in an assisted living facility. The resident's diagnoses included Parkinson's disease and chronic pain syndrome. The resident's service plan included services with all personal care, medications, meals, and housekeeping. The resident's medical record indicated the resident was scheduled two times a day for one tablet of oxycodone 5 milligrams (mg) for pain. He also had one tablet of oxycodone 5 mg in addition to his scheduled doses and must be given six hours after the last scheduled dose as needed for pain.

Resident #1 admitted to the hospital on a Monday and discharged on a Tuesday evening to the facility with a bottle of 50 tablets of oxycodone 5mg.

A week later on the following Tuesday, resident #1 's incident report indicated registered nurse #1 reported to the director resident #1's bottle of 48 tablets of oxycodone (a narcotic pain reliever) was missing. The same document indicated the director reported this to the police three days later. The registered nurse #1 's signature space was left empty in the incident report.

The investigator requested resident #1 narcotic log from the facility, but none was provided.

During an interview, unlicensed person #2 stated she reported to registered nurse #1 about the AP signed off she gave resident #1 one tablet of oxycodone when resident #1 was not at the facility. Unlicensed person #2 said she witnessed the AP put resident #1 's oxycodone in the AP's pocket. When she asked the AP what she was doing, she said resident #1 requested pain medication and accidentally put the medication in her pocket. Later after resident #1 returned to the facility, unlicensed person #2 asked resident #1 and he told her he did not ask for pain medication. Unlicensed person #2 confirmed the AP told her she knew about resident # 1's bottle containing 50 tablets of oxycodone. Unlicensed person #2 stated she had caught AP faking her initial in the narcotic count book and reported it to management staff, but she did not know if there was any follow-up.

During an interview, unlicensed person #3 stated she saw the document where the AP signed off, she gave resident #1 one tablet of oxycodone when resident #1 was in the hospital. Unlicensed person #3 stated she reported this to the director.

During an interview, unlicensed person #4 stated there were many incidents in which narcotics (controlled substances) went missing, but this did not seem to get addressed beyond paperwork. Unlicensed person #4 stated she saw the AP using other people's initials to sign in the narcotic book when those people were not working. Unlicensed person #4 stated she took a picture of narcotic book and provided it to management to demonstrate her concerns but when she came back to work the next day, the management staff took all the narcotic books away. Unlicensed person #4 stated she was unaware of any follow-up to this concern.

During an interview, registered nurse #1 stated the AP signed off in the narcotic count book she gave resident #1 one tablet of oxycodone on Tuesday morning, but resident #1 was still in the hospital. Registered nurse #1 confirmed he made note of this incident in the narcotic book and reported it to the director. Registered nurse #1 stated the resident #1 returned to the facility with a bottle of 50 tablets of oxycodone and registered nurse #1 kept it in the medication closet. When he came back to work the next day, he found out two tablets were missing so he took the bottle with the remaining 48 tablets of oxycodone and put it in the nurse's office downstairs to keep it safe over the weekend but did not lock the door. When he returned to work the following Tuesday, he discovered the bottle of 48 oxycodone tablets was missing and he reported to the director. Registered nurse #1 stated he requested the director report this to the police department right away, however the director did not do so until three days later. Registered nurse #1 stated the director needed to report the missing medication so insurance would reimburse resident #1 for the medication.

During an interview, resident #1 stated he took oxycodone as pain killer and sometime staff gave him a different pill. Resident #1 stated he could not recall who because so many people worked there. Resident #1 said the nurse showed him the oxycodone was a small tablet and the one he used to take was a big one like Tylenol. He was concerned that staff did not give him the right medication. Resident #1 stated he did not know about his bottle of oxycodone had gone missing.

During an interview, the AP stated she did not sign off any medication when resident #1 was in the hospital. She stated she did not see resident #1's bottle and only heard about it. The AP stated she did not put any resident's medication in her pocket.

Resident #2

Resident #2 resided in an assisted living facility. The resident's diagnoses included Parkinson's disease and chronic pain syndrome. The resident's service plan included services with all personal care, medications, meals, and housekeeping. The resident's medical record indicated the resident was ordered one tablet of oxycodone-acetaminophen 5 mg- 325 mg by mouth up to two times a day as needed for pain.

A review of the facility's timeclock punch in/punch out documents indicated unlicensed person #1 worked night shifts started at 11:00 p.m. and ended at 7:00 a.m.

The same documents indicated unlicensed person #1, who worked the night shift, punched out of work at the following times on these dates of one month:

- On the 4th at 6:55 a.m.
- On the 5th at 7:06 a.m.
- On the 18th at 7:03 a.m.
- On the 19th at 7:11 a.m.
- On the 20th at 7:04 a.m.

Resident #2's electronic medical administration (EMAR) record indicated unlicensed person #1 documented administering oxycodone-acetaminophen 5 mg-325 mg, on the following occasions in the same month:

- On the 4th at 7:01 a.m.
- On the 5th at 7:44 a.m.
- On the 18th at 7:29 a.m.
- On the 19th at 7:30 a.m.
- On the 20th at 7:24 a.m.

Resident #2's narcotic count log for the same month indicated the AP with medication passing responsibilities, signed out oxycodone-acetaminophen 5 mg-325 mg on the following dates:

- On the 4th at 7:00 a.m.
- On the 5th at 7:15 a.m. and at 7:30 a.m.
- On the 18th at 7:25 a.m.
- On the 19th at 7:30 a.m.
- On the 20th at 7:30 a.m.

A review of the narcotic count log indicated unlicensed person #1's initials did not appear on the 4th, the 5th, the 18th, the 19th, nor the 20th.

The same document indicated the AP removed *two* oxycodone-acetaminophen 5 mg -325 mg on the following date of the same month

- On the 7th at 6:40 a.m.

The resident's EMAR indicated the AP administered *one* tablet oxycodone-acetaminophen 5 mg -325 mg following date of the same month:

- On the 7th at 6:38 a.m.

The investigator requested all resident #2 narcotic logs, and no other narcotic logs were provided.

The investigator requested internal investigation documentation regarding resident #2's medications, however the facility provided no more.

During an interview, registered nurse #1 stated he noticed the AP documented she removed two oxycodone tablets and resident #2 orders were for one tablet. Registered nurse #1 stated he compared resident #2's EMAR to the narcotic count book, which indicated the AP documented administering 20 oxycodone tablets, but the narcotic book indicated she removed 40 tablets from resident #2's supply.

During an interview, the AP stated she was not sure either the oxycodone was ordered three times a day or one tablet every six hours for resident #2. However, she stated she did not give resident #2 two tablets of oxycodone at once.

Resident #3

Resident #3 resided in an assisted living facility. The resident's diagnoses included Parkinson's disease major depressive disorder, and low back pain. The resident's service plan included services with all personal care, medications, meals, and housekeeping. The resident's medical record indicated the resident was ordered scheduled oxycodone 10 mg tabs and lorazepam (an antianxiety medication) 0.5 mg every three hours for comfort care.

Resident #3's nurse's notes indicated resident #3 took his last breath and passed away at approximately 2:07 p.m. written by registered nurse #3.

On the same day, resident #3's electronic medical record indicated the AP signed out and administered the oxycodone 10 mg tabs and lorazepam 0.5 mg at 2:15 p.m.

On the same day, the narcotic count log indicated the AP signed off the oxycodone 10 mg tabs and lorazepam 0.5 mg at 2:15 p.m.

Three days after his death, resident #3's nurses notes written by registered nurse #2 indicated resident #3's medications included eight syringes of lorazepam 0.25 milliliters (ml).

Six days after his death, resident #3's nurses notes written by registered nurse #2 indicated resident #3's medications included five syringes of lorazepam.

The investigator requested all resident #3 narcotic logs, and no other narcotic logs were provided.

Resident #3's incident report indicated three syringes of lorazepam were missing. The same document did not include registered nurse #2's signature but did include registered nurse #3's signature.

The investigator requested internal investigation documentation regarding resident #3's medications, however the facility provided no more.

During an interview, registered nurse #2 stated the facility assigned registered nurse #2 to destroy resident #3's medication after resident #3 died. However, registered nurse #2 found the documentation in the narcotic book was "messy" and it was unclear how many controlled medications resident #3 should have left although she could tell there were three syringes of lorazepam unaccounted for. Registered nurse #2 stated she approached the director with her concerns, but the director told her not to worry and go ahead with the medication destruction.

During an interview, resident #3's family member stated she stayed with him the whole time on the day he passed away. She said he did not take any pain medication before he passed. Resident #3 was lying in bed resting peacefully so there was no reason for him taking pain medication.

During an interview, the AP stated she gave resident #3 pain medication right before he passed away.

The investigation included an attempt to reach registered nurse #3, who worked with resident #3 at that time for an interview, but without success.

During an interview, the director stated she did not have any records of the narcotic count book for resident #1, resident #2, and resident #3. She stated since they switched to a computer system, she could not find the books anywhere. The director stated she did not report any incidents to the Minnesota Adult Abuse Reporting Center (MAARC) website even though she knew she should have. The director stated she did not know about the incident which AP sign off the medication when resident #1 was in the hospital until later and was not sure what they did for investigation and deferred to the human resource director (HRD). Regarding the resident #1's missing bottle of oxycodone, the director stated the HRD did an investigation and interviewed all the staff members who worked over the weekend. The director stated the interviews indicated no one saw the bottle besides registered nurse #1. The director stated she thought neither registered nurse #1 nor the AP took the resident #1's bottle of oxycodone but rather she suspected resident #1 took it and hid it in his room. The director stated HRD did a room search but found nothing. The director confirmed she reported resident #1's missing bottle of oxycodone three days after it was reported to her.

During an interview, the HRD stated she aware of the incident which the AP signed off the medication when resident #1 was in the hospital. The HRD states she was not herself a registered nurse and it was not her responsibility to do the investigation. The HRD stated it was registered nurse #1's responsibility to follow up, so she did not know what he did. Regarding resident #1's missing bottle of oxycodone, HRD stated she did an investigation, but she did not identify anyone who saw the bottle of oxycodone and the search of resident #1's room found nothing. The HRD stated she did not know who took resident #1's bottle of oxycodone.

In conclusion, the Minnesota Department of Health determined financial exploitation was substantiated regarding resident #1 and resident #2. The AP was responsible for the maltreatment.

Regarding resident #3, the Minnesota Department of Health determined financial exploitation was inconclusive.

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.

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;
(2) obtains for the actor or another the performance of services by a third person for the wrongful profit or advantage of the actor or another to the detriment of the vulnerable adult;
(3) acquires possession or control of, or an interest in, funds or property of a vulnerable adult through the use of undue influence, harassment, duress, deception, or fraud; or
(4) forces, compels, coerces, or entices a vulnerable adult against the vulnerable adult's will to perform services for the profit or advantage of another.

Vulnerable Adult interviewed:

- Resident #1: Yes
- Resident #2: Yes
- Resident #3: No (deceased)

Family/Responsible Party interviewed:

- For resident #1: Yes
- For resident #2: Yes
- For resident #3: Yes

Alleged Perpetrator interviewed: Yes

Action taken by facility:

None.

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 651-201-4890 to receive a copy via mail or email

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

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Hennepin County Attorney
Bloomington City Attorney
Bloomington Police Department
Minnesota Board of Executives for Long Term Services and Supports
Minnesota Nursing Assistant Registry

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24675	A. BUILDING: _____ B. WING _____	C 11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST BLOOMINGTON RESIDENCE	10441 JOHNSON AVENUE SOUTH BLOOMINGTON, MN 55437

(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 Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.10 to 144G.93, the Minnesota Department of Health issued correction orders pursuant to an 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: HL246751542M / HL246752937C HL246753726M / HL246756114C HL246753725M / HL246756113C On October 24, 2022, the Minnesota Department of Health initiated an investigation of complaint #HL246751542M /HL246752937C, HL246753726M/HL246756114C, and HL246753725M/HL246756113C. At the time of the investigation, there were 2 residents receiving services under the Assisted Living license. During the course of the investigation, an immediate order for corrrection was issued for HL246751542M /HL246752937C at tag identification at 1290 on November 3, 2022.	0 000	The Minnesota Department of Health documents the State Licensing 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that 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. Per Minnesota Statute §144G.30, Subd. 5 (c), the assisted living facilities must document any action taken to comply with the correction order. A copy of the provider ' s records documenting those actions may be requested for follow-up surveys. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider ' s Plan of Correction." The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144G.31, Subd. 2 and 3.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24675	A. BUILDING: _____ B. WING _____	C 11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST BLOOMINGTON RESIDENCE	10441 JOHNSON AVENUE SOUTH BLOOMINGTON, MN 55437

(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	Continued From page 1 The following additional correction orders are issued for #HL246751542M /HL246752937C, HL246753726M/HL246756114C, and HL246753725M/HL246756113C tag identification 0620, 0750, and 1880. The followeing correction order is issued for HL246751542M /HL246752937C and HL246753726M/HL246756114C tag identification at 2360.	0 000		
0 620 SS=F	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma 144G.42 Subd. 6. Compliance with requirements for reporting maltreatment of vulnerable adults; abuse prevention plan. (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. This MN Requirement is not met as evidenced by: Based on document review and interview, the licensee failed to comply with the requirements for reporting suspected maltreatment of vulnerable adults to the Minnesota Adult Abuse Reporting Center (MAARC) for three of three residents (R1, R2, R3). In addition, the licensee failed to complete a thorough investigation following three of three, (R1, R2, R3) reportable events. 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	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24675	A. BUILDING: _____ B. WING _____	C 11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST BLOOMINGTON RESIDENCE	10441 JOHNSON AVENUE SOUTH BLOOMINGTON, MN 55437

(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
0 620	Continued From page 2 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 was admitted on March 3, 2022, with diagnoses which included Parkinson's disease and chronic pain syndrome. R1 was admitted to the hospital on March 28 and was discharged back to the house late evening of March 29. R1 later was discharged to another facility on July 1, 2022. R2 was admitted on June 30, 2020, with diagnoses which included Parkinson's disease and chronic pain syndrome. R2 was discharged on April 14, 2022. R3 was admitted on September 24, 2019, with diagnoses which included Parkinson's disease, major depressive disorder, and low back pain. R3 was in hospice and passed away on August 17, 2021. When interviewed on October 25, 2022, at 12:13 p.m., registered nurse (RN)-A stated he saw in the narcotic count book, unlicensed personnel (ULP)-B signed off that she gave R1 one tablet of oxycodone in the morning of March 29 when R1 was not in the house. R1 was still at the hospital at that time. He confirmed he made note of that incident in the narcotic book and reported it to the Licensed Assisted Living Director (LALD). When R1 came back later that evening, he had a bottle of 50 tablets of oxycodone with him. RN-A stated he kept it in the medication closet. When he	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24675	A. BUILDING: _____ B. WING _____	C 11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST BLOOMINGTON RESIDENCE	10441 JOHNSON AVENUE SOUTH BLOOMINGTON, MN 55437

(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
0 620	Continued From page 3 came back to work a few days later, he found out two tablets were missing. Therefore, he took a bottle containing 48 tablets of oxycodone and put it in the nurse's office downstairs to keep it safe over the weekend. He confirmed he did not lock the door. He reported R1's incident to LALD on April 5, 2022. When interviewed on October 25, 2022, at 12:43 p.m., RN-A stated on September 7, 2021, in R2's narcotic count book, ULP-B signed off two tablets of oxycodone as needed for R2 during an eight-hour shift. However, per R2's order, she was supposed to have one tablet every 6 hours. He compared the computer system against the narcotic count book. The computer system showed ULP-B signed off 20 tablets but in the narcotic count book, she signed off 40 tablets. When interview on October 25, 2022, at 2:44 p.m., ULP-E confirmed she saw the document where ULP-B signed off she gave R1 one tablet of oxycodone when R1 was not in the house. She reported it to LALD. ULP-E confirmed she did not see any of R1's bottle of medication when he was back from the hospital. When interview on October 26, 2022, at 3:26 p.m., ULP-D stated she reported to RN-A about ULP-B signed off she gave R1 one tablet of oxycodone when R1 was not in the house. When interviewed on October 27, 2022, at 2:03 p.m., RN-G stated she worked for an agency, and it was the 1st time she was there. She showed the text message when she asked the nurse manager (NM) to help with destroying medication and no response from NM . She said she was uncomfortable beacuse she was asked to destroy R3 medication when she had nothing to compare.	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24675	A. BUILDING: _____ B. WING _____	C 11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST BLOOMINGTON RESIDENCE	10441 JOHNSON AVENUE SOUTH BLOOMINGTON, MN 55437

(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
0 620	Continued From page 4 She stated she did not know how many medications R3 was supposed to have left to destroy. The narcotic book was so messy, she could not know what was going on by looking at them. The only she knew there were three syringes of lorazepam missing. She reported it to LALD. LALD told her not to worry and went ahead destroy them. She felt pressured to destroy the medication with no support from LALD or the NM. RN-G stated the NM refused to destroy the medication with her, so she had to do it with a ULP. After she destroyed the medication, she filed a report with her agency and emailed it to LALD. She confirmed that was the last time she worked there. When interview on November 2, 2022, at 8:31 a.m., LALD stated she did not have any records of narcotic count book in March for R1, in September for R2, and in August for R3. She stated since they switched to a computer system, she could not find the books anywhere. She confirmed she did not report any incidents to the MAARC website even though she knew she should have. R1's incident report dated April 5, 2022, indicated the incident of a bottle of 48/50 oxycodone were missing from the nurse's office. RN's signature space was left empty. R3's incident report dated August 23, 2022, indicated the incident of three syringes of lorazepam were missing. RN-G's signature was not in the document. The facility had no further investigation regarding R2's incident nor R3's missing syringes. The licensee's Vulnerable Adult Maltreatment	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24675	A. BUILDING: _____ B. WING _____	C 11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST BLOOMINGTON RESIDENCE	10441 JOHNSON AVENUE SOUTH BLOOMINGTON, MN 55437

(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
0 620	Continued From page 5 Policy dated August 1, 2021, indicated for reporting maltreatment any staff person who witnesses, or suspects maltreatment of a vulnerable adult (VA) would immediately report the incident to their assisted living director and that person would complete an incident report. If the incident appears to be suspected abuse, neglect, or financial exploitation, assisted living director/regional nurse would immediately make a report to the CEP (common entry point). MAARC website was indicated on the policy. "Immediately" means as soon as possible, but no longer than 24 hours from the time the assisted living director/registered nurse received initial knowledge that the incident occurred. If it appears at any time a crime may have been committed, assisted living director/regional nurse would immediately contact the police if the witness had not already done so. Internal Investigation: staff would complete an incident report. The LALD, or designee would complete an internal investigation pertaining to the report of potential or suspected maltreatment. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
0 750 SS=C	144G.43 Subd. 5 Record retention Following the resident's discharge or termination of services, an assisted living facility must retain a resident's record for at least five years or as otherwise required by state or federal regulations. Arrangements must be made for secure storage and retrieval of resident records if the facility ceases to operate. This MN Requirement is not met as evidenced by:	0 750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24675	A. BUILDING: _____ B. WING _____	C 11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST BLOOMINGTON RESIDENCE	10441 JOHNSON AVENUE SOUTH BLOOMINGTON, MN 55437

(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
0 750	Continued From page 6 Based on the interview and record review, the licensee failed to retain the residents' records following the residents' discharge or termination of services, for the licensee's three residents (R1, R2, and R3) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 started receiving services under the assisted living license on August 1, 2021, and discharged on July 1, 2022. R2 started receiving services under the assisted living license on August 1, 2021, and discharged on April 14, 2022. R3 started receiving services under the assisted living license on August 1, 2021, and passed away on August 17, 2021. On November 1, 2022, at 5:23 p.m., the Licensed Assisted Living Director (LALD) stated she did not have the records of narcotic book count for R1, R2, and R3. She said they switched to computer system charting recently and she cannot find any hard copies of narcotic books. The licensee's Retention of Resident Records policy dated July 14, 2021, noted the resident record would be retained for at least five years following the resident's transfer or termination of	0 750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24675	A. BUILDING: _____ B. WING _____	C 11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST BLOOMINGTON RESIDENCE	10441 JOHNSON AVENUE SOUTH BLOOMINGTON, MN 55437

(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
0 750	Continued From page 7 services. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 750		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a background study was submitted and received for three of four employees (unlicensed personnel (ULP)-A, ULP-B, ULP-C) with employee records reviewed. 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 a widespread scope (when problems	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24675	A. BUILDING: _____ B. WING _____	C 11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST BLOOMINGTON RESIDENCE	10441 JOHNSON AVENUE SOUTH BLOOMINGTON, MN 55437

(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
01290	Continued From page 8 are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-A was hired on March 22, 2016, to provide direct care and services to the licensee's residents under the comprehensive home care license and began providing services under the assisted living licensure on August 1, 2021. On October 24, 2022, at approximately 11:54 a.m., the surveyor observed ULP-A provide medications to a resident. ULP-A's employee record lacked documentation of a submitted and received background study prior to ULP-A providing care and services to the residents. On November 2, 2022, at approximately 9:30 a.m., licensed assisted living director (LALD) confirmed via the phone she did not do the background check for ULP-A, ULP-B and ULP-C. She said ULP-B was hired on September 10, 2022, and ULP-C was hired on March 21, 2022. A policy regarding background checks was requested but not provided. TIME PERIOD FOR CORRECTION: Immediate	01290		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24675	A. BUILDING: _____ B. WING _____	C 11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST BLOOMINGTON RESIDENCE	10441 JOHNSON AVENUE SOUTH BLOOMINGTON, MN 55437

(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
01880	Continued From page 9 permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were properly stored and secured. This had the potential to affect all residents in the facility. 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: During an observation on October 24, 2022, at 11:56a.m., the investigator observed a key hanging on the wall to the left corner of the closet right next to the kitchen and in front of the garage entry way. On October 24, 2022, at 12:02 p.m., the investigator asked unlicensed person (ULP)-B was asked to open the narcotic cabinet for viewing. ULP-B unlocked and opened the medication closet and used the same key hanging inside the door observed at 11:56 a.m. to open the narcotic box. ULP-B verified the second container should always be locked. ULP-B stated the facility kept all the medication(s) in the closet right at the front entry and confirmed the key was hung right next to it. She said the facility only have two residents at this time, so she did not have any problem with anyone get into the	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24675	A. BUILDING: _____ B. WING _____	C 11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST BLOOMINGTON RESIDENCE	10441 JOHNSON AVENUE SOUTH BLOOMINGTON, MN 55437

(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
01880	Continued From page 10 medication closet. ULP-B stated there was locked box in the closet for narcotics and the key to open the narcotic box was hung inside the door of the closet. On November 2, 2022, at 8:31 a.m., the Licensed Assisted Living Director (LALD) confirmed the key to the medication closet was hung next to it. She said she installed the camera and sound sensor in front of the medication closet so she would know if someone tried to steal the medications. The licensee's policy titled Storage of Medications, dated July 14, 2021, indicated medications managed must be in securely locked and constructed compartments and permit only authorized personnel to have access. Schedule drugs will be stored under a double lock system and stored separately from other medications. TIME PERIOD FOR CORRECTION: Seven (7) days.	01880		
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 two of three residents reviewed (R1, R2 and R3) were free from maltreatment. R1 nd R2 were maltreated. The investigation regarding R3 was inconclusive. Findings include:	02360	No plan of correction is required for tag 2360. Please refer to the public maltreatment report for details.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24675	A. BUILDING: _____ B. WING _____	C 11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST BLOOMINGTON RESIDENCE	10441 JOHNSON AVENUE SOUTH BLOOMINGTON, MN 55437

(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
02360	Continued From page 11 The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual staff person was responsible for the maltreatment, in connection with incidents which occurred at the facility.	02360		