

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL30425001M Date Concluded: April 26, 2022

Compliance #: HL30425002C

Name, Address, and County of Licensee

Investigated:

Pathstone Crossing 718 Mound Avenue Mankato, MN 56001 Blue Earth County

Facility Type: Assisted Living Facility with

Dementia Care (ALFDC)

Evaluator's Name: Erin Johnson-Crosby, RN

Special Investigator

Finding: Substantiated, facility responsibility

Nature of Visit:

Vulnerable adult investigations:

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.

Allegation(s): It is alleged: The facility and the alleged perpetrator (AP) neglected the resident when the resident did not receive his diabetes-related services, including blood glucose checks and insulin resulting in hyperglycemia requiring emergency treatment.

Investigative Findings and Conclusion:

Neglect was substantiated. The facility was responsible for the maltreatment. The facility did not ensure the AP, who was unlicensed personnel (ULP), was competent to administer medications including insulin administration or perform blood sugar checks.

The investigation included interviews with facility staff members, including nursing staff, and unlicensed staff. The investigator also made observation of resident cares and medication administration. The investigator reviewed the resident's record, hospital records and AP's employee file.

The resident resided in memory care with current diagnoses of dementia, diabetes, and hypertension (high blood pressure). The resident's service plan indicated the resident required assistance with all activities of daily living (ADLs) including dressing, grooming, medication administration, fasting blood glucose four times daily, and insulin administration three times daily as well as assistance with transferring in and out of bed.

The resident's Medication Incident Report indicated the resident did not receive scheduled Novolog (short acting insulin) 16 units at 8:00 a.m. and had cognitive changes. The same document indicated the AP admitted she did not give the resident the ordered medication. The same document indicated contributing factors included the AP was unfamiliar with the medication cart, was a new employee, and arrived late for her shift.

The resident's medication administration record (MAR) indicated the AP did not administer any of the resident's morning medications, which included Tresiba (long-acting insulin) 22 units, Novolog 16 units (short acting insulin). The same document indicated the AP did not complete a blood sugar check and sliding scale (extra insulin given based on blood sugar check).

The same document indicated the AP did not complete the ordered blood sugar check at noon or administer Novolog 16 units with sliding scale based on blood sugar.

The resident's progress notes on the day of the incident indicated the resident had a blood sugar of 493, pulse of 27, and oxygen saturation of 82%, and staff were unable to obtain a blood pressure. The same document indicated the resident became increasingly unresponsive, and staff called emergency medical services (EMS) for transportation to the hospital.

The hospital records indicated the resident transported to the hospital for hyperglycemia (high blood sugar) and was starting on an insulin drip. The same document indicated when the resident arrived at the hospital the resident had complete heart block. The hospital offered a pacemaker, but the resident declined the intervention due to personal preference.

The AP's employee record included clinical orientation skills check off list which indicated the AP passed skills including blood glucose testing, insulin pen administration, sliding scale insulin administration and medication administration. While this document included a signature of licensed practical nurse (LPN), it lacked the AP's signature. The AP's employee record did not include documentation of written or oral tests or return demonstration of skills. The AP's employee record did not contain any re-education or training regarding medication administration, blood sugar checks or insulin administration after this incident.

During an interview, the AP said the day of the incident she was still in training and was on a medication cart she had not received training on. The AP said the facility was short staffed, and she offered to work a double shift from 6:00 a.m. to 10:30 p.m. The AP said she got behind on passing medications and asked the ULP that came in at 2:00 p.m. for assistance. The AP said

when she and ULP went into the resident's room he was unresponsive and had a high blood sugar. The AP also said she had never administered insulin or completed a blood sugar check before and wanted to see how to do it. The AP said she should have administered the resident's Novolog insulin 15 minutes before meals. The AP said did not remember if the resident ate breakfast and noon meal without a blood sugar check and scheduled insulin. The AP said she did not receive any medication training including blood sugar checks or insulin administration from the licensed practical nurse (LPN) or registered nurse (RN) after this incident.

During an interview, the ULP said she arrived to work around 2:00 p.m. the day of the incident. The ULP said at 2:15 p.m., the AP told the ULP the AP had missed some medications. The ULP went and checked what medications the AP missed, and the ULP noticed the AP missed many medications for different residents including the resident's blood sugar check and insulin. The ULP was concerned since she knew the resident was a diabetic. The ULP said she and the AP went and checked on the resident and he was not responding, and his eyes were rolling around. The ULP called the RN triage and EMS transported the resident to the hospital.

During an interview, RN#1 said she worked on the day of the incident at 3:00 p.m., when she arrived the ambulance was enroute. RN#1 said when she arrived the resident started to throw up. RN#1 said the resident was still alert and responding when emergency medical technicians (EMTs) arrived. RN#1 said after the incident RN#1 instructed the AP on the six rights of medication administration and RN#1 moved the AP to different cart to administer medication for the evening shift. RN#1 said she did not contact the director about this incident. RN#1 was not aware other residents did not receive their scheduled medications on the date of the incident.

During an interview, the director of nursing (DON) said The DON said the AP admitted she did not give any scheduled medications, including blood sugar checks and insulin administration during the morning and noon medications pass for the resident. The DON said the AP lacked training for her assigned medication cart. The DON said the AP did not communicate to other co-workers she was behind on tasks.

During an interview, the nurse practitioner said there was not a connection between the resident's heart block and the omitted medications and insulin.

In conclusion, neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.

"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17

"Neglect" means:

- (a) 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.
- (b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Vulnerable Adult interviewed: Yes

Family/Responsible Party interviewed: Yes

Alleged Perpetrator interviewed: Yes

Action taken by facility:

No action taken

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

Or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

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
Blue Earth County Attorney
Mankato City Attorney
Mankato Police Department

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		 ` ´	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING			
		30425	B. WING		02/1	5/2022
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0 000	Initial Comments		0 000			
	Initial comments ******ATTENTION** ASSISTED LIVING CORRECTION ORI In accordance with 144G.08 to 144G.99 issued pursuant to a Determination of whrequires compliance provided at the state When a Minnesota items, failure to combe considered lack INITIAL COMMENT #HL30425002C/#H On February 15, 20 Department of Heal investigation at the following correction of the complaint inv residents receiving Assisted Living with The following correct #HL30425002C/#H	PROVIDER LICENSING DER Minnesota Statutes, section 5, these correction orders are a complaint investigation. nether a violation is corrected with all requirements ute number indicated below. Statute contains several apply with any of the items will of compliance. TS: L30425001M 22, the Minnesota of the conducted a complaint above provider, and the orders are issued. At the time estigation, there were 117 services under the provider's Dementia Care license. ction orders are issued for L30425001M, tag		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal so Tag numbers have been assigned Minnesota State Statutes for Assis Living Facilities. The assigned tag number appears in the far left coldentitled "ID Prefix Tag." The state number and the corresponding textate Statute out of compliance is the "Summary Statement of Deficicolumn. This column also includes findings which are in violation of the requirement after the statement, "Minnesota requirement is not met evidenced by." Following the evaluation for Corplease DISREGARD THE HEALTHE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION STATUTES. THE LETTER IN THE LEFT COLUMN.	oftware. to sted Jumn Statute of the listed in encies" s the le state This as lators' rection. ON FOR TATE	
	identification 0620, 2360.	0740, 1360, 1750, 1760, and		THE LETTER IN THE LEFT COLU USED FOR TRACKING PURPOS REFLECTS THE SCOPE AND LE ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	ES AND	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

STATE FORM 6899 If continuation sheet 1 of 22 OZY011

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	l \ '	E SURVEY PLETED
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	for reporting maltre abuse prevention p (a) The assisted live the requirements for maltreatment of vulces of the facility implement a written cases of suspected. This MN Requirement by: Based on interview licensee failed to resimmediately (no long Minnesota Adult Abustines).	ing facility must comply with				
	violation that did not safety but had the president's health or cause serious injury was issued at an is limited number of real limited number of	ed in a level two violation (a tharm a resident's health or otential to have harmed a safety, but was not likely to y, impairment, or death), and olated scope (when one or a esidents are affected or one or staff are involved or the red only occasionally).				
	The findings include	e:				
	diagnoses of deme hypertension (high plan dated January required assistance (ADLs), including d administration, fast	ory care with current ntia, type 2 diabetes, and blood pressure). R1's service 4, 2022, indicated R1 with all activities of daily living ressing, grooming, medication ing blood glucose four times ministration three times daily.				

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	•	sistance with transferring in required a wheelchair for				
	at 2:54 p.m., indicated 493, pulse of 27, and and staff were unable R1 became increase.	s dated December 25, 2021, ted R1 had a blood sugar of nd oxygen saturation of 82%, ble to obtain a blood pressure. singly unresponsive, and staff nedical services (EMS) for pital.				
	dated December 25 personnel (ULP)-B morning medication dry eye, aspirin 81 r (antidepressant) 20 donepezil (cognitio fiber-tabs 625 mg, I 20 mg, memantine metoprolol succinat mg, refresh eye dro retention) 0.4 mg, T units subcutaneous acting insulin) and sigven based on blood sugar check. ULP-B did not component at a sliding scale based. On March 2, 2022, nurse (RN)-D said signed medication error that 2021, but did not reher supervisor. RN-	Iministration record (MAR) 5, 2021, indicated unlicensed did not administer R1's is including: artificial tears for milligrams (mg), citalopram mg, desitin paste to buttocks, in enhancing) 10 mg, isinopril (high blood pressure) (cognition enhancing) 10 mg, ise (high blood pressure) 25 ps, tamsulosin (urinary resiba (long acting insulin) 22 ly, Novolog 16 units (short sliding scale (extra insulined sugar check) or complete a The same MAR indicated plete the ordered blood sugar dminister Novolog 16 units with on blood sugar. at 11:00 a.m., registered she was aware of the lat occurred on December 25, port the incident to MAARC or D said she thought R1's related to R1's cardiac issues.				
	•	related to R1's cardiac issues. at 1:00 p.m., RN-A said the				

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	from a cardiac issue administrator report error on the side of	porting because they did not ad thought the incident was e. RN-A said he and the ed the incident days later to caution. RN-A said the e been reported within two				
	indicated any staff passed suspects maltreatment in director. If the incident abuse, neglect or findirector will immediate common entry point	y Vulnerable Adult , dated August 1, 2021, person who witnesses, or lent of a vulnerable adult will mmediately to the RN or ent appears to be suspected nancial exploitation, the RN or ately make a report to the t. Immediately means as soon longer than 24 hours.				
0 740		CORRECT: Seven (7) days ransfer of resident records	0 740			
SS=G	With the resident's resident is relocated nursing home, or if service provider, the the new facility, nursing the resident's furinsurance information (2) the name, telephethe resident's designed representative (3) the resident's cut that are relevant to (4) the resident's known (4) the resident's known (5) the name and telephethethethethethethethethethethethetheth	knowledge and consent, if a d to another facility or to a care is transferred to another e facility must timely convey to sing home, or provider: Il name, date of birth, and on; none number, and address of nated representatives and				

Minnesota Department of Health

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Minnesota Department of Health

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER	o. ` ´	CONSTRUCTION	COMPLETED
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physician orders that are relevant to the sent being provided; (6) all medication administration records that relevant to the services being provided; (7) the most recent resident assessment, if relevant to the services being provided; and (8) copies of health care directives, "do not resuscitate" orders, and any guardianship or or powers of attorney. This MN Requirement is not met as evident by: Based on interview and record review, the licensee failed to convey advanced directive when the licensee transferred cares to the emergency room for one of one resident (Records reviewed. This practice resulted in a level three violation violation that harmed a resident's health or so not including serious injury, impairment, or or a violation that has the potential to lead to serious injury, impairment, or death), and we issued at an isolated scope (when one or a limited number of residents are affected or or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 resided in memory care with current diagnoses of dementia, type 2 diabetes, and hypertension (high blood pressure). R1's see plan dated January 4, 2022, indicated R1 required assistance with all activities of daily (ADLs), including dressing, grooming, medic administration, fasting blood glucose four tin daily and insulin administration three times of as well as assistance with transferring in and of bed. R1 required a wheelchair for mobility	rders ced es 1) on (a safety, death, or as one or dirvice / living cation mes daily d out		

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	indicated R1 preser department (ED) dupulse and became emergency department have a signed DNR one round of Advan (ACLS) which includes restore cardiac rhytocompressions, which medical records not sending documents. On March 2, 2022, nurse (RN)-D said to face sheet and POL emergency medical stated, "I did not verbut she is/was one	Is dated December 25, 2021, anted to the emergency are to hyperglycemia and low unresponsive outside of the nent (ED). Since R1 did not or POLST form, R1 received ced Cardiac Life Support ded epinephrine (helps to hm) and two minutes of the were successful. The ED ted R1 was full code and R1's (face sheet) showed DNR. at 11:00 a.m., registered JLP-G made copies of the ST and handed them to the technician (EMTs). RN-D rify what she had necessarily, of our lead RAs (resident assumed that she knew				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED
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0 740	On March 7, 2022, personal (ULP)-G s she sent R1's face s status and medicati licensee never asked with R1 on Decembers and the did not know she did not know she did not know she did not know she couments sent resident's face sheet record and the POL what documents UL not aware ULP-G dhospital. The licensee's Resipolicy dated August resident is safe and When possible, a sed documents to send ambulance. These sheet, physician's of POLST, advanced on No further informatical.	as to be giving them. I trusted of the right stuff." at 1:00 p.m., unlicensed aid on December 25, 2021, sheet that included the code on list. ULP-G said the ed what documents she sent per 25, 2021. ULP-G also said he was supposed to send the er documents. at 1:00 p.m., RN-A said when are a resident to the hospital, the with should include the et, medication administration and sar use of the end of the	0 740		
01360 SS=D	competency evalua	tion requirem petency evaluators must	01360		

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01360	unlicensed personn living services specisubdivision 9, claus conducted by individuant training in prov (2) training and confunctions and training and confunctions with the services must be confuse, or another in in conjunction with the services must be confused on interview licensee failed to prompetency evaluated (ULP) providing asserted nurse (Reprofessional (ULP). This practice results violation that did not safety but had the president's health or cause serious injury was issued at an iselimited number of real limited number of situation has occurred. The findings included to provide direct calculated to provide	npetency evaluations of el who only provide assisted ified in section 144G.08, es (1) to (5), must be duals with work experience iding these services; and apetency evaluations of el providing assisted living onducted by a registered structor may provide training the registered nurse. Ent is not met as evidenced and record review, the ovide training and tions of unlicensed personnel sisted living services by a N) for one of one unlicensed B with records reviewed. End in a level two violation (at harm a resident's health or obtential to have harmed a safety, but was not likely to a safety are affected or one or staff are involved or the red only occasionally). End ULP-B on December 1, 2021, we services to residents. The cord indicated on December or				

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		30425	B. WING		02/1	; 5/2022
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01360	- Activities of dail including transfers - Range of motio - Medication/trea - Handling of em Orientation to e provided - Medication stor - Reordering medication order, a - Shift to shift rep - Answering the p - Emergency per - scheduling During an interview p.m., licensed pract times, she was resp skills portion of train skills training took 3 through the clinical said there were no demonstrate competraining she would with the skills with the st portion of the training the check off list to During an interview a.m., registered nur deemed ULP-B con The licensee's deleguly 25, 2021, indicating services to completed the training and had demonstrate health professional	nitoring and first aid y living and mobility skills- ntment administration ergencies ach client and the services age dication, receiving new and disposing of medications fort ohone adant system on March 2, 2022, at 2:10 ical nurse (LPN)-F stated, at consible for completing the aing with staff. LPN-F said the 4-4 hours and LPN-F went skills check off list. LPN-F other documents used to etency. LPN-F said during the valk through the steps of all aff. LPN-F said when the skills ag was complete, LPN-F gave RN-D. on March 2, 2022, at 11:00 se (RN)-D said LPN-F	01360			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY	
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01360	Continued From pa	ge 9	01360			
	the knowledge and complexity of the ta	skills consistent with the sk.				
	TIME PERIOD FOR days	R CORRECTION: Seven (7)				
01750 SS=G		elegation of medication	01750			
	to unlicensed personal the ensure that the comper methods to and the unlicensed the ability to comper (2) specified, in write each resident and on the resident's recognition (3) communicated value (4) commu	n of medications is delegated nnel, the assisted living facility e registered nurse has: nlicensed personnel in the administer the medications, personnel has demonstrated tently follow the procedures; ing, specific instructions for locumented those instructions ords; and with the unlicensed personnel needs of the resident.				
	Based on interview licensee failed to en (ULP)-B demonstratasks and administed blood sugar checks one of one resident other resident recorresponsible for med ULP-B did not administed three other 6:00 a.m. to 2:00 p. another resident's relicensee also failed	and record review, the usure unlicensed personnel ted competency for nursing ering medications, including and insulin administration for (R1) reviewed. Review of four ds indicated ULP-B was dication administration, and inister some or all ordered tember 25, 2021. ULP-B residents' medications from m. ULP-B also omitted nedications at 5:30 p.m. The to ensure ULP-B was trained etent by a registered nurse				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l `´´	E CONSTRUCTION	(X3) DATE COMF	SURVEY
		30425	B. WING			C 1 5/2022
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
PATHST	ONE CROSSING		ND AVENUE D, MN 56001			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
01750	violation that harmed not including serious or a violation that has serious injury, impaissued at an isolate limited number of realimited number of situation has occurred. The findings included R1 resided in memorial diagnoses of demential hypertension (high plan indicated R1 reactivities of daily living grooming, medication blood glucose four administration three with transferring in R1's Medication Included Novolog (short activation and had cognitated R1 the ordered factors included UL medication cart, was arrived late for her strong in R1's progress notes indicated R1 had a R1's progress notes indicated R1's progress no	ed in a level three violation (a ed a resident's health or safety, is injury, impairment, or death, as the potential to lead to airment, or death), and was id scope (when one or a esidents are affected or one or staff are involved or the red only occasionally). ed: ory care with current intia, type 2 diabetes, and blood pressure). R1's service equired assistance with all ing (ADLs), including dressing, on administration, fasting times daily, and insuling it interest daily, and assistance and out of bed. cident Report dated December R1 did not receive scheduleding insuling 16 units at 8:00 tive changes. The same if ULP-B admitted she did not it medication. The contributing increase and out of the contributing increase and employee, and	01750			

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	AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l `´	CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		30425	B. WING			C 15/2022
NAME OF	PROVIDER OR SUPPLIER		,	TATE, ZIP CODE		
PATHST	ONE CROSSING		ND AVENUE O, MN 56001			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
01750	Continued From pa	ige 11	01750			
	medical services (E hospital.	MS) for transportation to the				
	not administer R1's including: artificial to milligrams (mg), cit mg, desitin paste to (cognition enhancin lisinopril (high blook (cognition enhancin succinate (high blook eye drops, tamsulo Tresiba (long acting subcutaneously, No insulin) and sliding based on blood sugar check. The sanot complete the or	scale (extra insulin given gar check) or complete a blood ame MAR indicated ULP-B did dered blood sugar check at Novolog 16 units with sliding				
	indicated ULP-B co checklist dated Dec ULP-B's training red demonstrated comp	file on February 14, 2022, impleted a clinical orientation cember 14, 2021. However, cord lacked evidence ULP petency in medication ilin administration or blood				
	2021, indicated ULI	k-Off list dated December 25, P-B completed R1's services, ns, blood sugar checks and on.				
	ULP-B was response administration, and	er resident records indicated sible for medication ULP-B did not administer medications on December				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	30425	B. WING		02/1	5/2022
NAME OF PROVIDER OR SUPPLIER PATHSTONE CROSSING	718 MOU	DRESS, CITY, S ND AVENUE O, MN 56001	TATE, ZIP CODE		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
medications from 6: also omitted anothe 5:30 p.m. On February 15, 20: on December 25, 20: and had not comple ULP-B said the licer she offered to work to 10:30 p.m. ULP-training on the medit that day. ULP-B said insulin or completed and wanted to see h questions. ULP-B said wanted to see h questions. ULP-B said medications. ULP-ate breakfast and not sugar check and so she did not receive the licensed practical incident. ULP-B said medications and as ULP-B said when shoom he was unresponded sugar. On March 2, 2022, I (LPN)-F stated, at ticcompleting the skills upon the clius LPN-F said there we to demonstrate complete training she would lithe skills with the	nitted three other residents' 00 a.m. to 2:00 p.m. ULP-B r resident's medications at 22, at 2:30 p.m., ULP-B said 021, she was still in training ted all her training days. Insee was short staffed, and a double shift from 6:00 a.m. B said she had not received ication cart she worked on d she had never administered if a blood sugar check before how it was done and had aid she should have lovolog insulin 15 minutes B said did not remember if R1 boon meal without a blood heduled insulin. ULP-B said any medication training from all nurse (LPN) or RN after this d she got behind on passing ked ULP-G for assistance. The and ULP-G went into R1's boonsive and had a very high icensed practical nurse mes, she was responsible for sportion of training with staff, as training took 3-4 hours and nical skills check off list. There no other documents used appetency. LPN-F said during all walk through the steps of the staff. LPN-F said when the training was complete, LPN-F	01750	DEI ROIENCI)		

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		30425	B. WING			C 15/2022
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
PATHST	ONE CROSSING		ND AVENUE D, MN 56001			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPRIES (EACH)	ULD BE	(X5) COMPLETE DATE
01750	worked on December when she arrived the started to throw up R1 was alert and reambulance arrived. RN-D instructed UL medication administ different cart. RN-D residents did not redid not interview the morning shift. RN-D regarding this incide other residents did on December 25, 2 error should have be resident that did not On March 7, 2022, December 25, 2027 told ULP-G went and change of the missed, and ULP-G were missed for market arrived to the started	ge 13 at 11:00 a.m., RN-D said she per 25, 2021, at 3:00 p.m., ne ambulance was enroute. R1 so RN-D assisted. RN-D said esponding when the RN-D said after the incident P-B on the six rights of stration and moved ULP-B to a did not know how many ceive their medications and e other staff that worked the did not contact the director ent. RN-D was not aware not receive their medications o21, and said a medication een completed for each t receive medications. at 1:00 p.m., ULP-G said on 1, at around 2:15 p.m., ULP-C d missed some medications necked what medications ecked what medications any different residents, d sugar check and insulin.	01750			
		ned since she knew R1 was a led the RN triage, and EMS ne hospital.				
	December 25, 2027 hour late and was recart. RN-A said ULF other co-workers sh the licensee comple report for R1 on De the licensee did not report for the other medications. RN-A	at 1:00 p.m., RN-A said on I, ULP-B arrived to work an ot familiar with the medication P-B did not communicate to be was behind on tasks. RN-A eted one medication error ecember 25, 2021, and verified a complete a medication error resident's omitted said ULP-B admitted she did ations to R1. RN-A said ULP-B				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		30425	B. WING		02/1	5/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PATHSTO	ONE CROSSING		ND AVENUE D, MN 56001			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETE DATE
01750	what he knows now administered medic completed the skills was not aware a LF training. RN-A said manager were responsively 25, 2021, indicated the training services to completed the training and had demonstrated the license to complete the training and had demonstrated the knowledge and complexity of the tasks.	s that evening but knowing ULP-B should not have cations. RN-A verified LPN-F sportion of the training. RN-A PN could not complete the that he or the RN case onsible to ensure staff were dministering medications or gation of nursing tasks dated ated a RN may delegate ULPs that have successfully ing required, has been trained ted to the RN or licensed the ability to competently es for the client and possess skills consistent with the	01750			
I	living facility staff management's record. The include the signature administered the management include the manag		01760			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
	30425	B. WING			C 15/2022
NAME OF PROVIDER OR SUPPLIE	718 MOU	DDRESS, CITY, ST IND AVENUE O, MN 56001	TATE, ZIP CODE		
PREFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
This MN Require by: Based on observe review, the licens were administered seven residents of records reviewed. This practice restricted restriction that harmone including serious injury, important a limited number of than a limited number of the findings including to be perventional. R1 R1 resided in mediagnoses of denotes the serious in the findings included the serious in the serious injury.	ment is not met as evidenced ation, interview, and record ee failed to ensure medications d as prescribed for five out of R1, R4, R5, R6 and R7) with . ulted in a level three violation (a med a resident's health or safety, ous injury, impairment, or death, has the potential to lead to pairment, or death), and was in scope (when more than a f residents are affected, more mber of staff are involved, or the urred repeatedly; but is not asive).				
required assistant (ADLs), including medication, fasting and insulin admir well as assistance bed. R1 required R1's Medication	ry 4, 2022, indicated R1 ce with all activities of daily living dressing, grooming, and blood glucose four times daily histration three times daily as e with transferring in and out of a wheelchair for mobility. ncident Report dated December p.m., indicated R1 did not				
receive schedule	d Novolog 16 units at 0800 and anges. The same document				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. DOILDING.			2
		30425	B. WING			5/2022
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
PATHST	ONE CROSSING		ND AVENUE D, MN 56001			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOOT CROSS-REFERENCED TO THE APPROPRIES (CROSS-REFERENCE)	OULD BE	(X5) COMPLETE DATE
01760	Continued From pa	ge 16	01760			
	admitted R1 did not services. The contract was unfamiliar with	nsed personnel (ULP)-B receive the scheduled ibuting factors included ULP-B the medication cart, ULP-B e, and ULP-B arrived late for				
	at 2:54 p.m., indicated 493, pulse of 27, and and staff were unable R1 became increase	s dated December 25, 2021, ted R1 had a blood sugar of nd oxygen saturation of 82%, ble to obtain a blood pressure. singly unresponsive, and staff nedical services (EMS) for spital.				
	December 2021, incadminister R1's moder artificial tears for drawing, citalopram (and paste to buttocks, denhancing) 10 mg, for (high blood pressur (cognition enhancing succinate (high blood eye drops, tamsulos Tresiba (long acting subcutaneously, Notinsulin) and sliding significant subcutaneously, Notinsulin) and sliding significant subcutaneously.	ministration record (MAR) dicated ULP-B did not rning medications including: y eye, aspirin 81 milligrams ntidepressant) 20 mg, desitin lonepezil (cognition liber-tabs 625 mg, lisinopril le) 20 mg, memantine le) 10 mg, metoprolol od pressure) 25 mg, refresh sin (urinary retention) 0.4 mg, y insulin) 22 units evolog 16 units (short acting scale (extra insulin given par check) and a blood sugar				
	indicated ULP-A co	21 Service Check-Off list mpleted R1's services, ns, blood sugar checks and on.				
	R4					
	R4 resided in memo	ory care with diagnoses				

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TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	30425	B. WING			5/ 2022
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
PATHSTONE CROSSING		ND AVENUE D, MN 56001			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
(weak and brittle bor service plan dated CR4 required assistant escorts, dressing, gradministration and a mobility and transfer. R4's December 202 not administer R4's calcimining-salmon and stool softener. There was no docume completed a medical contacting R4's physical contacting R5's physica	hypertension, osteoporosis nes) and depression. R4's October 19, 2021, indicated nce with showers, dining room rooming, medication assistance of one staff for bed red with a mechanical lift. 1 MAR indicated ULP-B did prescribed nasal spray (osteoporosis) mentation the licensee ation error report, including sician and family member. bry care with diagnoses mpairment, osteoporosis, ase and hypothyroidism al). R4's service plan dated ling, dining escorts, dressing, on administration, bed mobility 1 MAR indicated ULP-B did prescribed medications cine (thyroid hormone) 50 mcg Miralax (laxative) 17 gram (G).				

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	E SURVEY PLETED
		30425	B. WING		I	C 15/2022
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, ST	TATE, ZIP CODE		
PATHST	ONE CROSSING		O, MN 56001			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF O (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC)	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
01760	Continued From pa	ge 18	01760			
	anxiety. R6's service 2021, indicated R6 bathing, dining esce	r's disease, depression, and se plan dated September 9, required assistance with orts, dressing, grooming, stration, and redirection related				
	not administer R6's including aspirin 81 donepezil 10 mg, es 20 mg, gabapentin 10 mg, multivitamin Miralax 17 G, prese (antipsychotic medi	21 MAR indicated ULP-B did prescribed medications mg, , stool softener, scitalopram (antidepressant) (anxiety) 300 mg, memantine n, Nystatin (for reddened skin), ervision (eye health), seroquel (cation) 25 mg and vitamin D3 cg) 5000 international units				
		mentation the licensee ation error report, including sician.				
	R8					
	including heart dise hypertension, enlar disease. R8's service 2021, indicated R8 dressing, grooming	ory care with diagnoses ase, atrial fibrillation, ged prostate and Alzheimer's ce plan dated October 18, required assistance with , escorts, medication redirection related to				
	25, 2021, at 5:30 p. administer R8's me including tamsulosi acetaminophen 650 chest pain) 15 mg v	cident report dated December m., indicated ULP-B did not dications at 5:30 p.m., n (urinary retention) 0.4 mg, mg, isosorbide (prevent were all left in bubble pack cations were not given.				

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		30425	B. WING		1	C 1 5/2022
NAME OF	PROVIDER OR SUPPLIER		,	STATE, ZIP CODE		
PATHST	ONE CROSSING		ND AVENUE D, MN 56001			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01760	Continued From pa	ge 19	01760			
	completed a medical contacting R8's physical During an inteview of p.m., ULP-B said or was still in training a training days and was he had not received licensee was short work a double shift 6:00 a.m. to 10:30 phehind on passing of for assistance when ULP-B said when said room he was unrestablood sugar. ULP-B administered insuling check before and was questions. ULP-B said when said ministered R1's Not before meals. ULP-ate breakfast and not sugar check and so she did not receive	mentation the licensee ation error report, including rician. on February 15, 2022, at 2:30 in December 25, 2021, she and had not completed all her as on a medication cart that ad training on. ULP-B said the staffed, and she offered to on December 25, 2021, from o.m. ULP-B said she got medications and asked ULP-G in ULP-G arrived hours later. The and ULP-G went into R1's ponsive and had a very high a said she had never in or completed a blood sugar ranted to see it done and had aid she should have Novolog insulin 15 minutes. B said did not remember if R1 oon meal without a blood sheduled insulin. ULP-B said any medication training from al nurse (LPN) or RN after this				
	December 25, 2021 told ULP-G she had ULP-G went and changes and ULP-G were missed for maincluding R1's blood ULP-G was concerned diabetic. ULP-G call	at 1:00 p.m., ULP-G said on I, at around 2:15 p.m., ULP-B missed some medications. The secked what medications were any different residents, any different residents, and since she knew R1 was a led the RN triage and I services transported R1 to				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE COMI	E SURVEY PLETED
		30425	B. WING			C 15/2022
	PROVIDER OR SUPPLIER	718 MOU	DRESS, CITY, ST ND AVENUE O, MN 56001	TATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
01760	nurse (RN)-D said a 2021, at 3:00 p.m., ambulance was end so RN-D assisted. It and responding who after the incident R six rights of medical ULP-B to a different RN-D did not know receive their medical the other staff that a RN-D did not containcident. RN-D was not receive their medical and receive their medical and said a medical have been completed and receive medical and receive m	at 11:00 a.m., registered she worked on December 25, when she arrived the route. R1 started to throw up RN-D said R1 was still alert en EMT's arrived. RN-D said N-D instructed ULP-B on the ation administration and moved t cart for the evening shift. how many residents did not ations and did not interview worked the morning shift. In the director about this a not aware other residents did edications on December 25, edication error report should ed for each resident that did tions.	01760			
	December 25, 2027 medication cart she said the licensee or report for R1, and recompleted for the outperson to R1. RN-A said U evening. RN-A said U evening. RN-A verification. RN-A said manager was respondent before a treatments. The licensee's Medicated August 2019, included omission, error will report the	at 1:00 p.m., RN-A said on 1, ULP-B was assigned to a was not familiar with. RN-A hly had a medication error to error reports were not other four residents. RN-A said e did not give any medications LP-B passed medications that fied licensed practical nurse the skills portion of the that he or the RN case onsible to ensure staff were administering medications or lication Error Reporting Policy indicated medications errors. The person discovering the error to the supervisor of the physician will be notified.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					С
		30425	B. WING		02/15/2022
NAME OF	PROVIDER OR SUPPLIER		,	STATE, ZIP CODE	
PATHST	ONE CROSSING		ND AVENUE O, MN 5600′		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETE
01760	Continued From pa	ge 21	01760		
	notified. The superv	d or responsible party will be visor or nurse on call will edication error is a Vulnerable ent.			
	No further informati	on was provided.			
	TIME PERIOD FOR days	R CORRECTION: Seven (7)			
02360	144G.91 Subd. 8 F	reedom from maltreatment	02360		
	sexual, and emotion exploitation; and all	right to be free from physical, nal abuse; neglect; financial forms of maltreatment /ulnerable Adults Act.			
	by: Based on interviews licensee failed to er	ent is not met as evidenced s, and record review, the nsure one of one residents free from maltreatment. R1		No Plan of Correction (PoC) requi Please refer to the public maltreat report (report sent separately) for of this tag.	ment
	Findings include:				
	Health (MDH) issue occurred, and the familiar maltreatment, in co				

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