Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306317703M
Compliance #: HL306313167C

Date Concluded: February 3, 2025

Name, Address, and County of Licensee Investigated:
Edgewood EGF Senior Living
608 5th Avenue NW
East Grand Forks, MN 56721
Polk County

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

Evaluator's Name: Barbara Axness, RN
Special Investigator

Finding: Substantiated, facility responsibility

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

Initial Investigation Allegation(s):
The facility failed to provide continuous monitoring for signs and symptoms of a diabetic condition, resulting in the resident being admitted to the hospital with diabetic ketoacidosis. In addition, the facility caused a rib fracture by improperly transferring the resident into a car.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to report 22 out of range blood sugar readings to the primary care provider (PCP) as ordered over a six week period. The resident was admitted to the intensive care unit (ICU) with diabetic ketoacidosis (a complication of diabetes that results from increased levels of a chemical called ketones. Symptoms include excessive thirst, frequent urination, fatigue, and vomiting.) The facility also transferred the resident into a private car when the resident was not able to be safely transferred; however, it is unable to be determined when the rib fractures occurred.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the nurse practitioner. The investigation included review of the resident record, hospital records, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed care and services at the facility.

The resident resided in an assisted living memory care unit. The resident's diagnoses included type one diabetes, Alzheimer's disease, and dementia. The resident's service plan included assistance with diabetic management, medication administration, and transfer assistance. The resident's assessment indicated the resident was on diabetic protocols and staff were to report abnormal blood sugar readings to the nurse. The assessment failed to identify the resident was non-compliant with a diabetic diet.

The resident's record contained an order to notify the primary care provider if blood sugars were below 60 or above 400. The order was noted to have been reviewed and received by a facility nurse.

The resident's record indicated over a six-week period, the resident had at least 22 blood sugars that fell outside of the normal parameters and should have been reported to the PCP, including blood sugar levels as low as 34 and as high as 520. The registered nurse (RN) was not consistently notified of the abnormal blood sugar readings. The RN notified the provider twice of abnormal blood sugar levels and new orders for insulin were obtained after the provider was notified.

On the day the resident was hospitalized, the resident's blood sugar level at 6:30 a.m. was reading "HI" [too high for the monitor to read] so the RN was notified. The RN notified the PCP at 8:00 a.m. and the PCP directed facility staff to have the resident be evaluated in the emergency room to rule out ketoacidosis or sepsis. Facility records indicated the resident's daughter was notified and was asked to bring the resident to the walk-in clinic. The daughter came to pick up the resident but was unable to get him into her car. Facility staff had to help get the resident into the car. The resident was brought to the walk-in clinic but was told by clinic staff he needed to be seen in the emergency room.

Hospital records indicated the resident was admitted with diagnoses including diabetic ketoacidosis, closed fracture of multiple ribs, and pneumothorax (collapsed lung) to right lung. Hospital documentation indicated the resident's blood pressure was 66/42 (normal is 120/80). Diagnostic imaging indicated the resident had two acute rib fractures on his right side, and a rib fracture on his left side. A fourth rib fracture with signs of early healing was also noted. The resident's right lung was collapsed, and a chest tube was placed. The resident was transferred to the intensive care unit (ICU.) The resident was still hospitalized in the ICU at the time of the investigation.

During an interview, the resident’s family member stated the resident was dressed in a coat, sitting in a wheelchair and was "just out of it" with his head hanging down when she arrived at the facility that day. The resident’s family asked how they were supposed to get the resident in the car, as he would normally be able to get himself into the car and staff assured her they'd help her. The family member stated they "put this strap" around him and were trying to pull him into the car but he was just dead weight and she got upset with the staff. The family member stated she didn't feel like the transfer was safe, but figured they had done this before and knew what they were doing, so she did not stop them. The family member stated one staff member was in the back seat and another was trying to get him in the passenger side, but the resident was just dead weight. After they finally got him in the car, the family brought him to urgent care as she was directed to do but the urgent care told them that they needed to go to the emergency room.

During an interview, the resident's primary care provider (PCP) confirmed she did not see any documentation of being notified on 22 blood sugar readings that fell outside the parameters of when to call the provider. The PCP stated she would expect to be notified per the parameters so the resident's insulin could be adjusted. The PCP stated the RN had sent her a Teams message [online chat] about the resident's blood sugar being high, so she called them to see what was going on. The PCP stated she was told he had a blood sugar that was reading high, and the resident was weaker and given that he recently started treatment for a urinary tract infection, she was worried he might be septic or have diabetic ketoacidosis. The PCP stated she directed the resident be taken to the emergency room, not the urgent care. The PCP stated she would have expected the RNs to use their judgment and if the resident was not stable for transport in a private car, to call for an ambulance. The PCP stated she was not aware the resident was that critical or that he had been having so many high and low blood sugar readings as they hadn't been reported. The PCP stated she had reviewed the resident's chart and her opinion based off the medical records, was that the diabetic ketoacidosis had started a week prior to his hospitalization, and it wasn't an acute or sudden onset.

During an interview, a nurse responsible for checking the resident’s blood sugar levels stated she was never given any direction about contacting the provider for high or low blood sugar readings and they were only directed to contact the RN on-call for anything outside of normal ranges.

During an interview, the facility RN stated the resident was very noncompliant with his diabetic diet and would eat a lot of snacks. The RN confirmed that information about his non-compliance should have been in the assessment and was not sure why it was not included. The RN stated staff usually called and report out of range blood sugars to the on-call RN, which was a contracted company. The RN confirmed they did not have documentation to show the nurse practitioner was updated on the out-of-range blood sugar readings but confirmed the PCP should have been updated as ordered. The RN stated the day the resident was hospitalized, she contacted the PCP who said the resident needed to go in and be seen. The RN stated unlicensed personnel (ULP) had gone out to help the resident into the car and she was in the building and

looked out the window and saw the daughter standing there and the ULP in the car, and the resident's legs had "slid" out of the car. The resident wasn't on the ground, so she went outside and climbed in the back seat and told the ULP to grab his legs and she put her arms under his arms, and they lifted him up into the car. The RN stated the resident seemed fine and she went over to the clinic to help the daughter transfer the resident in and out of the car again. The RN was asked why the resident wasn’t immediately sent to the emergency room and instead went to the urgent care clinic. The RN stated the daughter had asked if she had to drive him across town to the emergency room and she told him there were a couple of walk-in clinics here and since he was going in for an infection and blood sugar, she had the choice to go where she wanted and that the walk-in clinic would be appropriate. The RN was asked if she felt that was the appropriate level of care and replied that the resident's daughter had a choice of where she wanted to go.

During an interview, the ULP who helped get the resident into the car stated the resident was normally a bit tired and they had been providing increased transfer assistance to him. The ULP stated after the resident stood up to get into the car and another staff member brought his wheelchair inside, his legs wouldn’t move, and she couldn’t get the resident into the car and didn’t have the wheelchair to sit him back down. The ULP stated she eventually went in through the driver’s side of the car and pulled the gait belt to get the resident into the car, but his lower half of his body wouldn’t go in. The ULP stated the RN eventually came out and they were able to get the resident into the car.

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

Vulnerable Adult interviewed: Unavailable for interview.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:

The facility reported the resident's rib fractures to MAARC.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Polk County Attorney
East Grand Forks City Attorney
East Grand Forks Police Department
Minnesota Board of Executives for Long Term Services and Supports
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30631	A. BUILDING: _____ B. WING _____	C 12/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD EGF SENIOR LIVING	608 5TH AVENUE NW EAST GRAND FORKS, MN 56721

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL306317702M/#HL306313166C #HL306317703M/#HL306313167C On December 27, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 37 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL306317702M/#HL306313166C, tag identification 0620, 1760, 2360. The following correction orders are issued for #HL306317703M/#HL306313167C, tag identification 2310, 2360.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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0 620	Continued From page 1	0 620		
0 620 SS=D	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma (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. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point.	0 620		

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0 620	Continued From page 2 (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment for one of one residents (R1) reviewed for maltreatment. 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).	0 620		

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0 620	Continued From page 3 The findings include: The licensee failed to immediately report suspected neglect after the resident missed ten days of essential medications, including medications to treat heart failure and fluid overload. The resident was hospitalized with congestive heart failure exacerbation. Facility nurses failed to notify the resident's primary care provider, failed to notify the resident's family, and failed to investigate the incident. R1 had been hospitalized and treated for congestive heart failure and was started on nine new medications. After returning to the facility, the new medications did not immediately arrive. Clinical nurse supervisor (CNS)-A and registered nurse (RN)-B were aware of this but failed to contact the pharmacy to follow up and failed to notify the primary care provider (PCP) that new medications to treat heart failure had not been started. The facility did not have a process in place to ensure the family and primary care provider were updated or a process to ensure new orders were followed up on to ensure the medications arrived. The resident missed ten days of essential medications. The resident was rehospitalized with exacerbation of congestive heart failure. On December 27, 2024, at 1:00 p.m., licensed practical nurse (LPN)-D stated she was extremely concerned how many doses of medications the resident missed and she went to both CNS-A and RN-B and told them "this is neglect", we're not giving medications for his heart failure, what are we doing about this and they "gave her the run around" that it was the pharmacy's fault and the family's fault, not the facility's. LPN-D stated she told nursing management she would call 911 and	0 620		

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0 620	Continued From page 4 send the resident to the hospital if he couldn't get his medications and she was frustrated with their inaction because "I'm the one putting unavailable" for his medications. LPN-D stated she had told nursing management it needed to be reported but RN-B replied with "report what?" LPN-D stated they felt they were not at fault for the incident and that it did not need to be reported. On December 31, 2024, at 11:00 a.m., CNS-A stated when the incident happened, they hadn't looked at it as being possible neglect but in looking at things now, it was probably something they should have done a MAARC report on. On December 31, 2024, at 2:15 p.m. registered nurse (RN)-B stated she did not believe the incident was neglect and felt the resident's son was responsible for neglect because he wanted to use an outside pharmacy. On January 2, 2024, at 11:40 a.m., licensed assisted living director (LALD)-C stated he was not initially aware of the incident but usually nursing would take care of determining if something was reportable and they would have reported it if they felt like there was neglect. The licensee's Abuse Prevention, Intervention, Reporting, and Investigation policy dated July 2024, indicated the community had developed a system for identifying, investigating, preventing, and reporting any incident, or suspected incident, of abuse as defined above. All staff were mandated reporters and must comply with state and federal regulations regarding reporting suspected abuse. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		

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0 620	Continued From page 5 No further information provided.	0 620		
01760 SS=G	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure medication was administered as prescribed for one of one residents (R1) and failed to follow-up on medication administration practices when R1's medications were out of stock for eight days, resulting in R1 being admitted to the hospital. The licensee also failed to identify and follow up on nine medication errors. 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	01760		

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01760	Continued From page 6 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's diagnoses included vascular dementia, Alzheimer's disease, and heart failure. R1's service plan, dated March 28, 2024, indicated the resident received services including medication administration. R1's assessment dated December 23, 2024, indicated the resident's medications were ordered by facility staff through an outside pharmacy. The resident returned to the facility after a hospitalization on November 27, 2024, where he was treated for heart failure. The resident was started on nine new medications as a result of the hospitalization, including medications to reduce fluid overload. R1's November 2024 Medication Administration Record (MAR) indicated the resident did not receive the following medications on November 28, 29, 30: Protonix (a medication to treat acid reflux) 40 milligrams (mg) daily Bumex (a medication to reduce extra fluid caused by heart failure) 2 mg daily. Losartan (a medication to treat high blood pressure) 25 mg daily Metformin (a medication to control high blood sugar) 1,000 mg twice daily with meals. Metoprolol (a medication to treat heart failure) ER [extended release] 25 mg once daily. Mucus ER (a medication to temporarily treat coughing) 600 mg twice daily. The medication	01760		

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01760	Continued From page 7 was marked as administered, despite not being in stock, on November 27. Plavix (a medication to prevent blood clots) 75 mg daily. Spironolactone (a medication to treat heart problems and reduce fluid retention) 25 mg daily. Allopurinol (a medication to treat kidney stones) 300 mg daily. The medication was marked as administered, despite not being in stock, on November 28 and November 30. R1's December 2024 MAR indicated the resident did not receive the following medications on December 1, 2, 3, 4, 5, 6, 7: Protonix (a medication to treat acid reflux) 40 mg daily Bumex (a medication to reduce extra fluid caused by heart failure) 2 mg daily. The medication was marked as administered, despite not being in stock, on December 4. Losartan (a medication to treat high blood pressure) 25 mg daily Metformin (a medication to control high blood sugar) 1,000 mg twice daily with meals. The medication was marked as administered, despite not being in stock, on December 6. Metoprolol (a medication to treat heart failure) ER [extended release] 25 mg once daily. Mucus ER (a medication to temporarily treat coughing) 600 mg twice daily. Plavix (a medication to prevent blood clots) 75 mg daily. Spironolactone (a medication to treat heart problems and reduce fluid retention) 25 mg daily. Allopurinol (a medication to treat kidney stones) 300 mg daily. The medication was marked as administered, despite not being in stock, on December 5, 6. Atorvastatin (a medication to treat high cholesterol) 40 mg daily. The medication was	01760		

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01760	Continued From page 8 marked as administered, despite not being in stock, on December 5, 6. R1's December 2024 MAR indicated the resident did not receive the following medications on December 8: Protonix (a medication to treat acid reflux) 40 mg daily Bumex (a medication to reduce extra fluid caused by heart failure) 2 mg daily. Losartan (a medication to treat high blood pressure) 25 mg daily Metformin (a medication to control high blood sugar) 1,000 mg twice daily with meals. Metoprolol (a medication to treat heart failure) ER 25 mg once daily. Mucus ER (a medication to temporarily treat coughing) 600 mg twice daily. Plavix (a medication to prevent blood clots) 75 mg daily. Spironolactone (a medication to treat heart problems and reduce fluid retention) 25 mg daily. R1's progress notes contained the following entries: -November 27, registered nurse (RN)-B documented the resident's "medications were reviewed again as [hospital case manager] had faxed all new orders earlier. Medications have been updated in Edgewood EMR [electronic medical record] and reviewed by [CNS-A]. [Hospital case manager] was aware that all new medications needed to be sent to [pharmacy] to be filled promptly per son's request as they do not fill medications in town..." -November 28, RN-B documented she spoke with a pharmacist from a pharmacy the resident did not use as the pharmacist was questioning if medications needed to be filled. RN-B "educated [pharmacist] that medications were sent to	01760		

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01760	Continued From page 9 [outside pharmacy] to be filled. Son prefers [outside pharmacy] fills. [Pharmacy] states they can fill until the [outside pharmacy] fills but they need payment up front due to past issues. 1 antibiotic tab was filled and billed out per RN direction. Awaiting [outside pharmacy] meds to arrive." -December 9, RN-B documented she spoke with a nurse at the hospital and wrote the resident had been hospitalized for congestive heart failure exacerbation. "Hospital is aware that patient's medications have been ordered through [outside pharmacy] but have not arrived yet..." Later that day, RN-B documented she spoke with a pharmacy tech who stated they never received orders from the hospital on November 27. The resident's daughter "called right after and stated that she got a call from a mail order last week asking about medications filled. She referred them to Edgewood but nursing never received a phone call. Daughter asked if medications could be filled at a local pharmacy..." RN-B advised the daughter that the local pharmacy would not fill due to an outstanding bill and the daughter stated she would follow up with the pharmacy and pay the bill so medications could be filled. -December 12, CNS-A documented he "spoke with the resident's daughter about medications that were ordered at [hospital] but not sent with resident. Her consent was given to contact [local pharmacy] to obtain supply of medications that were started at [hospital] as resident normally gets meds from [outside pharmacy] and will not be available until they ship." The facility failed to document when symptoms started and when or why the resident was sent to the emergency room. RN-B stated the facility had records showing the progression of the resident's symptoms and when he was sent in and that she	01760		

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01760	Continued From page 10 would email the records, however records were not provided. Hospital records indicated the resident came to the emergency room on December 8, 2024, at 3:52 p.m. for evaluation of shortness of breath. The resident reported having chest pain earlier in the day but that it had improved. The resident was noted to have had shortness of breath for the past two days. Upon arrival to the emergency room, the resident's oxygen saturation was 88% (normal is greater than 95%) and the resident "appeared uncomfortable." The resident was admitted for congestive heart failure exacerbation and spent four days in the hospital. Documentation of medication errors for instances when the medication was marked as given despite being out of stock were requested on December 30, 2024. Partially completed medication error reports dated December 30, 2024, were provided. On December 27, 2024, at 1:00 p.m., licensed practical nurse (LPN)-D stated she was responsible for passing R1's medications and when she noticed the resident did not have the new medications he needed to treat his heart failure, she told both CNS-A and RN-B that he didn't have any medications and they needed to do something as he should not be missing so many doses. LPN-D stated she would be told they were looking into it and that it was being sent. LPN-D stated she voiced concerns about not giving the medications as neglect because the medications were for heart failure but nursing management kept telling her the medications were ordered. LPN-D stated she had gotten into an argument with RN-B because she didn't feel like they were doing any follow up to see if the	01760		

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01760	Continued From page 11 resident's medications were actually coming. On December 31, 2024, at 8:10 a.m., R1's son stated the facility had not called to tell him his dad wasn't getting medications. R1's son stated he only found out about it after the resident was hospitalized and the hospital told him the resident hadn't received his medications which caused a fluid build up. R1's son stated he spoke with clinical nurse supervisor (CNS)-A and RN-B and they had said the hospital screwed up and didn't send the prescriptions and was under the impression his dad had only missed a few medications. R1's son stated if he would have been made aware of the medications never arriving, he would have called the pharmacy himself or found a way to get the medications for his dad. On December 31, 2024, at 10:20 a.m., a representative with the outside pharmacy confirmed they did not receive any orders after the resident's November 28th hospitalization and they did not have any record of the facility reaching out to them to check the status of the medications. On December 31, 2024, at 11:00 a.m., CNS-A stated he was not sure why there was no documentation leading up to the resident's December 8th hospitalization or when nursing was notified of concerns. CNS-A confirmed the facility had not reached out to the primary care provider about the new medications not being able to be started and the resident's family was not notified about the issues with obtaining the new prescriptions that had been started to treat the resident's congestive heart failure. CNS-A stated the hospital should have sent the new orders to the outside pharmacy but they never	01760		

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01760	Continued From page 12 followed up or called the outside pharmacy in the days after he returned to the facility. CNS-A stated the resident was the first time he had worked with this outside pharmacy before and confirmed they did not have a process in place for when a new order was initiated but the outside pharmacy wasn't able to deliver for 7 to 10 days. CNS-A confirmed until it was identified by the investigator, he was not aware of the medication errors where a staff member documented the medication that was not available as given and that they did not really have a process to identify errors like that. On December 31, 2024, at 2:15 p.m., RN-B stated the son was "well aware" the resident was not receiving the new medications to treat his heart failure because the son chose to use an outside pharmacy that took a while to deliver. RN-B confirmed the PCP was not notified the medications would not be able to be started immediately and she was not aware they could ask to get a hold order and thought they were to just mark it as med not available. RN-B stated the resident's son would have been educated in the hospital about the risks of not starting the medications and that he was well aware they did not have the medications. RN-B stated she never followed up to see if the pharmacy got the new orders because the hospital said they sent it and the outside pharmacy would take a few days to send it. On December 31, 2024, at 3:30 p.m., a registered nurse (RN) with the resident's primary care provider's office stated they had reviewed the resident's clinic record and visited with the PCP and did not see any evidence they were notified the resident's new medications could not be started immediately. The RN stated they would	01760		

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01760	Continued From page 13 expect the facility contact them to either hold the medication or find alternatives until the medications could be delivered. The RN stated they weren't even aware the resident had been sent to the hospital and only found out after the fact. On January 2, 2025, at 1:00 p.m., R1's daughter stated she wasn't aware the resident missed any medications until a nurse at the hospital told her the facility had reported he didn't get his new medications filled. R1's daughter stated she spoke with CNS-A after the resident was hospitalized and asked him why didn't someone call somebody to see if they could get medications filled elsewhere while they were waiting on the outside pharmacy instead of just marking it down as not available the whole time. R1's daughter stated if the facility had notified her that the medications never arrived she would have taken action to get them filled immediately. R1's daughter stated she was not told about the outstanding bill at the local pharmacy that prevented them from being able to fill there but as soon as she was aware of it, she paid it and was able to get the medications filled until the outside pharmacy could send the medications. The licensee's Physician Orders policy dated July 2024, indicated the licensee would process all new orders for medication or treatment and carry out as prescribed. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01760		

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02310	Continued From page 14	02310		
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for one of one residents (R2) with a change in condition. The RN failed to report 22 out of range blood sugars to the primary care provider (PCP) as ordered over six weeks. The resident was admitted to the intensive care unit (ICU) with diabetic ketoacidosis (a complication of diabetes that results from increased levels of a chemical called ketones. Symptoms include excessive thirst, frequent urination, fatigue, and vomiting.) In addition, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for one of one residents (R2) with falls. The RN failed to implement interventions after each fall. 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).	02310		

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02310	Continued From page 15 The findings include: CHANGE IN CONDITION R2's diagnoses included type one diabetes, Alzheimer's disease, and dementia. R2's service plan dated November 26, 2024, indicated the resident received diabetic management, medication administration, and transfer assistance. R2's record contained a signed prescriber order dated October 10, 2024, which was reviewed and received by registered nurse (RN)-B. Instructions included to contact the provider if blood sugars were below 60 or above 400. R2's November 27, 2024, assessment indicated the resident would transfer and ambulate with a walker and he had decreased strength and endurance due to physical decline. The resident had memory loss and was disoriented occasionally. The assessment indicated the resident was a type one diabetic but did not mention noncompliance with diet. The assessment did not identify that staff were update the primary care provider of out-of-range blood sugars as directed by the October 10th order. R2's December 4, 2024, assessment indicated the resident needed assistance with transfers and he was encouraged to ask for assistance with transfers. The resident had an unsteady gait with weakness, and he was to transfer with one person and a gait belt. The resident did not use a wheelchair. The resident was on a diabetic protocol and staff were to report blood sugars above 400 or below 70 to the nurse, however the assessment did not identify that staff were to also update the primary care provider. The resident	02310		

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02310	Continued From page 16 had confusion including memory loss and was on 30 minute safety checks. The assessment indicated the resident was a type one diabetic but did not mention noncompliance with diet. R2's progress notes and documentation of blood sugar included: -November 2, 2024, the resident's blood sugar was 53 at 6:30 a.m., the on-call RN was notified, but the RN failed to notify the primary care provider as directed. Later that day, the resident's blood sugar was 422 at 12:38 p.m., The on-call RN was notified, but the RN failed to notify the primary care provider as directed. -November 3, 2024, the resident's blood sugar was 57 at 12:18 a.m., the on-call RN was notified, but the RN failed to notify the primary care provider as directed. -November 4, 2024, the resident's blood sugar was 439. The record lacked evidence the RN on call was notified. Later that day, the resident's blood sugar was 34 and then 56. The on-call RN was notified, but the RN failed to notify the primary care provider as directed. -November 11, 2024, the resident's blood sugar was 520 at 11:00 a.m. The RN was notified, but the RN failed to notify the primary care provider as directed. -November 25, 2024, the resident's blood sugar was 429 at 11:00 a.m. The record lacked evidence the RN on call was notified. -November 28, 2024, the resident's blood sugar was 440 at 11:00 a.m., later that day it was 447 at 5:00 p.m. The RN was notified, but the RN failed to notify the primary care provider as directed. The RN directed staff to administer regularly scheduled insulin. -November 29, 2024, the resident's blood sugar at 6:30 a.m. was 482. The record lacked evidence the RN on call was notified.	02310		

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02310	Continued From page 17 -November 30, 2024, the resident had to be assisted by staff to walk with his walker and his "legs were weak and needed a second assist with walking the rest of the way to the table..." Later that evening, it was documented the resident's "legs are shaky if standing more than about 60 seconds at a time, resident becomes weak as if he needs to sit down, rest legs and then stand up again." -December 1, 2024, the resident required an assist to supper with a wheelchair due to being "too weak to walk all the way there. Legs became weak and resident want to sit even though nowhere to sit..." -December 2, 2024, the resident became weak while walking to breakfast and reported he couldn't make it to the table. Occupational therapy relayed concerns to LPN-D about the resident's weakness and complaints of lightheadness with ambulation, standing, and activities, as well as concerns with his nutrition. Licensed practical nurse (LPN)-D documented she informed clinical nurse supervisor (CNS)-A and RN-B were notified at 11:00 a.m. of these concerns. -December 4, 2024, the resident's blood sugar was 424 at 6:30 a.m., at 5:00 p.m. it was 519, and at 8:00 p.m. it was 426. The RN was notified, but the RN failed to notify the primary care provider as directed. -December 5, 2024, the resident's blood sugar was 473 at 6:30 a.m., 540 at 11:00 a.m., and 404 at 3:29 p.m. The RN was notified, but the RN failed to notify the primary care provider as directed. -December 5, 2024, RN-B wrote she was notified of the resident being nauseated and having high blood sugar. The provider was notified and new lantus orders were obtained. A urine culture was ordered to rule out a urinary tract infection.	02310		

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02310	Continued From page 18 - December 6, 2024, the resident received assistance to walk to his room, but he had to sit down and use his wheelchair. -December 6, 2024, the resident's blood sugar was 488 at 11:00 a.m. Later that day, it was 443 at 5:00 p.m. The RN was notified, but the RN failed to notify the primary care provider as directed. -December 7, 2024, the resident's blood sugar was 437 at 6:30 a.m. The RN was notified, but the RN failed to notify the primary care provider as directed. At 5:00 p.m., the resident's blood sugar was 422. The RN was notified, but the RN failed to notify the primary care provider as directed. -December 8, 2024, the resident's blood sugar was 441 at 5:00 p.m. The RN was notified, but the RN failed to notify the primary care provider as directed. At 8:00 p.m., the resident's blood sugar was 562. The RN was notified, but the RN failed to notify the primary care provider as directed. -December 9, 2024, RN-B wrote the resident continued to have nausea and had vomited throughout the night. Another progress note indicated the resident reported being sore but was ambulating with a gait belt and an assist of two without any complaints. -December 10, 2024, the resident was started on an antibiotic for a urinary tract infection. -December 11, 2024, the resident's blood sugar reading at 6:30 a.m. was "HI" (too high to be read by the machine) at 6:30 a.m., and the registered nurse was notified. RN-B contacted the primary care provider at 8:00 a.m. and documented the nurse practitioner's response to be, "I am sure this is due to his infection as well. I feel he should go in and be evaluated. He could be in ketoacidosis. Call family and let them know my recommendation please." RN-B wrote, "Daughter	02310		

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02310	Continued From page 19 notified and will be coming to take him to the walk-in clinic." R2 was admitted to the hospital on December 11, 2024, with diagnoses including diabetic ketoacidosis, closed fracture of multiple ribs, and pneumothorax (collapsed lung) to right lung. Hospital documentation indicated the resident's blood pressure was 66/42 (normal is 120/80, a blood pressure below 90/60 is considered hypotensive). Diagnostic imaging indicated the resident had two acute rib fractures on his right side, and a rib fracture on his left side. A fourth rib fracture with signs of early healing was also noted. The resident's right lung was collapsed and a chest tube was placed. The resident was transferred to the intensive care unit (ICU.) R2 was still hospitalized at the time of the investigation. On January 6, 2025, at 10:00 a.m., R2's daughter stated when she arrived at the facility on December 11th, the resident was dressed with a coat on, sitting in a wheelchair and was "just out of it" with his head hanging down. R2's daughter stated she asked how she was supposed to get the resident in the car as he would normally be able to get himself into the car and staff assured her they'd help her. R2's daughter stated they "put this strap" around him and were trying to pull him into the car but he was just dead weight and she got upset with the staff and told them it was "bullshit." R2's daughter stated she didn't feel like the transfer was safe, but figured they had done this before and knew what they were doing so she did not stop them. R2's daughter stated one staff member was in the back seat and another was trying to get him in the passenger side, but the resident was just dead weight. R2's daughter stated after they finally got him in the car, she	02310		

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02310	Continued From page 20 brought him to the urgent care as she was directed to do but the urgent care told her they needed to go to the emergency room. R2's daughter stated she had some concerns with care at the facility related to the resident's blood sugars as they had removed candy from his room and gave him sugar free chippers and licorice, but they'd still find candy and sweets in his room that the facility had given to him. R2's daughter stated she had asked that the resident not be given the candy and sweets, but it'd still end up in his room. On January 6, 2025, at 10:30 a.m., the resident's nurse practitioner (NP)-F reviewed the resident's chart while on the phone with the investigator and confirmed she did not see any documentation of being notified on blood sugar readings that fell outside the parameters of when to call the provider. NP-F stated she would expect to be notified per the parameters so the resident's insulin could be adjusted. NP-F stated RN-B had sent her a Teams message [online chat] about the resident's blood sugar being high and so she called them to see what was going on. NP-F stated she was told he had a blood sugar that was reading high, and the resident was more weak and given that he recently started treatment for a urinary tract infection, she was worried he might be septic or have diabetic ketoacidosis. NP-F stated she directed the resident be taken to the emergency room, not the urgent care. NP-F stated she would have expected the RNs to use their judgment and if the resident was not stable for transport in a private car, to call for an ambulance. NP-F stated she was not aware the resident was that critical or that he had been having so many high and low blood sugar readings as they hadn't been reported. NP-F stated she had reviewed the resident's chart and	02310		

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02310	Continued From page 21 her opinion based off the medical records was that the diabetic ketoacidosis had started a week prior to his hospitalization, and it wasn't an acute or sudden onset. On January 6, 2025, at 12:10 p.m., LPN-D stated she was never given any direction about contacting the provider for high or low blood sugar readings and they were only directed to contact the RN on call for anything out of normal ranges. On January 6, 2025, at 1:20 p.m., RN-B stated R2 was very noncompliant with his diabetes and would eat a lot of snacks. RN-B confirmed that information should have been in the assessment and was not sure why it was not included. RN-B stated staff would usually call and report out of range blood sugars to the on-call RN, which was a contracted company. RN-B confirmed they did not have documentation to show the nurse practitioner was updated of all out of range blood sugars but confirmed the nurse practitioner should have been updated as ordered. RN-B stated on December 11, she contacted NP-F who said the resident needed to go in and be seen. RN-B stated a ULP had gone out to help the resident into the car and she was in the building and looked out the window and saw the daughter standing there and the ULP in the car, and the resident's legs had "slid" out of the car. R2 wasn't on the ground so she went outside and climbed in the back seat and told the ULP to grab his legs and she put her arms under his arms, and they lifted him up into the car. RN-B stated the resident seemed fine and she went over to the clinic to help the daughter transfer the resident in and out of the car again. RN-B was asked why the resident was immediately sent to the emergency room and instead went to the urgent	02310		

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	30631	A. BUILDING: _____ B. WING _____	C 12/27/2024

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02310	Continued From page 22 care clinic. RN-B stated the daughter had asked if she had to drive him across town to the emergency room and she told him there were a couple of walk-in clinics here and since he was going in for an infection and blood sugar, she recommended she had the choice to go where she wanted and that the walk-in clinic would be appropriate. RN-B was asked if she felt that was the appropriate level of care and replied that the resident's daughter had a choice of where she wanted to go. On January 7, 2025, at 10:40 a.m., ULP-G stated the resident was normally a bit tired and they had been providing increased transfer assistance to him. ULP-G stated after the resident stood up to get into the car and another staff member brought his wheelchair inside, his legs wouldn't move, and she couldn't get the resident into the car and didn't have the wheelchair anymore to sit him back down. ULP-G stated she eventually went in through the driver's side of the car and pulled the gait belt to get the resident into the car, but his lower half of his body wouldn't go in. ULP-G stated RN-B eventually came out and they were eventually able to get the resident into the car. FALLS R2's November 27, 2024, assessment indicated the resident would transfer and ambulate with a walker and he had decreased strength and endurance due to physical decline. The resident had memory loss and was disoriented occasionally. Staff were to encourage the resident to use his call light for assistance with transfers. R2 had a fall on November 2 and the resident was encouraged to call staff for assistance with transfers when he feels weak. Staff were to provide 2 hour safety checks. The assessment	02310		

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02310	Continued From page 23 did not identify falls that happened on November 1, November 9, or November 26. R2's December 4, 2024, assessment indicated the resident needed assistance with transfers and he was encouraged to ask for assistance with transfers. The resident had an unsteady gait with weakness, and he was to transfer with one person and a gait belt. The resident did not use a wheelchair. The resident had confusion including memory loss and was on 30 minute safety checks. The resident had a fall on November 1, 2024, and the resident was encouraged to call staff for assistance with transfers when he feels weak. Staff were to provide 30 minute safety checks as an intervention. The assessment indicated the resident had a fall on November 29, and 30 minute safety checks were performed by staff as an intervention. Staff were also to encourage the resident to use his call light for assistance and wait for help. The assessment did not identify falls that happened on November 30, November 26, or November 9. R2's Service Recap Summary for November 2024 and December 2024 lacked documentation of every 30 minute safety checks. R2's record contained the following fall incident reports: -November 2, 2024, the resident fell in his room while walking to the bathroom. The intervention added was, "Resident encouraged to call staff for assistance with transfers when he feels weak. Staff to provide 2 hour safety checks." -November 9, 2024, the resident fell again in his room. It was noted the resident had a history of falling after standing in his room. No individualized intervention was implemented after the fall.	02310		

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02310	Continued From page 24 -November 26, 2024, the resident fell again in his room and sustained a "large cut." The intervention added was, "Staff to encourage resident to utilize call light for assistance with transfers. Staff to encourage resident to wear proper footwear with ambulation/transfers." -November 29, 2024, the resident fell in his room while walking to the bathroom. No individualized intervention was implemented after the fall. The resident's record lacked evidence the RN reviewed the fall incident report. -November 30, 2024, the resident fell in his bathroom. No individualized intervention was implemented after the fall. The resident's record lacked evidence the RN reviewed the fall incident report. On January 6, 2024, at 9:30 a.m., CNS-A confirmed the resident was "pretty forgetful" and had impaired cognition. CNS-A stated they tried to come up with interventions after each fall, but it wasn't always easy to come up with a new intervention. On January 6, 2024, at 1:20 p.m., RN-B confirmed the resident had impaired cognition and would not be able to remember reminders to use his call light. RN-B stated she was not sure why there weren't interventions implemented after each fall but confirmed there should be. RN-B confirmed the facility did not document every 30 minute checks and instead staff would just document once at the end of the shift that they checked on the resident every 30 minutes. The licensee's Communication policy dated July 2024, indicated Community staff would inform the primary care provider and resident ' s responsible party about each event that results in a resident's need for medical attention, other obligation to	02310		

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02310	Continued From page 25 report, or recognized potential harm to a resident. The Community staff would retain documentation for communication to and from providers and responsible parties and shall store documentation in the resident ' s electronic health record. The licensee's Assessments policy dated July 2024, indicated the RN would be responsible for evaluating a significant change in resident condition. The RN would assess, diagnose, plan, implement, and evaluate and report findings to the primary care provide as necessary. The licensee's Falls policy dated July 2024, indicated if a resident fell, the facility would implement fall reduction strategies. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure two of two residents reviewed (R1, R2) were free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person and the facility were	02360	No plan of correction required for this tag.	

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02360	Continued From page 26 responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		