Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL302844121M
Compliance #: HL302844781C

Date Concluded: November 19, 2024

Name, Address, and County of Licensee Investigated:
Amira Choice Champlin
119 East Hayden Lake Road 144
Champlin, MN 55316
Hennepin County

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

Evaluator's Name: James Larson, RN
Special Investigator

Finding: Not Substantiated

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

Initial Investigation Allegation(s):
The facility neglected the resident when they failed to administer scheduled medications as prescribed.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. There was not a preponderance of evidence to support that the actions of facility staff met the definition of neglect. Although a medication error occurred, when staff became aware of the error, the resident was assessed and monitored and returned to their baseline health condition.

The investigator conducted interviews with facility staff members, including administrative staff and nursing staff. The investigation included review of the resident record, death record, facility internal investigation documentation, personnel files, staff schedules, and facility policies and procedures. The investigator also toured the facility, observed staff members interacting with residents, and medication administration.

The resident resided in an assisted living facility memory care unit with a diagnosis of dementia. The resident's service plan included assistance with housekeeping, laundry, medication administration, and

safety checks. The resident's assessment indicated that the resident was independent with most activities of daily living but required queuing and reorientation to place and situation as needed.

During a routine medication pass, a facility staff member noticed a discrepancy between the amount of available medication and the medication count log and reported this information to the nurse. The nurse initiated an audit of the available medication and medial record documentation and identified that an incorrect dose of the medication had been administered.

The nurse contacted the resident's hospice provider who directed to withhold additional medication administration and closely monitor the resident for signs of distress. The resident returned to his baseline condition without need for hospitalization. The resident remained at the facility and received hospice care until he passed away the following week.

An internal investigation completed by the facility identified that on four separate occasions, over a two-day period, an unlicensed staff member administered the resident's Morphine (narcotic pain medication) incorrectly. This oversite resulted in the resident receiving a dose three times greater than that which was ordered.

During an interview, a facility administrator stated that one of the unlicensed personnel identified in the internal investigation had a documented history of not following facility policy and procedures relating to medication administration but was reeducated and deemed competent by the nurse four months prior to the incident. Upon completion of the internal investigation the unlicensed personnel was dismissed.

During investigative interviews, multiple nursing staff members stated that a physician's order for morphine was updated days before the medication error occurred and there were inconsistencies in the process between the processing and verification of the physician's order between the facility and the pharmacy. Nursing staff also acknowledged errors within the facility's system of documentation of receipt of narcotic medication from the pharmacy and narcotic count and storage processes.

Further review of the medication administration record for this resident also identified on at least two other occasions, additional facility staff may have administered the resident's morphine at incorrect times or incorrect dosages.

During an interview with a family member of the resident, she could not recall specific details of the incident but felt the facility handled the situation appropriately. The family member did not have further concerns with the care provided by the facility's licensed staff.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

"Not Substantiated" means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means neglect by a caregiver or self-neglect.

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

Vulnerable Adult interviewed: No, deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility conducted an internal investigation. As a result, an unlicensed staff member’s employment was terminated, and all facility staff received additional training regarding medication administration process and procedure.

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
	30284	A. BUILDING: _____ B. WING _____	C 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMIRA CHOICE CHAMPLIN	119 EAST HAYDEN LAKE ROAD CHAMPLIN, MN 55316

(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: #HL302844781C/#HL302844121M On September 17, 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 80 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL302844781C/#HL302844121M, tag identification 1690 and 1760.	0 000	Assisted Living Provider 144G. Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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01690	Continued From page 1	01690		
01690 SS=F	144G.71 Subdivision 1 Medication management services (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and	01690		

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01690	Continued From page 2 implement policies and procedures to ensure security and accountability for the overall management, control, storage, and disposition for controlled substances in compliance with state and federal regulations and with subdivision 23. 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) 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: A complaint investigation was initiated on September 17, 2023. On September 17, 2024, during interview with licensed practical nurse (LPN)-F in her office, LPN-F presented the investigator a locked plastic container filled with several narcotic medication cards for inspection. LPN-F stated it contained discontinued and expired narcotic medication awaiting disposition and disposal. LPN-F failed to identify how long the container had been full or when the last time it had been emptied. LPN-F failed to recall what the facility policy was or what the policy stated for timeline for disposal once medication was placed in this container. LPN-F could not provide or describe the process in place for disposition of medication or who was responsible for the disposition of the medications at the facility. LPN-F could not provide information on a system of monitoring or tracking the disposition of medications. During an interview on September 17, 2024,	01690		

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01690	Continued From page 3 registered nurse (RN)-D stated that after having a discussion with the current director of nursing (DON)-B she was informed that the facility had on June 5, 2024, reverted back to a outdated process for accountability of narcotic medication which involved individual worksheets and did not follow current facility policy. RN-D went on to state that facility staff failed to document the correct narcotic count using the individual worksheets into the correct page of the narcotic logbooks. RN-D confirmed that the process in place was not being implemented by facility staff. During further investigation observations on September 17, 2024, RN-D was asked to review the facility medication storage process along with one of the narcotic logbooks stored on the medication carts. RN-D stated the facility failed to document the narcotic count as outlined in the facility policy and had failed to consolidate the medication count in the logbook with the entries made in the electronic health records. RN-D confirmed the narcotic medication counts were not documented or monitored accurately by facility staff. The licensee's Controlled Substances/ Schedule II - V Drugs policy dated June 1, 2022, stated all reasonable precautions will be taken to mitigate the theft, diversion or misuse of controlled substances and will comply with requirements regarding the safe storage and disposal of these drugs. All Narcotics Received: A. The controlled substances/Schedule II - V medications will then be recorded in bound narcotic book for tracking and placed in a designated locked compartment separate from	01690		

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01690	Continued From page 4 containers for non-controlled medications. Each storage area needs its own controlled medication record along with a count book. o All narcotics will be tracked in a Nurse only controlled medication record book B. The bound narcotic book is retained for 2 years after last entry. C. It will be the responsibility of the Director of Health Services to ensure proper adherence this practice. D. Each Narcotic Book will be labeled alphabetically in sequence example: A, B, C E. When the nursing office receives a Controlled Substance for a client the medication is checked to ensure the medication, dosage, and instructions for use matches the Doctor's order F. The nurse then signs the Medication into Narcotic Book : o Identify the first available index line starting with the alphabet "A" Narcotic Book o Fill in each column with the information corresponding to the Controlled Substance: o Client's Name o Physician o Drug-Rx Number. o In the column, titled Date Started, put the date that the medication was received into the Nurse's Office o Open the book to the page number that corresponds with the index number o Fill in the information at the top the page OR put a sticker that was sent with the medication from pharmacy at the top of the page with the following information: o Client's Name o Name of Medication o Prescribing Physician o Directions o Route of Administration	01690		

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01690	Continued From page 5 o Date Received o Quantity Received o On the Medication label write the alphabet letter of the book and the page number: for example A7 o The Medication is then "checked in" and remains in the double locked Narcotic cabinet in the nursing office until the client needs the medication The licensee's Controlled Substances/ Schedule II - V Drugs policy dated December 2, 2020 stated Disposition Of Medication/ Legend And Controlled Substances states Unused portions of controlled substances and legend drugs remain in the housing with services establishment after client death or discharge, or any controlled substance or legend drugs permanently discontinued, will be destroyed according to current regulations from State and federal entities and the Minnesota Board of Pharmacy. 1. Disposition of Unused or Discontinued Prescription (Legend) Drugs A. Prescription drugs remaining at the assisted living after death or discharge of a client for whom the drug was prescribed, or any prescription drug permanently discontinued will be destroyed as Hazardous Waste (HW). The collection containers will be kept in a designated area. Environmental Services will pick up the container and transfer the contents lo the hazardous waste container on a regular basis, but no less than monthly. The transporter will provide empty containers, if part of contract, when the full containers are picked up. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01690		

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01760	Continued From page 6	01760		
01760 SS=G	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure medications were administered and documented as ordered for one of one resident (R1) when R1's narcotic medication was not administered as ordered on four seperate occasions over a two day period resulting in R1 becoming lethargic and unresponsive. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	01760		

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01760	Continued From page 7 The findings include: R1's admitted to the facility on August 22, 2022, with diagnoses that included Dementia, chronic obstructive pulmonary disease (COPD), and bladder cancer. R1's service plan dated May 9, 2024, included assistance with activities of daily living (ADLs), housekeeping, laundry, medication administration, and safety checks. R1's assessment dated May 5, 2024, indicated R1 was independent with most activities of daily living although required queuing and reorientation to place and situation as needed. R1's electronic health record (EHR) was reviewed and included a progress note entered by a registered nurse (RN) on June 3, 2024, which indicated an order for Morphine was received by the facility from the Hospice provider as follows: Morphine 15 mg (milligram) Solutab; give 1 solutab by mouth QID (four times a day) for pain. Morphine 15mg Solutab; give 1 solutab by mouth Q (every) 3 hours PRN (as needed) for pain. A review of R1's June 2024 month long medication administration record (MAR) included, but not was limited to, the following active orders on June 7 and June 8, 2024, for scheduled medication: MORPHINE SULFATE 5MG SOL TAB (MORPHINE SULFATE 5MG SOL TAB) 3 TABLETS (5MG) ORALLY OR SUBLINGUALLY 4 TIMES DAILY CONTROLLED MEDICATION. STORED IN DOUBLE LOCKED STORAGE. Effective June 3, 2024, to be given at 8AM, 12PM, 4PM and 8PM.	01760		

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01760	Continued From page 8 R1's June 2024 MAR indicated medication administration errors occurred on the following dates and times: - June 7, 2024, at 9:00 a.m., -June 7, 2024, at 12:00 p.m. - June 8, 2024, at 9:00 a.m. - June 8, 2024, at 12:00 p.m. On these dates and times ULP-G documented on the MAR that R1 was administered three 5 milligrams (MG) tablets of Morphine Sulfate; however, when compared to R1's Morphine medication card signed by ULP-G on June 7 and 8th, ULP-G had administered three 15mg Morphine tablets from another supply. Further review of R1's June 2024 MAR indicated additional medication administration errors occurred on the following dates and times: -June 7, 2024, at 9:14 p.m. -June 7, 2024, at 10:34 p.m. -June 8, 2024, at 7:00 a.m. ULP-G and ULP-H documented administering as needed (PRN) doses of Morphine Sulfate at intervals less than that of every three hours as ordered in addition to the scheduled doses (inaccurately) administered. Review of R1's Progress Notes dated June 5, 2024, 1:48 p.m. described the resident as agitated, and restless. The following day on June 6, 2024, at 9:45 a.m. staff documented the resident as combative. Review of R1's Progress Notes on June 10, 2024, at 5:36 p.m. that on June 9, 2024, that the resident now remained lethargic and too sedated to take in anything orally, and now when asleep was not responsive to stimuli. R1's record indicated that staff alerted the primary care provider, and an order was placed to hold further	01760		

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01760	Continued From page 9 administration of Morphine until the resident became more alert. The resident passed six days later on June 14, 2024. During an interview on September 17, 2024, RN-D stated that an internal investigation by the facility identified that on four separate occasions, June 7, 2024, at 9:00 a.m., June 7, 2024, at 12:00 p.m. June 8, 2024, at 9:00 a.m. and June 8, 2024, at 12:00 p.m., ULP-G administered three 15mg Morphine tablets to R1 after having retrieved the drug from an incorrect morphine medication card. This oversite resulted in R1 receiving a morphine dose three times greater than that which was ordered on four separate occasions over a two-day period. RN-D went on to state that during the internal investigation by the facility it was also identified that on June 7, 2024, at 9:14 p.m., June 7, 2024, at 10:34 p.m., and June 8, 2024, at 7:00 a.m. ULP-H and ULP G each administered an additional PRN dose of Morphine 15mg tablet to R1. This resulted in R1 receiving a PRN dose of Morphine at intervals at less than that of every three hours as needed in addition to the already scheduled (inaccurately administered) doses. During an interview on September 17, 2024, the licensed assisted living director (LALD)-A stated that at the conclusion of the internal investigation ULP-G was terminated. During an interview on September 17, 2024, at 2:50 p.m. ULP-H recalled that at the beginning of the evening shift on June 9, 2024, she was told at approximately 3:00 p.m. that R1 was not having a good day and that he had a change in condition. She stated that it was reported to her that R1 had remained unresponsive throughout the day.	01760		

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01760	Continued From page 10 The licensee's undated internal investigation dated indicated that R1 recieved three times the prescribed dose of Morphine four times; twice on June 7th and twice on June 8th 2024. The investigation indicated that this occurred due to the MAR and the medication supply and directions on the medication supply did not match and R1's June 2024 MAR stated give 3 of 5 mg tabs to equal a 15mg dose QID. The medication supply (bubble pack) stated to give 1 15mg tab to equal 15mg dose QID. The summary of the investigation indicated that the pharmacy delivered the medication supply in 15mg tabs and not 5mg tabs and that the nurse who recieved the medication and added the medication to the cart did not check the card with the MAR and did not catch the difference in medication supply versus what was documented in the MAR. The summary also indicated there were scheduled dose medication cards in the medication cart along with PRN dose cards with 5mg tablets. The internal investigation indicated that due to the medication error and excess dosage of morphine, R1 was lethargic, not responsive to stimuli. The internal investigation also identified concerns with the process of verifying orders from the pharmacy as a nurse had ended the order and no follow-up was completed. The investigation notes and correspondance with the facility and corporate office indicated action needed to be taken to review prn medications, prn narcotic medications, and staff required education. The licensee's Medication and Treatment Implementation Policy dated August 1, 2021, states The RN will update any client records and service plan as necessary to reflect a new order or prescription. If a new order or prescription will require that unlicensed staff follow a new procedure, the RN will develop written	01760		

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(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 11 instructions and will train staff and evaluate staff competency to carry out any delegated medication administration task or treatment that is new. The RN is responsible for assuring that the prescriptions and orders have been implemented appropriately through client monitoring, supervision of staff and review of client records. The licensee's Medication Administration and Documentation of As Needed (PRN) Medications dated August 1, 2021, states as needed (PRN) medications will be administered consistent with the parameters specified in the prescriber's prescription and with the procedures identified by the Registered Nurse (RN) for the administration and documentation of the PRN. No further information was provided. TIME PERIOD FOR CORRECTION: Seven days (7) days	01760		