Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL30425001M
Compliance #: HL30425002C

Date Concluded: April 26, 2022

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30425	A. BUILDING: _____ B. WING _____	C 02/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHSTONE CROSSING	718 MOUND AVENUE MANKATO, MN 56001

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0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING 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: #HL30425002C/#HL30425001M On February 15, 2022, 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 117 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL30425002C/#HL30425001M, tag identification 0620, 0740, 1360, 1750, 1760, and 2360.	0 000	Minnesota Department of Health is documenting 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 is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 620 SS=D	144G.42 Subd. 6 Compliance with requirements for reporting ma	0 620		

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0 620	Continued From page 1 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 interview and record review, the licensee failed to report suspected maltreatment immediately (no longer than 24 hours) to the Minnesota Adult Abuse Reporting Center (MAARC) for one of one resident (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 resided in memory care with current diagnoses of dementia, type 2 diabetes, and hypertension (high blood pressure). R1's service plan dated January 4, 2022, indicated R1 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.	0 620		

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0 620	Continued From page 2 R1 also required assistance with transferring in and out of bed. R1 required a wheelchair for mobility. R1's progress notes dated December 25, 2021, at 2:54 p.m., indicated R1 had a blood sugar of 493, pulse of 27, and oxygen saturation of 82%, and staff were unable to obtain a blood pressure. R1 became increasingly unresponsive, and staff called emergency medical services (EMS) for transport to the hospital. R1's medication administration record (MAR) dated December 25, 2021, indicated unlicensed personnel (ULP)-B did not administer R1's morning medications including: artificial tears for dry eye, aspirin 81 milligrams (mg), citalopram (antidepressant) 20 mg, desitin paste to buttocks, donepezil (cognition enhancing) 10 mg, fiber-tabs 625 mg, lisinopril (high blood pressure) 20 mg, memantine (cognition enhancing) 10 mg, metoprolol succinate (high blood pressure) 25 mg, refresh eye drops, tamsulosin (urinary retention) 0.4 mg, Tresiba (long acting insulin) 22 units subcutaneously, Novolog 16 units (short acting insulin) and sliding scale (extra insulin given based on blood sugar check) or complete a blood sugar check. The same MAR indicated ULP-B did not complete the ordered blood sugar check at noon or administer Novolog 16 units with sliding scale based on blood sugar. On March 2, 2022, at 11:00 a.m., registered nurse (RN)-D said she was aware of the medication error that occurred on December 25, 2021, but did not report the incident to MAARC or her supervisor. RN-D said she thought R1's hospitalization was related to R1's cardiac issues. On March 8, 2022, at 1:00 p.m., RN-A said the	0 620		

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0 620	Continued From page 3 licensee delayed reporting because they did not connect the dots and thought the incident was from a cardiac issue. RN-A said he and the administrator reported the incident days later to error on the side of caution. RN-A said the incident should have been reported within two hours. The licensee's policy Vulnerable Adult Maltreatment policy, dated August 1, 2021, indicated any staff person who witnesses, or suspects maltreatment of a vulnerable adult will report the incident immediately to the RN or director. If the incident appears to be suspected abuse, neglect or financial exploitation, the RN or director will immediately make a report to the common entry point. Immediately means as soon as possible, but no longer than 24 hours. TIME PERIOD TO CORRECT: Seven (7) days	0 620		
0 740 SS=G	144G.43 Subd. 4 Transfer of resident records With the resident's knowledge and consent, if a resident is relocated to another facility or to a nursing home, or if care is transferred to another service provider, the facility must timely convey to the new facility, nursing home, or provider: (1) the resident's full name, date of birth, and insurance information; (2) the name, telephone number, and address of the resident's designated representatives and legal representatives, if any; (3) the resident's current documented diagnoses that are relevant to the services being provided; (4) the resident's known allergies that are relevant to the services being provided; (5) the name and telephone number of the resident's physician, if known, and the current	0 740		

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0 740	Continued From page 4 physician orders that are relevant to the services being provided; (6) all medication administration records that are 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 orders or powers of attorney. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to convey advanced directives when the licensee transferred cares to the emergency room for one of one resident (R1) 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 resided in memory care with current diagnoses of dementia, type 2 diabetes, and hypertension (high blood pressure). R1's service plan dated January 4, 2022, indicated R1 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. R1 required a wheelchair for mobility.	0 740		

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0 740	Continued From page 5 R1's Provider's Order for Life Sustaining Treatment (POLST) dated December 18, 2019, indicated R1 chose DNR (Do Not Resuscitate) or intubate (breathing tube). R1's December 25, 2021, medication administration record (MAR) indicated unlicensed personnel (ULP)-B did not administer R1's morning or noon medications including blood sugar checks and insulin administration. R1's progress notes dated December 25, 2021, at 2:54 p.m., indicated R1 had a blood sugar of 493, pulse of 27, and oxygen saturation of 82%, and staff were unable to obtain a blood pressure. R1 became increasingly unresponsive, and staff called emergency medical services (EMS) for transport to the hospital. R1's hospital records dated December 25, 2021, indicated R1 presented to the emergency department (ED) due to hyperglycemia and low pulse and became unresponsive outside of the emergency department (ED). Since R1 did not have a signed DNR or POLST form, R1 received one round of Advanced Cardiac Life Support (ACLS) which included epinephrine (helps to restore cardiac rhythm) and two minutes of compressions, which were successful. The ED medical records noted R1 was full code and R1's sending documents (face sheet) showed DNR. On March 2, 2022, at 11:00 a.m., registered nurse (RN)-D said ULP-G made copies of the face sheet and POLST and handed them to the emergency medical technician (EMTs). RN-D stated, "I did not verify what she had necessarily, but she is/was one of our lead RAs (resident assistants) so I just assumed that she knew	0 740		

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0 740	Continued From page 6 exactly what she was to be giving them. I trusted her to make copies of the right stuff." On March 7, 2022, at 1:00 p.m., unlicensed personal (ULP)-G said on December 25, 2021, she sent R1's face sheet that included the code status and medication list. ULP-G said the licensee never asked what documents she sent with R1 on December 25, 2021. ULP-G also said she did not know she was supposed to send the POLST with the other documents. On March 8, 2022, at 1:00 p.m., RN-A said when the licensee transfers a resident to the hospital, the documents sent with should include the resident's face sheet, medication administration record and the POLST. RN-A did not ask ULP-G what documents ULP-G sent with R1. RN-A was not aware ULP-G did not send R1's POLST to the hospital. The licensee's Resident Emergencies/911 Calls policy dated August 1, 2021, indicated ensure the resident is safe and a staff member is with them. When possible, a second staff member will copy documents to send with the resident in the ambulance. These documents included face sheet, physician's orders, and code status - POLST, advanced directives etc. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) days.	0 740		
01360 SS=D	144G.61 Subdivision 1 Instructor and competency evaluation requirem Instructors and competency evaluators must meet the following requirements:	01360		

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01360	Continued From page 7 (1) training and competency evaluations of unlicensed personnel who only provide assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), must be conducted by individuals with work experience and training in providing these services; and (2) training and competency evaluations of unlicensed personnel providing assisted living services must be conducted by a registered nurse, or another instructor may provide training in conjunction with the registered nurse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide training and competency evaluations of unlicensed personnel (ULP) providing assisted living services by a registered nurse (RN) for one of one unlicensed professional (ULP)-B with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee hired ULP-B on December 1, 2021, to provide direct care services to residents. ULP-B's employee record indicated on December 14, 2021, licensed practical nurse (LPN)-F trained ULP-B on the following topics: - Infection control skills	01360		

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01360	Continued From page 8 - Vital signs, monitoring and first aid - Activities of daily living and mobility skills- including transfers - Range of motion - Medication/treatment administration - Handling of emergencies - Orientation to each client and the services provided - Medication storage - Reordering medication, receiving new medication order, and disposing of medications - Shift to shift report - Answering the phone - Emergency pendant system - scheduling During an interview on March 2, 2022, at 2:10 p.m., licensed practical nurse (LPN)-F stated, at times, she was responsible for completing the skills portion of training with staff. LPN-F said the skills training took 3-4 hours and LPN-F went through the clinical skills check off list. LPN-F said there were no other documents used to demonstrate competency. LPN-F said during the training she would walk through the steps of all the skills with the staff. LPN-F said when the skills portion of the training was complete, LPN-F gave the check off list to RN-D. During an interview on March 2, 2022, at 11:00 a.m., registered nurse (RN)-D said LPN-F deemed ULP-B competent with skills. The licensee's delegation of nursing tasks dated July 25, 2021, indicated a RN may delegate nursing services to ULPs that have successfully completed the training required, has been trained and had demonstrated to the RN or licensed health professional the ability to competently follow the procedures for the client and possess	01360		

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01360	Continued From page 9 the knowledge and skills consistent with the complexity of the task. TIME PERIOD FOR CORRECTION: Seven (7) days	01360		
01750 SS=G	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure unlicensed personnel (ULP)-B demonstrated competency for nursing tasks and administering medications, including blood sugar checks and insulin administration for one of one resident (R1) reviewed. Review of four other resident records indicated ULP-B was responsible for medication administration, and ULP-B did not administer some or all ordered medications on December 25, 2021. ULP-B omitted three other residents' medications from 6:00 a.m. to 2:00 p.m. ULP-B also omitted another resident's medications at 5:30 p.m. The licensee also failed to ensure ULP-B was trained and deemed competent by a registered nurse	01750		

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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
01750	Continued From page 10 (RN). 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). The findings included: R1 resided in memory care with current diagnoses of dementia, type 2 diabetes, and hypertension (high blood pressure). R1's service plan indicated R1 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, and assistance with transferring in and out of bed. R1's Medication Incident Report dated December 25, 2021, indicated R1 did not receive scheduled Novolog (short acting insulin) 16 units at 8:00 a.m. and had cognitive changes. The same document indicated ULP-B admitted she did not give R1 the ordered medication. The contributing factors included ULP-B was unfamiliar with the medication cart, was a new employee, and arrived late for her shift. R1's progress notes dated December 25, 2021, indicated R1 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 R1 became increasingly unresponsive, and staff called emergency	01750		

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01750	Continued From page 11 medical services (EMS) for transportation to the hospital. R1's medication administration record (MAR) dated December 25, 2021, indicated ULP-B did not administer R1's morning medications including: artificial tears for dry eye, aspirin 81 milligrams (mg), citalopram (antidepressant) 20 mg, desitin paste to buttocks, donepezil (cognition enhancing) 10 mg, fiber-tabs 625 mg, lisinopril (high blood pressure) 20 mg, memantine (cognition enhancing) 10 mg, metoprolol succinate (high blood pressure) 25 mg, refresh eye drops, tamsulosin (urinary retention) 0.4 mg, Tresiba (long acting insulin) 22 units subcutaneously, Novolog 16 units (short acting insulin) and sliding scale (extra insulin given based on blood sugar check) or complete a blood sugar check. The same MAR indicated ULP-B did not complete the ordered blood sugar check at noon or administer Novolog 16 units with sliding scale based on blood sugar. ULP-B's employee file on February 14, 2022, indicated ULP-B completed a clinical orientation checklist dated December 14, 2021. However, ULP-B's training record lacked evidence ULP demonstrated competency in medication administration, insulin administration or blood sugar checks. R1's Service Check-Off list dated December 25, 2021, indicated ULP-B completed R1's services, including medications, blood sugar checks and insulin administration. Review of four other resident records indicated ULP-B was responsible for medication administration, and ULP-B did not administer some or all ordered medications on December	01750		

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01750	Continued From page 12 25, 2021. ULP-B omitted three other residents' medications from 6:00 a.m. to 2:00 p.m. ULP-B also omitted another resident's medications at 5:30 p.m. On February 15, 2022, at 2:30 p.m., ULP-B said on December 25, 2021, she was still in training and had not completed all her training days. ULP-B said the licensee was short staffed, and she offered to work a double shift from 6:00 a.m. to 10:30 p.m. ULP-B said she had not received training on the medication cart she worked on that day. ULP-B said she had never administered insulin or completed a blood sugar check before and wanted to see how it was done and had questions. ULP-B said she should have administered R1's Novolog insulin 15 minutes before meals. ULP-B said did not remember if R1 ate breakfast and noon meal without a blood sugar check and scheduled insulin. ULP-B said she did not receive any medication training from the licensed practical nurse (LPN) or RN after this incident. ULP-B said she got behind on passing medications and asked ULP-G for assistance. ULP-B said when she and ULP-G went into R1's room he was unresponsive and had a very high blood sugar. On March 2, 2022, licensed practical nurse (LPN)-F stated, at times, she was responsible for completing the skills portion of training with staff. LPN-F said the skills training took 3-4 hours and went through the clinical skills check off list. LPN-F said there were no other documents used to demonstrate competency. LPN-F said during the training she would walk through the steps of all the skills with the staff. LPN-F said when the skills portion of the training was complete, LPN-F gave the check off list to RN-D.	01750		

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01750	Continued From page 13 On March 2, 2022, at 11:00 a.m., RN-D said she worked on December 25, 2021, at 3:00 p.m., when she arrived the ambulance was enroute. R1 started to throw up so RN-D assisted. RN-D said R1 was alert and responding when the ambulance arrived. RN-D said after the incident RN-D instructed ULP-B on the six rights of medication administration and moved ULP-B to a different cart. RN-D did not know how many residents did not receive their medications and did not interview the other staff that worked the morning shift. RN-D did not contact the director regarding this incident. RN-D was not aware other residents did not receive their medications on December 25, 2021, and said a medication error should have been completed for each resident that did not receive medications. On March 7, 2022, at 1:00 p.m., ULP-G said on December 25, 2021, at around 2:15 p.m., ULP-C told ULP-G she had missed some medications. ULP-G went and checked what medications were missed, and ULP-G noticed many medications were missed for many different residents, including R1's blood sugar check and insulin. ULP-G was concerned since she knew R1 was a diabetic. ULP-G called the RN triage, and EMS transported R1 to the hospital. On March 8, 2022, at 1:00 p.m., RN-A said on December 25, 2021, ULP-B arrived to work an hour late and was not familiar with the medication cart. RN-A said ULP-B did not communicate to other co-workers she was behind on tasks. RN-A the licensee completed one medication error report for R1 on December 25, 2021, and verified the licensee did not complete a medication error report for the other resident's omitted medications. RN-A said ULP-B admitted she did not give any medications to R1. RN-A said ULP-B	01750		

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01750	Continued From page 14 passed medications that evening but knowing what he knows now ULP-B should not have administered medications. RN-A verified LPN-F completed the skills portion of the training. RN-A was not aware a LPN could not complete the training. RN-A said that he or the RN case manager were responsible to ensure staff were competent before administering medications or treatments. The licensee's delegation of nursing tasks dated July 25, 2021, indicated a RN may delegate nursing services to ULPs that have successfully completed the training required, has been trained and had demonstrated to the RN or licensed health professional the ability to competently follow the procedures for the client and possess the knowledge and skills consistent with the complexity of the task. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01760 SS=H	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	01760		

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01760	Continued From page 15 with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as prescribed for five out of seven residents (R1, R4, R5, R6 and R7) with 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1 resided in memory care with current diagnoses of dementia, type 2 diabetes, and hypertension (high blood pressure). R1's service plan dated January 4, 2022, indicated R1 required assistance with all activities of daily living (ADLs), including dressing, grooming, medication, fasting blood glucose four times daily and insulin administration three times daily as well as assistance with transferring in and out of bed. R1 required a wheelchair for mobility. R1's Medication Incident Report dated December 25, 2021, at 3:00 p.m., indicated R1 did not receive scheduled Novolog 16 units at 0800 and had cognitive changes. The same document	01760		

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01760	Continued From page 16 indicated the unlicensed personnel (ULP)-B admitted R1 did not receive the scheduled services. The contributing factors included ULP-B was unfamiliar with the medication cart, ULP-B was a new employee, and ULP-B arrived late for her shift. R1's progress notes dated December 25, 2021, at 2:54 p.m., indicated R1 had a blood sugar of 493, pulse of 27, and oxygen saturation of 82%, and staff were unable to obtain a blood pressure. R1 became increasingly unresponsive, and staff called emergency medical services (EMS) for transport to the hospital. R1's medication administration record (MAR) December 2021, indicated ULP-B did not administer R1's morning medications including: artificial tears for dry eye, aspirin 81 milligrams (mg), citalopram (antidepressant) 20 mg, desitin paste to buttocks, donepezil (cognition enhancing)10 mg, fiber-tabs 625 mg, lisinopril (high blood pressure) 20 mg, memantine (cognition enhancing) 10 mg, metoprolol succinate (high blood pressure) 25 mg, refresh eye drops, tamsulosin (urinary retention) 0.4 mg, Tresiba (long acting insulin) 22 units subcutaneously, Novolog 16 units (short acting insulin) and sliding scale (extra insulin given based on blood sugar check) and a blood sugar check. R1's December 2021 Service Check-Off list indicated ULP-A completed R1's services, including medications, blood sugar checks and insulin administration. R4 R4 resided in memory care with diagnoses	01760		

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01760	Continued From page 17 including dementia, hypertension, osteoporosis (weak and brittle bones) and depression. R4's service plan dated October 19, 2021, indicated R4 required assistance with showers, dining room escorts, dressing, grooming, medication administration and assistance of one staff for bed mobility and transferred with a mechanical lift. R4's December 2021 MAR indicated ULP-B did not administer R4's prescribed calcimining-salmon nasal spray (osteoporosis) and stool softener. There was no documentation the licensee completed a medication error report, including contacting R4's physician and family member. R5 R5 resided in memory care with diagnoses including cognitive impairment, osteoporosis, chronic kidney disease and hypothyroidism (under active thyroid). R4's service plan dated September 15, 2021, indicated R4 required assistance with bathing, dining escorts, dressing, grooming, medication administration, bed mobility and transfers. R5's December 2021 MAR indicated ULP-B did not administer R5's prescribed medications including: levothyroxine (thyroid hormone) 50 mcg (micrograms), and Miralax (laxative) 17 gram (G). There was no documentation the licensee completed a medication error report, including contacting R5's physician. R6 R6 resided in memory care with diagnoses	01760		

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01760	Continued From page 18 including Alzheimer's disease, depression, and anxiety. R6's service plan dated September 9, 2021, indicated R6 required assistance with bathing, dining escorts, dressing, grooming, medication administration, and redirection related to wandering. R6's December 2021 MAR indicated ULP-B did not administer R6's prescribed medications including aspirin 81 mg, , stool softener, donepezil 10 mg, escitalopram (antidepressant) 20 mg, gabapentin (anxiety) 300 mg, memantine 10 mg, multivitamin, Nystatin (for reddened skin), Miralax 17 G, preservision (eye health), seroquel (antipsychotic medication) 25 mg and vitamin D3 125 microgram (mcg) 5000 international units (IU). There was no documentation the licensee completed a medication error report, including contacting R6's physician. R8 R8 resided in memory care with diagnoses including heart disease, atrial fibrillation, hypertension, enlarged prostate and Alzheimer's disease. R8's service plan dated October 18, 2021, indicated R8 required assistance with dressing, grooming, escorts, medication administration and redirection related to wandering. R8's medication incident report dated December 25, 2021, at 5:30 p.m., indicated ULP-B did not administer R8's medications at 5:30 p.m., including tamsulosin (urinary retention) 0.4 mg, acetaminophen 650 mg, isosorbide (prevent chest pain) 15 mg were all left in bubble pack indicating the medications were not given.	01760		

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01760	Continued From page 19 There was no documentation the licensee completed a medication error report, including contacting R8's physician. During an inteview on February 15, 2022, at 2:30 p.m., ULP-B said on December 25, 2021, she was still in training and had not completed all her training days and was on a medication cart that she had not received training on. ULP-B said the licensee was short staffed, and she offered to work a double shift on December 25, 2021, from 6:00 a.m. to 10:30 p.m. ULP-B said she got behind on passing medications and asked ULP-G for assistance when ULP-G arrived hours later. ULP-B said when she and ULP-G went into R1's room he was unresponsive and had a very high blood sugar. ULP-B said she had never administered insulin or completed a blood sugar check before and wanted to see it done and had questions. ULP-B said she should have administered R1's Novolog insulin 15 minutes before meals. ULP-B said did not remember if R1 ate breakfast and noon meal without a blood sugar check and scheduled insulin. ULP-B said she did not receive any medication training from the licensed practical nurse (LPN) or RN after this incident. On March 7, 2022, at 1:00 p.m., ULP-G said on December 25, 2021, at around 2:15 p.m., ULP-B told ULP-G she had missed some medications. ULP-G went and checked what medications were missed, and ULP-G noticed many medications were missed for many different residents, including R1's blood sugar check and insulin. ULP-G was concerned since she knew R1 was a diabetic. ULP-G called the RN triage and emergency medical services transported R1 to the hospital.	01760		

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01760	Continued From page 20 On March 2, 2022, at 11:00 a.m., registered nurse (RN)-D said she worked on December 25, 2021, at 3:00 p.m., when she arrived the ambulance was enroute. R1 started to throw up so RN-D assisted. RN-D said R1 was still alert and responding when EMT's arrived. RN-D said after the incident RN-D instructed ULP-B on the six rights of medication administration and moved ULP-B to a different cart for the evening shift. RN-D did not know how many residents did not receive their medications and did not interview the other staff that worked the morning shift. RN-D did not contact the director about this incident. RN-D was not aware other residents did not receive their medications on December 25, 2021, and said a medication error report should have been completed for each resident that did not receive medications. On March 8, 2022, at 1:00 p.m., RN-A said on December 25, 2021, ULP-B was assigned to a medication cart she was not familiar with. RN-A said the licensee only had a medication error report for R1, and no error reports were not completed for the other four residents. RN-A said ULP-B admitted she did not give any medications to R1. RN-A said ULP-B passed medications that evening. RN-A verified licensed practical nurse (LPN)-F completed the skills portion of the training. RN-A said that he or the RN case manager was responsible to ensure staff were competent before administering medications or treatments. The licensee's Medication Error Reporting Policy dated August 2019, indicated medications errors included omission. The person discovering the error will report the error to the supervisor of nurse. The resident's physician will be notified	01760		

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01760	Continued From page 21 and the resident and or responsible party will be notified. The supervisor or nurse on call will determine if the medication error is a Vulnerable Adult reportable event. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: Based on interviews, and record review, the licensee failed to ensure one of one residents reviewed (R1) was free from maltreatment. R1 was neglected. Findings include: On April 26, 2022, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	