Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL341735763M
Compliance #: HL341738131C

Date Concluded: February 12, 2025

Name, Address, and County of Licensee Investigated:
Healthpoint HWS @93rd
351 93rd Avenue Northeast
Blaine, Minnesota 55434
Anoka County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Nicole Myslicki, 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 the resident when the facility failed to provide the resident multiple doses of clozapine, his antipsychotic medication. The resident sustained a mental health crisis and was hospitalized. Additionally, the resident received double the prescribed dose of lumateperone, an antipsychotic medication, for five days when restarting on the medication with titrated (gradual increase) dosing.

The alleged perpetrator (AP) neglected the resident when the AP failed to discontinue lamotrigine, an antiseizure medication (used for mental health disorder), and the resident continue to receive doses.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment in regards to management of clozapine. The facility failed to ensure the resident had the needed number of doses of clozapine (antipsychotic) to get him

through his vacation with family. The facility failed to notify the resident, family, and pharmacy the resident would not be available for his scheduled blood draw, a requirement for receiving his clozapine. The resident went into a mental health crisis and required hospitalization. Additionally, the facility failed to ensure the resident received a titrated dose of lumateperone (antipsychotic) and instead administered the higher dose for five days. However, the facility updated the resident's psychiatrist with the error resident, the resident did not experience significant side effects and the resident's psychiatrist directed to continue on the higher dose.

The Minnesota Department of Health determined neglect was not substantiated against the alleged perpetrator (AP). There was no evidence to support the AP held responsibility for the resident receiving a discontinued medication, lamotrigine. The resident's mental health clinic included the medication on the resident's after-visit summary (AVS) and pharmacy delivered a supply of the medication.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted case workers, mental health providers, and the pharmacist. The investigation included review of the resident records, hospital records, mental health clinic records, facility internal investigations, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed medication administration.

The resident resided in an assisted living facility. The resident's diagnoses included several mental health diagnoses, including schizophrenia. The resident's service plan included assistance with medication administration. The resident's assessment indicated the resident had scheduled medications to manage his mental health disorders and as needed medications available.

CLOZAPINE

According to The National Institutes of Health website, articles from the National Library of Medicine indicated clozapine is an atypical antipsychotic medication used for treatment-resistant schizophrenia. Adult dosing included a titration to a target level of 300 to 450 milligrams (mg) by day 14. Clozapine is highly monitored clinically with a federal registration program and lab testing due to high risk of serious health side effects. Withdrawal-associated psychosis is associated with abrupt discontinuation or dose reduction of clozapine. Clozapine has a half-life of 12 hours. A slow taper over several months or years may reduce the risk of withdrawal effects.

According to Mayo Clinic, when clozapine therapy is interrupted for two or more days, it needs to be restarted at a lower dose.

The resident's record included an order for clozapine 450 mg daily.

An internal investigation indicated the resident went on vacation with family for one week. The resident had clozapine doses for the first five days of the vacation. The pharmacy had a blood draw scheduled at the facility four days into their vacation. The blood draw was needed for the resident to get a refill on his clozapine. Due to the resident missing his blood draw, the pharmacy did not deliver the next supply of clozapine. The resident returned on a Sunday, so he had to wait until the next day to get his blood drawn.

The resident's record did not include documentation of who packed the resident's medications, what medications were sent nor the quantity for his time away from the facility. The resident's medication administration record (MAR) indicated the resident did not receive any of his scheduled morning medications on a Sunday, correlating with the day the resident's family member stated they left for vacation.

A progress note in the resident's record indicated the resident's family member reached out to staff four days into the vacation to inform them the resident did not have enough medication to last through the trip and would miss the dose on Saturday.

Four days later, a progress note indicated the resident missed his blood draw that had been scheduled while the resident was on vacation, and the pharmacy did not refill the clozapine. The resident received his last dose of clozapine on Friday and returned to the facility on Sunday. The resident's family member brought the resident to the pharmacy for a blood draw on Monday. Because the resident's mental health provider had been out of the office that day, the pharmacy could only provide one 25 mg dose of clozapine. The mental health provider needed to contact the pharmacy to restart clozapine.

The next day, a progress note indicated the resident's mental health provider sent new clozapine dosages to the pharmacy. The resident's family member picked up the medication from the pharmacy and brought it to the facility.

The resident's MAR indicated the clozapine restarted on Tuesday at 50 mg daily, 400 mg less than his therapeutic dose. After three doses, the titration increased to 100 mg daily scheduled for the next three days.

Over the following three days, facility staff monitored the resident's mental health symptoms.

Six days after he returned to the facility, a progress note indicated the resident woke up confused and became agitated. He instructed staff to call emergency medical services (EMS). Facility staff contacted the resident's family member who picked him up and brought him to the hospital.

The resident's hospital record indicated the resident presented to the emergency department (ED) with complaints of auditory and visual hallucinations which worsened over the past few days. The resident admitted to the hospital while titrating back up to his normal clozapine dose

of 450 mg. The resident continued to experience distressing sudatory hallucinations, even after returning to his normal dose. After making other medication changes, the resident's mental health began to improve. The resident discharged back to the facility after more than three weeks in the hospital.

During an interview, a pharmacist stated blood draws were required for monitoring for neutropenia (low salt levels causing serious health risk) for people taking clozapine. The resident received monthly draws. After the blood draw, the clozapine was dispensed to the facility. The phlebotomist provided a yearly calendar with the blood draw dates highlighted. More than 48 hours of missed doses required a restart titration of clozapine due to risk of seizures.

During an interview, the resident's family member stated the resident had a history of psychosis and had been on clozapine for several years. The resident had been stable on his medications. The family member stated she gave the facility a two-week's advanced notice the resident would be out of the facility for a week. When they arrived at their vacation place, the resident realized he was short one dose of clozapine. The family member texted the nurse who reported the resident had a four-week supply at the facility. After the resident returned to the facility, he called the family member to report the facility did not have any clozapine. The resident went a second night without the medication. The family also had not been notified the resident would miss his blood draw while on vacation. Because the resident missed more than two days-worth of doses, he needed to restart the medication at the lowest dose. Within about a week, the resident was hospitalized due symptoms of psychosis. The resident spent about three weeks in the hospital before returning to the facility.

During an interview, the resident stated after missing his clozapine, he started experiencing a burning sensation in his head. He decided to go to the hospital to make sure he was okay.

During an interview, the AP, who was a nurse, stated the unlicensed personnel (ULP) on duty would put all the medications in a bag with the resident prior to leaving the facility for time away.

During an interview, the licensed assisted living director (LALD), who was also a nurse, stated the resident's family member notified them about the vacation one or two weeks before the vacation. The LALD stated a ULP packed the resident's medications. During the vacation, the resident notified the LALD he did not have enough clozapine. The LALD went to the facility to look for the medication, thinking staff misplaced it. Then, the LALD discovered the resident missed his blood draw, so the pharmacy did not send out more of the med. While living at the facility, the resident had never missed his blood draw, so he did not know the pharmacy would not send out more medication without having the blood draw completed. After the resident returned, the facility had to wait for the pharmacy to open and manage any mental health symptoms with as needed medications in the meantime. When the LALD learned about him missing the clozapine for more than 48 hours, he checked in on the resident a couple of times a

day. A couple of days after restarting the clozapine, the resident began showing symptoms and not feeling like himself. Everyone agreed the resident needed to go to the ED.

Minnesota statute 144G.71 subdivision 10, required a licensed nurse or pharmacist to prepare medications for resident to leave with during a planned time away from the facility and medication set up documentation was required.

LAMOTRIGINE

According to Mayo Clinic, lamotrigine is an anti-seizure medication also used to help treat mood episodes related to a mental health disorder. Stevens-Johnson syndrome (SJS) is a rare but serious disorder that is a adverse risk reaction to the medication. SJS is a medical emergency that usually requires hospitalization.

The resident's hospital record indicated the hospital discontinued the resident's lamotrigine and lumateperone.

The resident's record included a clinic AVS from his mental health provider's clinic from a visit about one and a half weeks after the resident returned from the hospital related to clozapine withdrawal. The AVS included lamotrigine 100 mg tablets, one tablet by mouth once daily.

A nursing note in the resident's record at his mental health clinic indicated they sent the AVS to the facility at the end of business day, the day after the visit.

The resident's MAR indicated the resident did not receive lamotrigine after discharging from the hospital until after the facility received the clinic AVS and new month's supply of medication.

Two days after the resident's visit with his mental health provider, an incident report indicated the pharmacy delivered the resident's next month supply of medications to the facility, and the bubble pack included lamotrigine 100 mg tablets. This coincided with the provider's orders sent to the facility. The AP contacted the provider's clinic to confirm the medication but did not reach anyone. Five days later, the AP reached out again and spoke with the provider's nurse who stated she would call back to confirm the medication and if it needed to be tapered. The provider's nurse called back the next day and informed the facility nurse lamotrigine had not been part of the new orders but instructed the resident should take the medication in the morning in case the resident needed to taper down from it. The provider's clinic called back, instructing the facility to remove the lamotrigine from the bubble pack, and no taper was needed. The AP removed all lamotrigine tablets from the bubble packs and notified ULP and the resident to watch for signs of SJS.

LUMATEPERONE

The resident's MAR indicated lumateperone 21 mg was scheduled for seven days, then titrated to 42 mg. The MAR indicated two ULP signed off they administered lumateperone 21 mg daily for seven days.

An internal investigation indicated the resident had been started on lumateperone 21 mg for five days, then 42 mg after that. Both dosages were sent out in one single bubble pack. ULP started the lumateperone at 42 mg instead of 21 mg. The resident exhibited no signs of mental health crisis, distress, or negative reaction to the error. The AP notified the resident's mental health provider and family. An investigation revealed a ULP made an error by not following the steps of medication administration. The ULP failed to notice the dates written on the back of the bubble pack.

An image showed the back side of the lumateperone's bubble pack. Each individual bubble had been dated with the date it was supposed to be administered. The doses were removed from the latest dates.

The resident's progress notes indicated the AP contact the resident's provider to report the medication error. The psychiatrist directed to continue the 42 mg dose if the resident does not have any negative side effects and to monitor for symptoms such as confusion and nausea. The resident and his family were updated to report any symptoms as well. Subsequent progress notes indicated the facility staff monitored the resident, and no side effects were noted.

During a follow up interview, the LALD discussed the lamotrigine and lumateperone errors. The resident had been on lamotrigine right before he went to the hospital. When he discharged from the hospital, the medication had been removed from his medication list. When the next month supply arrived from the pharmacy, the lamotrigine had been refilled. The AP discovered the issue the first or second day of the resident receiving the medication again. The AP called to clarify if they did want the resident to restart the medication but there had been a delay of communication between her and the mental health clinic. To their knowledge, the resident had no side effects from this error. Regarding the lumateperone error, the LALD stated "we" should have caught it. The LALD went to the facility and completed retraining with the ULPs.

During an interview, the AP stated the resident had not been taking the lamotrigine after he discharged from the hospital until the pharmacy refilled his medications for the month and included the lamotrigine. The resident had a visit with his mental health provider at the end of the month he returned from the hospital. The next day, the facility received the resident's AVS via fax. The AP addressed the AVS one day later and added the lamotrigine to the resident's medication administration record (MAR) since it was listed. The AP also reached out to the clinic to verify the order for lamotrigine because it had previously been discharged. After speaking with the resident's mental health clinic and confirming if should have remained discontinued, she stopped the medication and removed it from the resident's bubble pack. Regarding the resident's lumateperone concern, both doses came in the same one-month supply bubble pack.

During a follow up interview, the resident stated he did not remember much about the lamotrigine and lumateperone errors. Overall, the resident had less energy throughout the day and felt tired.

During an interview, the resident's family member stated while in the hospital for missing dose of clozapine, a doctor made medication changes including discontinuing the resident's lamotrigine. The pharmacy left that medication in the bubble pack, and the facility staff did not notice. He received several doses before the facility nurse called the resident's mental health provider. The situation caused the resident anxiety and confused him. The third medication issue involved lumateperone. The resident received a full dose of the medication right away after restarting the medication, doubling the correct dose for the first week.

In conclusion, the Minnesota Department of Health determined neglect was substantiated in regards to the facility. Regarding the AP, the Minnesota Department of Health determined neglect was not 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.

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

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Mitigating Factors considered, Minnesota Statutes, section 626.557, Subd. 9c(f):
(1) The facility did not 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: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility made proper notifications for each medication issue with lamotrigine and lumateperone. Facility staff monitored the resident after each medication error. Regarding the lumateperone error, the UPLs were retrained on medication administration.

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
Anoka County Attorney
Blaine City Attorney
Blaine 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
	34173	A. BUILDING: _____ B. WING _____	C 11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTHPOINT HWS @ 93RD	351 93RD AVENUE NE BLAINE, MN 55434

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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: HL341738131C/HL341735763M On November 25, 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 four residents receiving services under the provider's Assisted Living license. The following correction orders are issued. The following correction orders are issued for HL341738131C/HL341735763M, tag identification 1760, 1780, 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.	
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication	01760		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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01760	Continued From page 1 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: Base on interview and record review, the licensee failed to document medication administration accurately and documented administration when a resident was not in the facility for one of one residents (R1) reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included schizoaffective disorder. R1's service agreement dated November 21, 2022, indicated R1 received medication administration. The service agreement included a medication management plan which indicated the	01760		

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01760	Continued From page 2 registered nurse (RN) would delegate the packing of medications to staff when R1 left the facility. The plan also indicated staff were to notify the RN for medication refills, missing medications, and medication discrepancies. During an interview on December 5, 2024, at 8:35 a.m., R1's family member (FM)-J stated she told RN-B two weeks in advanced a planned vacation for seven or eight days. FM-J stated they left for vacation on a Sunday, August 11, 2024 and returned the following Sunday [August 18, 2024]. R1's medication administration record (MAR) dated August 2024, indicated R1 had no administrations of medications on August 11, 2024 during the day shift. The MAR indicated inaccurately administration of medications the evening of August 11, 2024 and both day and evening shifts on August 12 and 13, 2024. Additionally evening medications were documented inaccurately as administered when R1 was away from the facility while on vacation including: -lamotrigine 200 milligrams (mg) on August 14 and 16, 2024. -magnesium 100 mg on August 14 and 16, 2024. -prazosin 1 mg on August 14, 16 and 17, 2024. -clozapine 450 mg on August 14, 15, 16, 18 and 19, 2024. R1's MAR dated August 2024, indicated a clozapine titrate started August 20, 2024. The initial dose started with clozapine 50 mg daily for three days, then on August 23, 2024, the dose increased to 100 mg daily. R1's progress notes from August 11, 2024 through August 19, 2024, were reviewed. R1's progress note lacked a note indicating R1 had left	01760		

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01760	Continued From page 3 the facility on August 11, 2024, with only one note at 6:21 a.m., indicated R1 slept during the night. A progress note dated August 12, 2024, indicated R1 was out of the facility. A progress note dated August 14, 2024, indicated R1 was on vacation with his family. R1's progress note dated August 15, 2024, indicated RN-B received a text message from R1's family member reporting he did not have enough clozapine to last the duration of his family vacation. The last dose of clozapine would be given August 16, 2024. R1 planned to be back to the facility August 18, 2024. R1's progress note dated August 19, 2024, indicated R1 missed his lab draw for clozapine and his last dose of clozapine was given August 16, 2024 while on vacation. R1 returned to the facility on August 18, 2024. R1 went to the pharmacy for a lab draw on August 19, 2024 and received a dose of clozapine, 25 mg. R1's psychiatrist needed to send a new prescription to the pharmacy to restart R1's clozapine. The licensee's policy titled, Medication Management-Administration and Set-up, undated, indicated nursing and unlicensed personnel (ULP) will document accurately medication administration provided. For medication administration, ULP will refer to the MAR for medication name, dose, date and time of administration with initials. ULP will document the reason why medication was not administered. TIME PERIOD OF CORRECTION: Seven (7) Days	01760		

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01780	Continued From page 4	01780		
01780 SS=G	144G.71 Subd. 10 Medication management for residents who will (a) An assisted living facility that is providing medication management services to the resident must develop and implement policies and procedures for giving accurate and current medications to residents for planned or unplanned times away from home according to the resident's individualized medication management plan. The policies and procedures must state that: (1) for planned time away, the medications must be obtained from the pharmacy or set up by the licensed nurse according to appropriate state and federal laws and nursing standards of practice; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure medications were set up by the pharmacy or a licensed nurse, failed to provide a sufficient amount of medication doses and failed to reschedule a lab draw for a high risk medication pharmacy dispense for one of one residents (R1) for planned time away from the facility. R1's packed medications failed to include enough doses of clozapine, an antipsychotic medication with high clinical monitoring, including monthly lab draws. The facility failed to reschedule R1's lab draw when it was scheduled during his planned time away and R1 missed three doses requiring a restart titration at a low dose. R1's mental health symptoms worsened and admitted to the hospital for three weeks. 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	01780		

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01780	Continued From page 5 serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The National Institutes of Health website, https://www.ncbi.nlm.nih.gov/books/NBK535399/, included an article from the National Library of Medicine titled, "Clozapine," updated November 10, 2023, indicated clozapine is an atypical antipsychotic medication used for treatment-resistant schizophrenia. Adult dosing included a titration to a target level of 300 to 450 milligrams (mg) by day 14. Clozapine is highly clinically monitored with a federal registration and lab testing due to high risk of serious health side effects. Another article from the same webpage, titled, "Clozapine discontinuation with withdrawal symptoms in schizophrenia," indicated withdrawal-associated psychosis is associated with abrupt discontinuation or dose reduction of clozapine. Clozapine has a half life of 12 hours. A slow taper over several months or years may reduce the risk of withdrawal effects. The Mayo Clinic webpage, https://www.mayoclinic.org/drugs-supplements/clozapine-oral-route/description/drg-20066859, drug information titled, "Clozapine," missing two or more days may result in restarting clozapine at a lower dose. R1's diagnoses included schizoaffective disorder. R1's service agreement dated November 21, 2022, indicated R1 received medication administration. The service agreement included a medication management plan which indicated the	01780		

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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
01780	Continued From page 6 registered nurse (RN) would delegate the packing of medications to staff when R1 left the facility. The plan also indicated staff were to notify the RN for medication refills, missing medications, and medication discrepancies. R1's prescription order dated August 5, 2024, included clozapine 200 mg daily, take two tablets with a 50 mg tablet for a total for 450 mg. 56 tablets were dispensed, a 28 day supply. During an interview on December 5, 2024, at 8:35 a.m., R1's family member (FM)-J stated R1 had been on clozapine for several years and had a history of psychosis. FM-J stated R1 was medication compliant and had been mentally stable. R1 moved to the facility for increased independent living due to being stable. FM-J stated R1 had monthly lab draws for clozapine dosing and the facility managed scheduling the lab draws, which the lab went to the facility to complete on R1. FM-J stated she told RN-B two weeks in advanced a planned vacation for seven or eight days. She asked RN-B if R1 had enough supply of clozapine for a family vacation and the nurse verified he had a 30 day supply. FM-J stated they left for vacation on a Sunday, August 11, 2024 and returned the following Sunday [August 18, 2024]. When they arrived to their destination, R1 reported the staff did not pack enough clozapine, was one day short and missed Saturday's dose. FM-J stated when she returned R1 on Sunday, the facility did not have his supply of clozapine and therefore he missed Sunday's dose as well. Additionally, FM-J stated the facility did not reschedule his lab draw and it was missed while on vacation that she was not aware of. FM-J brought R1 to get his lab draw on Monday [August 19, 2024] and FM-J had to restart clozapine at the lowest dose, 12.5 mg on	01780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34173	A. BUILDING: _____ B. WING _____	C 11/25/2024

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01780	Continued From page 7 Tuesday [August 20, 2024]. FM-J stated R1 began having symptoms of hallucinations/paranoia, he was not sleeping and behaved unusually. R1 was hospitalized by the following Sunday after the missed doses and needed to be hospitalized for three weeks before stable. R1's record failed to include documentation R1's medications were packed for his time away from the facility August 11, 2024, to August 18, 2024. Review of the pharmacy lab draw calendar 2024 schedule indicated R1's previous lab draw was July 18, 2024 and the next lab draw was scheduled for August 15, 2024. R1's record included a progress note dated August 15, 2024, which indicated RN-B received a text message from R1's family member reporting he did not have enough clozapine to last the duration of his family vacation. The last dose of clozapine would be given August 16, 2024. R1 planned to be back to the facility August 18, 2024. A progress note dated August 19, 2024, written by RN-B, indicated R1 missed his blood draw scheduled for August 15, 2024, and the pharmacy did not fill his clozapine. R1 administered his last dose of the medication on August 16, 2024, and returned to the facility August 18, 2024. R1's family member brought him to get his blood drawn August 19, 2024, and the pharmacy provided one 25 mg dose for the day. R1's mental health provider needed to call the pharmacy to start the medication again. A progress note dated August 20, 2024, indicated R1's mental health provider contacted the pharmacy and sent a new order for the clozapine.	01780		

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01780	Continued From page 8 R1's medication administration record (MAR) dated August 2024, indicated a clozapine titrate started August 20, 2024. The initial dose started with clozapine 50 mg daily for three days, then on August 23, 2024, the dose increased to 100 mg daily. A progress note on August 24, 2024, indicated R1 texted RN-B wanting to get checked out due to his mental health symptoms. A second progress note on August 24, 2024, indicated R1 woke up confused and became agitated. R1 instructed the unlicensed personnel (ULP) to call 911. Staff updated R1's family member who picked up R1 and brought him to the emergency department (ED). R1's hospital record indicated he admitted to the hospital for three weeks. During the hospitalization, R1 titrated back up to his usual clozapine dose of 450 mg. During and after titration, R1 continued to experience distressing auditory hallucinations. R1 also continued to report anxiety and depression, generally associated with the auditory hallucinations. By the end of his hospitalization, R1's auditory hallucinations improved and became more positive in nature. During an interview November 27, 2024, at 9:02 a.m., RN-B stated the staff member on duty would put all the medications in a bag with the resident prior to leaving the facility for time away. During an interview November 27, 2024, at 11:01 a.m., licensed assisted living director (LALD)-A stated R1's family member let staff know R1 would be out of the building one to two weeks in	01780		

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01780	Continued From page 9 advance. LALD-A stated a ULP packed R1's medications. During an interview on December 10, 2024, at 11:03 a.m., pharmacist (PH)-E stated R1 was on a 28 day schedule for clozapine with a four week supply dispensed at the time of his lab draws. The lab draws were scheduled for a year. The lab draw could be rescheduled within a three day range, otherwise a consult with the doctor would be needed. More than 48 hours of missed doses required a restart titration of clozapine due to the risk of seizures. The licensee-provided policy Medication Management - Planned & Unplanned Time Away, undated, indicated the medications must be obtained by the pharmacy or set up by a licensed nurse. TIME PERIOD FOR CORRECTION: Seven (7) days	01780		
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 one of one resident(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred,	02360	No plan of correction is required for this tag.	

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02360	Continued From page 10 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		