Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL329131922M
Compliance #: HL329133230C

Date Concluded: July 22, 2025

Name, Address, and County of Licensee Investigated:
Volante of Hanover
10875 Settlers Lane
Hanover, MN 55341
Hennepin County

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

Evaluator's Name: Kris Detsch, 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 neglected a resident when they failed to administer medications accurately as ordered by the resident's physicians. As a result, the resident had emotional distress and increased falls.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The resident developed a systemic rash (whole body), required hospitalization and multiple medical appointments to determine the cause of the rash. The resident's physician discontinued her antidepressant in suspicion of the cause of the allergic reaction. However, the facility failed to control or monitor their medication order transcription process and failed to discontinue the medication. As a result, because the resident's allergic reaction persisted, the physicians (primary care and dermatologist) continued to discontinue

other medications under the assumption their previous orders were implemented, which included medications for her mental health and antibiotic.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident records, pharmacy records, facility internal investigation, facility incident reports, personnel files, and related facility policy and procedures. Also, the investigator toured the facility and observed medication administration.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's disease, meningioma (brain tumor), kidney failure, and diabetes. The resident's service plan included assistance with medication management. The resident's nursing assessment indicated the resident had severe memory loss and required frequent redirection from staff members. The resident had a callous on her foot, but indicated there were no other skin concerns.

Progress notes indicated the resident's neck and chest was "red" when she admitted into the facility because she received radiation treatment for a brain tumor. Progress notes indicated the resident began to scratch at her skin and had a few open areas. Approximately one week later, progress notes indicated the resident's rash was all over her body. The resident had blisters, and swelling of her lower limbs. Progress notes indicated the resident went to the emergency room (ER) and returned to the facility with physician orders for new medications and an order to discontinue (stop) taking the medication Lexapro (medication used to treat depression and anxiety.)

Medication administration records (MAR) indicated the facility did not discontinue the medication Lexapro until seventeen days after the physician ordered the facility to discontinue the medication. The resident received twenty-one dosages of Lexapro after the physician told the facility to discontinue the medication.

Physician visit records indicated the resident's family contacted them through a message portal system six days later because the resident's rash had not improved since the physicians discontinued the Lexapro. The records indicated the physician wanted to discontinue another medication called Depakote (used to prevent seizures and treat mood disorders). The records indicated the physician's office sent the facility a fax (electronic form) with this information. The fax indicated the facility should stop the Depakote immediately. The fax contained handwritten initials of the facility nurse who also wrote the letters "d/c" (discontinued) on the form which indicated she received the fax.

MAR records indicated the facility did not discontinue the Depakote until three days after the physician ordered the facility to discontinue the medication. However, after a brief stop, the MAR indicated someone placed another (duplicate) order for the medication, so staff members

continued to give the medication. The resident received nine dosages of Depakote after the physician ordered the facility to discontinue the medication immediately.

Progress notes three days later indicated the resident went to a dermatologist (skin specialist) who ordered topical (skin) ointments for the resident. Those ointments were Clobetasol and Desonide. The dermatologist had also ordered to start an antibiotic.

MAR records indicated the facility did not start applying Clobetasol and Desonide (topical steroid ointments) until six days after the physician gave the facility the order to start the medications. R1's medical records lacked indication for the delay.

MAR records indicated the resident had already been on the antibiotic for a week prior to the dermatologist's appointment. The licensee lacked records they informed the dermatologist of her orders. The dermatologist ordered to stop the antibiotic 15 days later. The MAR indicated the facility failed to stop the antibiotic.

Five days after the dermatologist appointment, the resident's physician ordered a new antidepressant, Celexa, to start because it would not result in a rash or serious allergic reaction called Steven-Johnson's syndrome.

MAR records indicated the facility started Celexa three days after it was ordered and discontinued Lexapro, the previous antidepressant, on the same day. However, the facility continued a "as needed" order of Lexapro and the resident received both antidepressants. Additionally, the facility briefly stopped, without a physician order, the Celexa after five days and restarted it again three days later.

Progress notes indicated the resident was aggressive. The resident hit staff members, threw items, and broke things. Progress notes indicated the resident had insomnia (difficulty sleeping) .

Facility Incident reports indicated the resident fell five times within this month. The resident fell twice in one day which resulted in hospitalization.

During an interview, a nurse said the resident saw multiple physicians and there were conflicting orders from the physicians. The nurse said the pharmacy entered orders into the facility's computer system, however she would have to "verify" the order. The nurse said she "could" enter orders into the licensee's computer system, but she did not. The nurse said some physicians sent medication orders electronically directly to the pharmacy, other times the orders went to the facility, and she would fax them to the pharmacy. The nurse said she was aware the MAR included duplicate orders, and this occurred because the pharmacy did not discontinue medications from the MAR. The nurse said once she became aware of the duplications, she spoke to upper management and the pharmacy. The nurse said she had a meeting with upper management and the resident's family to talk about the resident's

medications and physician orders. The nurse said she was aware there were discrepancies with the resident's Depakote, but said the orders kept changing daily. The nurse said she no longer works for the licensee.

During an interview, a manager said he attended a meeting with the nurse and resident's family member, but he left the meeting while the nurse and family continued to talk about medication. The manger said after the meeting, the nurse told him about the medication concerns and so he contacted senior leadership (corporate), and they began to investigate what occurred. The manager said he contacted the pharmacy, while the clinical staff (corporate nurses) addressed the MAR. The manager said the licensee's team spent several hours trying to sort things out, and described this process as "a mess." The manager said the pharmacy never received the orders to discontinue the medications.

Email communication from the pharmacy to the manager indicated the pharmacy did not receive any orders/communication to discontinue Lexapro or Depakote, so they continued to refill and send the medications to the facility.

During an interview, a clinical manager said part of the leadership team who tried to investigate concerns regarding the resident's medications. The clinical manager said the facility had a binder which contained a paper "face sheet" which listed the resident's medications, and a staff member gave the face sheet to the resident's family, however the face sheet did not contain the resident's current/accurate medication list. The clinical manager said the facility nurse documented medication order changes in the resident's progress notes, however the facility did not have an official physician order at the time she completed her documentation. The clinical manager said the resident's progress notes, did not match the medication list in the facilities computer system. The clinical manager said the pharmacy entered in resident medication orders into the facilities computer system, the nurses did not. The clinical manager said the nurse "could" enter in a treatment order, but not a medication order. The clinical manager said the nurse could "stop" a medication; however, they would then have to provide an order to the pharmacy otherwise the pharmacy would re-start the medication order. The clinical manger said she was unclear if the facility nurse would know if the pharmacy re-started a medication order. The clinical manager said there were communication errors with this process.

During an interview, a family member said anytime the resident had medical appointments she told the facility nurse. The facility nurse gave the family member paperwork to take to the medical appointments and she returned paperwork from the medical appointment to the facility. The family member said she noticed discrepancies with the medications list three different times and spoke to the facility nurse about the errors. The family member said the facility nurse told her she could not take orders from a family member, however the family member said she gave the facility nurse the orders from the resident's physician. The family member said the physicians were trying to determine what caused the resident's rash/blisters over her body. The family member said initially, the ER physician stopped Lexapro, then Depakote. The family member said she assumed the facility stopped those medications, but

they had not. The family member said the resident fell multiple times and had a lot of behavior changes. The resident fell twice in one day and went to the hospital. The family member said while in the hospital, physicians tested the resident's blood and determined she had Depakote in her system. The family member said physicians determined the Depakote caused the rash. The family member said the facility "double dosed" the resident's Lexapro (the scheduled dosage and the PRN dosage) which caused the resident to have behavior issues and falls.

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.

Mitigating Factors considered, Minnesota Statutes, section 626.557, Subd. 9c(f):

(1) The facility did follow an erroneous order, direction or care plan with awareness and failure to take action.

The facility did not direct an erroneous order, direction, or care plan.

(2) The facility was not in compliance with regulatory standards.

The facility provided proper training and/or supervision of staff.

The facility provided adequate staffing levels.

(3) The facility failed to follow professional standards and/or exercise professional judgement.

The facility failed to act in good faith interest of the vulnerable adult.

The maltreatment was not a sudden or foreseen event.

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

Action taken by facility:

The facility contacted senior leadership to assist with determination of what medication errors occurred.

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

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

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

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

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

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Hennepin County Attorney
Hanover City Attorney
Hanover Police Department
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32913	A. BUILDING: _____ B. WING _____	C 06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOLANTE OF HANOVER	10875 SETTLERS LANE HANOVER, MN 55341

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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: HL329133230C/HL329131922M HL329133193C/HL329131902M On June 11, 2025, 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 15 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for HL329133230C/HL329131922M, tag identification 1690, 2360. There are no correction orders are issued for HL329133193C/HL329131902M.	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.	
01690 SS=G	144G.71 Subdivision 1 Medication management services	01690		

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01690	Continued From page 1 (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced by: Based in interview and record reviewed, the licensee failed to ensure medications were administered as prescribed for one of one resident (R1) with records reviewed. The licensee failed to take ownership of their entire medication	01690		

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01690	Continued From page 2 administration system and differed responsibility to the pharmacy. As a result of this deficient practice, when R1 had an allergic reaction with a rash that persisted, physician's continued discontinuing medications under the assumption their order of a previous medication was implemented and the rash was the result of a different medication. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, ore 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's diagnoses included Alzheimer disease, chronic renal insufficiency, and diabetes. R1's service plan dated March 5, 2025, included assistance with medication management. Progress notes dated February 24, 2025, at 5:39 p.m., indicated R1 developed a rash on her neck and chest. The licensee updated R1's physician. Progress notes further indicated by March 2, 2025; the rash was "all over." R1 had blisters, and edema of her lower extremities. R1 went to the emergency room (ER) the next day on March 3, 2025. R1 returned to the licensee with new medication orders from the physician. Escitalopram: R1's hospital after visit summary (AVS), dated March 3, 2025, indicated physicians ordered R1 to stop taking Escitalopram (lexapro).	01690		

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01690	Continued From page 3 Progress notes dated March 3, 2025, at 5:38 p.m., indicated R1 returned from the hospital with new medication orders including an order to discontinue lexapro. R1's medication administration record (MAR) dated March 1, 2025, through March 30, 2025, indicated the licensee did not discontinue escitalopram until March 20, 2025. However, a duplicate order was also on the MAR and R1 received an additional dosage of the medication on March 25, 2025. The MAR indicated the licensee failed to discontinue the as needed "PRN" dosage of the medication, and R1 received PRN dosages on March 20, 21, 22, and 23. The licensee discontinued the PRN medication on March 26, 2025. The licensee failed to discontinue the escitalopram as ordered by the ER physician on March 3, 2025. R1 received 21 dosages of escitalopram after the ER physician discontinued the medication. Depakote: Physician records dated March 9, 2025, indicated a family member contacted them through a portal system (similar to email) because R1's rash did not improve after ER physicians discontinued the escitalopram on March 3, 2025. (However, the licensee failed to discontinue R1's escitalopram.) Because there was no improvement in R1's skin condition after the discontinuation of escitalopram and addition of a steroid medication (prednisone), they wanted the licensee to discontinue Depakote (medication used to treat seizures and mood disorders). The physician's documentation indicated the licensee should discontinue Depakote.	01690		

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01690	Continued From page 4 Fax Transmission form dated March 10, 2025, at 2:16 p.m., indicated R1's clinic sent the licensee a fax message indicating R1 should stop Depakote "stat" (immediately). The fax included the name and telephone number of the nurse who sent the licensee the fax, and included a message to call her if the licensee needed anything else. The fax contained handwritten initials from the licensee's nurse with the date March 11, 2025. The fax also included "D/C" with handwritten initials from the licensee's nurse. R1's MAR dated March 1, 2025, through March 30, 2025, indicated the licensee did not discontinue Depakote until March 13, 2025, at 8:00 p.m. On March 24, 2025, at 8:00 a.m., the MAR indicated the licensee added another order for staff to administer Depakote. The MAR indicated staff gave R1 Depakote on March 24, 2025, but then discontinued the order again on March 25, 2025, at 8:00 a.m. The MAR indicated R1 received nine additional dosages of Depakote after R 1's physician ordered the licensee to discontinue the medication immediately. R1's progress notes lacked indication the licensee discontinued Depakote on March 9, 2025, or on March 10, 2025, as indicated on the fax. R1's progress notes dated March 27, 2025, indicated the licensee received a new order to discontinue Depakote on March 27, 2025. Doxycycline: Progress notes dated March 12, 2025, at 3:39 p.m., indicated the licensee received new medication orders from R1's dermatologist. The note indicated the new medications included Doxycycline 100 milligrams (mg) (antibiotic) twice daily. The progress notes dated March 27, 2025,	01690		

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01690	Continued From page 5 at 8:40 p.m., indicated the dermatologist ordered the licensee to discontinue Doxycycline. R1's MAR dated March 1, 2025, through March 30, 2025, indicated R1 already received Doxycycline prior to the appointment on March 12, 2025. There were two entries/orders for Doxycycline in the MAR, and it was unclear if the licensee communicated with R1's dermatologist, she was already receiving the medication at the time of the appointment on March 12, 2025 from R1's records. The start date for the medication was March 4, 2025, and the instructions on the MAR read as follows: Doxycycline hyclate 100 mg capsule: Take one capsule by mouth twice daily for seven days. No Refills. The licensee did not discontinue the medication after the seven days but continued to administer this medication twice daily until March 19, 2025, when the licensee entered a new order for the medication into the MAR. The MAR indicated the licensee did not discontinue the Doxycycline on March 27, 2025, and R1 continued to receive the medication on March 28, 2028. R1 was out of the facility on March 29, 2025, therefore she did not receive the medication, but the licensee did not discontinue the order from the MAR. Medicated Ointments: Progress notes dated March 12, 2025, at 3:39 p.m., indicated the licensee received new medication orders from R1's dermatologist. The note indicated the new medications included clobetasol ointment twice daily to rash and Denonide ointment. The progress notes indicated the physician sent the orders to the pharmacy. R1's MAR dated March 1, 2025, through March 30, 2025, indicated the licensee started Clobetasol and Desonide on March 19, 2025.	01690		

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01690	Continued From page 6 This was six days after the physician ordered the licensee to start these medications. The MAR included a duplicate order for Clobetasol, but staff members did not administer the medication from the duplicate order. Celexa: Physician records dated March 17, 2025, at 1:54 p.m., indicated R1's physician ordered Celexa 10 milligrams (mg) daily because it would not result in a rash or serious allergic reaction called Stevens-Johnson syndrome. The records indicated the physician faxed the licensee. R1's MAR dated March 1, 2025, through March 30, 2025, indicated the licensee did not start the medication until March 20, 2025. The MAR indicated the licensee discontinued the medication on March 25, 2025. The MAR included a duplicate order, so staff member gave R1 the medication again on March 28, 2025. The order continued to be on the MAR as an active medication for staff members to administer the medication. Physician after-visit summary dated March 27, 2025, at 12:15 p.m., indicated a dermatologist evaluated R1. The after-visit summary record indicated R1's medication list included Celexa 10 mg by mouth daily. R1's nursing assessment dated March 19, 2025, indicated R1 "currently" had skin conditions. The skin assessment indicated R1 would need a possible hospice evaluation (end-of-life), but did not further describe why R1 required hospice evaluation due to skin conditions. The assessment indicated R1 was orientated to herself, but was frequently disorientated and required repeated re-direction. The assessment	01690		

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01690	Continued From page 7 indicated R1 had occasional disruptive, aggressive, and socially inappropriate behaviors. The assessment indicated the R1 had a history of occasional hallucinations or delusions. The assessment indicated R1 walked with minimal assistance from staff. R1 was at risk of falling and contributing factors to fall risk included her history of falls, seizures, brain tumor January 25, 2025, and psychotropic medications. The section titled, "Challenging Behaviors" indicated R1's behaviors may affect the safety of the resident. The assessment indicated R1's behavior was poor hygiene, resistive to care assistance, unsafe smoking habits, wandering. This section of the nursing assessment indicated R1 required the medication "Divalproex" (Depakote) to manage her behaviors. Email communication from family member (FM)-F to registered nurse (RN)-B and licensed assisted living director (LALD)-C dated March 26, 2025 at 9:55 a.m., indicated FM-F met with RN-B and LALD-C on March 25, 2025, to review R1's care plan, however FM-F felt they did not resolve the discrepancies with R1's medication lists. FM-F indicated a physician had been attempting to reach the licensee to to discuss the medication discrepancies. FM-F wrote in her email R1's health was fragile and it was critical they ensure she was receiving the correct medications and dosages of those medications. RN-B responded to the email March 26, 2025, at 11:21 a.m., RN-B's response indicated she reviewed R1's medications with neurology and was waiting for them to send her orders. RN-B wrote, "I agree on prioritizing. I have a Nursing practice act, I must follow." RN-B indicated the licensee set up an improved communication stream line. FM-A responded to RN-B at 12:59 a.m. FM-A indicated R1 had a medical appointment on March 27,	01690		

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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
01690	Continued From page 8 2025, and she wanted RN-B to provide a new medication list with any new medications prescribed by neurology. Facility incident log dated March 17, 2025, through March 28, 2025, indicated R1 fell five times and went to the ER twice due to injuries from her falls. On March 28, 2025, at 6:30 p.m., R1 fell and cut her head. She went to the hospital and did not return to the licensee. Email communication from the pharmacy to LALD-C, dated April 8, 2025, at 10:21 a.m., indicated the pharmacy did not receive any orders/communication to discontinue escitalopram or divalproex, so they continued to refill and send the medications. The email communication did not include information regarding Celexa. On June 11, 2025, at 12:33 p.m., operations specialist (OP)-A said R1's family emailed management over concerns R1 was not receiving medications correctly, however OP-A said she had limited knowledge about the incident and thought what occurred was the family had an old/not updated "face sheet" (list of medications). OP-A said sometimes when the physicians order new medications they send the order straight to the pharmacy, other times they give the order to the nurse. OP-A said management received an email from R1's family, and she heard discussions from the facility nurse that sometimes R1 went to a doctor and returned with documentation, but not an actual physician order. OP-A said she was unsure if the facility nurse could enter new orders into the licensee's computer system, or if only the pharmacy entered orders into the computer system. OP-A said the licensee is currently working on licensure order	01690		

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	32913	A. BUILDING: _____ B. WING _____	C 06/11/2025

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01690	Continued From page 9 corrections from prior survey. On June 16, 2025, at 2:41 p.m., RN-B said the pharmacy entered the physician orders into the licensee's computer system, however she would have to "verify" the order. RN-B said she also "could" enter orders into the licensee's computer system, but she did not enter medications orders into the computer system because the pharmacy did. RN-B said some physicians faxed orders to the pharmacy directly, others did not. RN-B said she faxed medication orders to the pharmacy for the physicians who did not fax the pharmacy directly, and this process would take longer. RN-B said she was aware the MAR included duplicate orders. RN-B said this occurred because the pharmacy would not discontinue medication orders from the MAR, and would re-send medication. RN-B said once she became aware of the duplications, she spoke to upper management and the pharmacy. RN-B said unlicensed personnel (ULP) would tell her if they noticed duplicate orders. RN-B acknowledged other resident's had medication duplications on their MARs, but said she did not think any harm occurred to them. On June 24, 2025, at 7:58 a.m., LALD-C said R1 was on numerous medications and her family wanted other medications added, however the nurse did not have physician orders to add them. LALD-C said they started digging into pharmacy records and discovered there were some medications the licensee should have discontinued for R1, but they had not. LALD-C said the pharmacy never received orders to discontinue medications. LALD-C said the licensee's team spent several hours trying to sort things out, and described this process as "a mess." LALD-C said he was unaware if the	01690		

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01690	Continued From page 10 licensee's team went through other resident's records to ensure accuracy. LALD-C said the licensee made no changes to their medication processes because this was an isolated incident. On June 25, 2025, at 1:38 p.m., regional director (RD)-E said she was part of the leadership team who tried to investigate concerns regarding R1's medications. RD-E said they discovered there were errors with RN-B's documentation process. RN-B documented inaccurately, not based on facts. RN-B documented physician order changes, however the licensee did not have an official physician order at the time she documented in R1's progress notes. RD-E said R1's progress notes, did not match the medication portal system. RD-E said the pharmacy entered in resident medication orders into the licensee's computer system, the nurses did not. RD-E said the nurse "could" enter in a treatment order, but not a medication order. RD-E said RN-B could "stop" a medication; however, they would then have to provide an order to the pharmacy otherwise the pharmacy would re-start the order. RD-E was unclear if the facility nurse would know if the pharmacy re-started an order. RD-E acknowledged there were communication errors with this process. RD-E said the licensee's process for medication reconciliation occurred daily as the nurse would check the computer system's dashboard, and check the licensee's fax machine for new orders. RD-E acknowledged the MAR contained duplicate orders and said the team spent hours trying to understand what occurred. RD-E said the licensee has made no changes to their medication ordering system. On June 30, 2025, at 11:35 a.m., FM-F said she told RN-B about R1's medical appointments in advance and she would give her "paperwork" to	01690		

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01690	Continued From page 11 take to the medical appointment. FM-F said she returned the paperwork from the medical appointment to the licensee. FM-F said she noticed discrepancies with R1's medication list three times and spoke to RN-B about those discrepancies. FM-F said RN-B told her she could not take orders from a family member, but FM-F said she gave RN-B the orders from R1's medical appointments. FM-F said R1's physicians were trying to determine what caused R1's systemic rash and blisters. FM-F said initially the ER physician stopped R1's escitalopram, then Depakote. FM-F said she assumed the licensee stopped these medications, but they had not. FM-F said R1 fell multiple times, and had a lot of behavior changes. FM-F said R1 went to the hospital after she fell twice in one day and the physicians tested her blood and discovered she still had Depakote in her system. FM-F said physicians determined Depakote caused R1's rash. FM-F said physicians determined the inaccurate dosages of escitalopram contributed to R1's behavior issues and multiple falls. The licensee's policy titled, Medication and Treatment Orders - Implementing, dated May 28, 2025, indicated the licensee would implement medication orders within 24/hours of receipt of a medication order from a physician. The policy indicated the original signed order or fax order would be placed in a designated place for the nurse to review and sign at the next scheduled nurse visit. Time period for correction: Fourteen (14) days.	01690		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

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02360	Continued From page 12 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 one of one resident(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		