Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL34175001M
Compliance #: HL34175002C

Date Concluded: May 6, 2022

Name, Address, and County of Licensee Investigated:
Keller Lake Commons
5771 Meadowview Drive
White Bear Lake, MN 55110
Sherburne County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Michele R. Larson
Special Investigator

Finding: Substantiated, facility responsibility

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

Allegation(s):
It is alleged: The facility neglected the resident when they failed to reorder the resident's insulin and prescribed eye drop medications in a timely manner, causing the resident to go without being administered medications for days. The resident had corneal transplant surgery and required six different prescribed eye drops to be administered in her eyes several times per day to prevent rejection of the transplanted cornea. In addition, the night before her scheduled corneal transplant surgery, the facility gave the resident the wrong insulin to self-administer. The resident injected several units of insulin before realizing it was the wrong insulin. The resident was up most of the night eating carbohydrates to prevent hypoglycemia (low blood sugar), when she should have been NPO (no food by mouth) prior to surgery.

Investigative Findings and Conclusion:
Neglect was substantiated. The facility was responsible for the maltreatment. Unlicensed personnel (ULP) staff did not administer schedule eye drops before and after the resident's corneal transplant due to nursing staff did not reorder medications in a timely manner. The facility did not follow their own policy on retraining direct care staff after they had several medication errors. Several ULP's passing medications did not have medication training records. In addition, the ULP made a critical insulin error the night prior to the resident surgery by given the resident short acting insulin instead of long-acting insulin requiring the resident to eat food five hours prior to her surgery.

The investigation included interviews with facility staff members, including nursing staff, and unlicensed staff. In addition, the resident and her family members were interviewed. The investigation included review of the resident's facility and external medical records, personnel files, and the facility's policies and procedures.

The resident's medical record was reviewed. The resident's diagnoses included Diabetes Type 1, legal blindness, Fuchs' dystrophy (hereditary eye condition), glaucoma, and macular degeneration. The resident's service plan indicated the resident required assistance with personal cares, toileting, medication assistance, meals, diabetic nail care, and housekeeping. The resident required a walker for mobility. The resident's assessments indicated the resident was alert and oriented and able to make her needs known.

The resident's record indicated on the eve before the resident's corneal transplant eye surgery, unlicensed personnel (ULP) 1 was assisting the resident with her evening cares and medication. ULP 1 gave the resident an insulin pen so the resident could self-administer her nighttime insulin. The resident proceeded to inject the insulin, but realized it was the wrong insulin due to the color of the insulin pen. The resident stopped, but still injected several units of the wrong insulin; her fast-acting insulin instead of her scheduled long-acting insulin. The resident was up until midnight eating carbohydrates to prevent her blood sugar levels from becoming too low. The resident left at 5:00 a.m. to go to her corneal transplant surgery.

The resident's medication administration records (MARs) indicated the resident was prescribed the following eye drops administered several times a day before and after her corneal transplant surgery to prevent rejection of the transplanted cornea: Sodium chloride (one drop to right eye four times per day (QID)), Ketorolac (one drop into right eye two times per day), Moxifloxacin (antibiotic) (one drop into right eye QID), Prednisolone (steroid) acetate (one drop into right eye QID), Restasis (one drop to right eye daily) and artificial tears (one drop into both eyes QID). Staff were directed to wait five minutes in between administer each type of eye drops. In addition, the resident was prescribed an eye ointment, Muro 128 (administer ½ ribbon to right eye) and administered five minutes after last eye drop.

The resident's MARs indicated the resident's missed 32 doses of eye drops before and after her eye surgery due to no supply and missed two doses of the eye ointment due to "declined" and staff not following prescriber's orders.

The resident's record lacked evidence the facility performed medication omission procedures after they failed to administer her medications.

The resident's record indicated approximately three weeks after her corneal transplant surgery, the resident missed three consecutive doses (8:00 p.m., 7:00 a.m., 11:00 a.m.) of moxifloxacin (antibiotic) eye drops, and five consecutive doses (5:00 p.m., 8:00 p.m., 7:00 a.m., 11:00 a.m., 4:00 p.m.) of prednisolone acetate (steroid) eye drops due to the facility not reordering the eye drops in a timely manner.

Review of the facility's medication error reports indicated there were 64 medication errors during a four-month period. Most of the medication errors were documented as "not given," "misread order," and "omission." The following ULP's had more than 3 medication errors in a one-month period: ULP 2: 19 medication errors; ULP 3: 13 medication errors; ULP 4: 3 medication errors; ULP 5: 6 medication errors.

Review of ULP 3, ULP 4, ULP 5's employee records lacked evidence they were retrained on medication administration.

Review of employee records indicated ULP 2 was required to do medication administration retraining due to continued medication errors, giving incorrect doses, and documenting "no supply" when supply was in a cabinet. ULP 2's retraining included completing online training on medication administration and completed three medication passes with a nurse within four days of the disciplinary action. The disciplinary document was completed and signed by registered nurse (RN) 1. Review of ULP 2's training record indicated ULP 2 completed her online retraining over two months after the due date. ULP 2's training record lacked evidence ULP 2 completed her retraining on three medication passes with a nurse. ULP 2 had an additional 13 medication errors after she was disciplined.

During an interview, RN 1 stated staff updated her through their work phones or medication reorder form. RN 1 stated the medication reorder forms were rechecked daily.

During an interview, ULP 1 stated she was distracted the night she gave the resident the wrong insulin. ULP 1 stated she immediately called RN 1 who advised her to monitor the resident through the rest of her evening shift. ULP 1 stated she and another ULP rechecked the resident's blood sugar.

During an interview, ULP 2 stated the resident expected her medications on time and would worry if she did not get them. ULP 2 stated the resident complained if the facility was out of her eye drops for "a while." ULP 2 stated, she knew the eye drops she was supposed to get for her

eye surgery. ULP 2 stated she did not think all the resident's eye drops were out at the same time, but stating, "I'm not sure."

During an interview, family member (FM) 1 stated the facility never informed her after ULP 1 gave the resident the wrong insulin. FM 1 stated RN 1 denied knowing anything about the incident. FM 1 stated there were many times the resident did not get her insulin because staff left the cap on the needle. FM 1 stated the facility ran out of the resident's eye medications two weekends in a row after the resident's corneal transplant surgery. FM 1 stated the resident never received her insulin on time. FM 1 stated she and other family members moved the resident out after the facility ran out of several doses of her eye medications.

During an interview, FM 2 stated the resident moved into the facility because she was legally blind and could no longer take care of herself. FM 2 stated she kept a log with dates and times when the resident did not get her eye medications and insulin. FM 2 stated there were a few times the resident missed her insulin because staff left the cap on the end of the needle, or the resident was not administered an eye medication because RN 1 lost the bottle.

During an interview, the resident stated she moved into the facility because she required daily assistance with her complicated eye medication regimen. The resident stated she was prescribed several different eye drops and eye ointment to be administered before and after her corneal transplant surgery to prevent rejection of her transplanted cornea. The resident stated the night before her early morning eye surgery, ULP 1 gave her the wrong insulin to self-administer. The resident stated once she realized it was the wrong insulin, she had already injected several units of insulin. The resident stated she was up until midnight eating carbohydrates to prevent her blood sugar levels from dropping too low. The resident stated her family moved her out of the facility after the facility ran out of two of her eye medications, causing her to miss eight consecutive doses. The resident stated her corneal transplant surgery did not go well, stating, "my eyesight is still very poor."

In conclusion, neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

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

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

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: Yes. Two family members were interviewed.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility held mandatory monthly meetings on topics of medication administration and retrained some unlicensed staff on medication administration.

Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit: https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html, or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Sherburne County Attorney
Big Lake City Attorney
Big Lake 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
	34175	A. BUILDING: _____ B. WING _____	C 02/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KELLER LAKE COMMONS	**655 NORWOOD LANE BIG LAKE, MN 55309**

(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 Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL34175002C/#HL34175001M On February 1, 2022, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 34 residents receiving services under the provider's Comprehensive Assisted Living license. The following correction orders are issued for #HL34175002C/#HL34175001M, tag identification 510, 620, 630, 1470, 1530, 1620, 1640, 1730, 1750, 1760, 1940, 2360, 3000.	0 000	Assisted Living Provider 144G. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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0 510	Continued From page 1	0 510		
0 510 SS=E	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical, and nursing standards for infection control related to COVID-19. This had the potential to affect all 84 residents who resided in the licensee's building. 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 a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include:	0 510		

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0 510	Continued From page 2 COVID-19 VISITOR SCREENING The licensee failed to ensure visitors were fully screened for temperature checks and COVID-19 symptoms. On February 1, 2022, at 10:00 a.m., the surveyor entered the facility. On February 1, 2022, at 10:50 a.m., an outside carpet cleaning person (CCP) was observed entering the facility without stopping to take his temperature or completing the COVID-19 symptom screening checklist at the entrance door was observed not wearing any personal protective equipment (PPE). On February 1, 2022, at 12:30 p.m., a visitor was observed not taking her temperature completing the COVID-19 symptom screening checklist before entering the facility. DISINFECTING REUSABLE MEDICAL EQUIPMENT & Hand Sanitizer The licensee failed to ensure the thermometer was properly disinfected after each use. In addition, the licensee failed to ensure hand sanitizer was located at the entrance table for visitors and staff to use before entering the facility. MDH guidance titled, COVID-19 Action Plan for Congregate Care Settings, updated December 21, 2021, indicated shared equipment should be cleaned and disinfected after each use. Disinfectant products should be easily accessible, if possible. On February 1, 2022, at 10:00 a.m., the surveyor entered the facility. Placed on a small table near the entrance door was a COVID-19 symptom	0 510		

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0 510	Continued From page 3 screen checklist and a thermometer. On February 1, 2022, at 10:00 a.m., LALD-I approached the investigator and proceeded to take the investigator's temperature using a thermomter that was placed on the entrance table. LALD-I did not sanitize the thermometer after taking the invesitgaor's temperature. The entrance table lacked hand sanitizer for visitors and staff to use before they entered the facility. The licensee titled Infection Control, updated August 1, 2021, indicated the licensee had a system for preventing, idientifyingm reporting, investigating, controlling infections, and communicable diseases.The policy indicated their infection control program was consistent with current Centers for Disease Control (CDC) guidelines. TIME PERIOD TO CORRECT: Two (2) days.	0 510		
0 620 SS=G	144G.42 Subd. 6 Compliance with requirements for reporting ma 144G.42 Subd. 6. Compliance with requirements for reporting maltreatment of vulnerable adults; abuse prevention plan. (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to comply with the requirements	0 620		

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0 620	Continued From page 4 for reporting to Minneosta Adult Abuse Reporting Center (MAARC) significant medication errors within 24 hours for one of three residents (R1) with records reviewed. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at 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 R1's medical record was reviewed. R1 admitted to the licensee on August 27, 2021. R1's diagnoses included Type 1 diabetes, legal blindness, Fuchs' dystrophy (hereditary eye condition), macular degeneration, and glaucoma. R1's service plan dated August 28, 2021, indicated R1 received assistance with personal cares, four times daily blood glucose checks, meals, medication assistance, diabetic foot care, toileting (pericare), and housekeeping. R1 used a walker for mobility. R1's registered nurse (RN) assessment dated September 10, 2021, indicated R1 required supervision with bathing, and stand-by assistance with mobility. R1 was unable to read medication labels due to poor vision. R1 was able to dial the correct number of insulin units on her insulin pens by listening to the clicks on the pens which staff verified and supervised. R1 had partial or total blindness. R1 was assessed as required staff	0 620		

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0 620	Continued From page 5 assistance in the event of an emergency. R1's individual abuse prevention plan (IAPP) dated November 9, 2021, indicated R1 needed assistance with medication administration due to partial or total blindness. R1's medical administration records (MARs) dated October and November 2021, indicated R1 was prescribed the following eye drops and insulin: sodium chloride ophthalmic solution, 5%, instill one drop into right eye four times per day (QID). Must wait five minutes between drops; moxifloxacin ophthalmic solution, 0.5%, instill one drop into right eye two times per day (BID); prednisolone acetate ophthalmic solution 1%, instill one drop into right eye QID. Must wait five minutes between different drops; ketorolac 0.5%; instill one drop BID in post-operative eye for one week, then one drop daily for seven more weeks, begin drops three days before surgery on October 13, 2021; Muro 128 5% eye ointment, apply 1/2 inch ribbon to right eye daily, must be administered after last eye drop; Restasis, administer one drop into right eye daily novalog 8-12 Units, resident to self-administer three times per day (TID), staff to verify dose; basaglar (long-acting insulin) 30 Units, resident to self-administer once daily (8:00 p.m.), staff to verify dose. R1's September, October, and November 2021 Medication Administration Summary, indicated R1 did not receive her eye drops on the following dates: *September 1-16, 2021, 8:00 p.m.: Ketorolac ophthalmic solution-not administered due to no supply *September 30, 2021, 8:00 p.m.: Sodium chloride ophthalmic solution-not administered-high	0 620		

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0 620	Continued From page 6 glucose *September 30, 2021, 8:00 p.m.: Muro 128 ophthalmic ointment-declined *October 6, 2021, 8:00 p.m.: Sodium chloride ophthalmic solution-declined *October 14, 2021, 4:00 p.m.: Sodium chloride ophthalmic solution-declined *October 15, 2021, 4:00 p.m.: Sodium chloride ophthalmic solution-not administered per RN *October 20, 2021, 4:00 p.m.: Sodium chloride ophthalmic solution-declined *October 22, 2021, not on the list *October 30, 2021, 8:00 a.m.: Moxifloxacin ophthalmic solution-unavailable-waiting to receive from pharmacy. *October 30, 2021, 8:00 p.m.: Restasis eyedrops-need refill *November 4-5, 2021: Moxifloxacin ophthalmic solution- (3 missed doses)-no supply *November 5-6 2021: Prednisolone acetate ophthalmic solution (5 missed doses)-no supply The Mayo Clinic website, www.mayoclinic.org, indicated eyedrops immediately after cornea transplant surgery and during recovery helped control infection, rejection, swelling, and pain. The Mayo Clinic website indicated ketorolac ophthalmic solution was a non-steroidal anti-inflammatory drug (NSAID) used to treat pain, burning, and inflammation of the eye before and after eye surgeries. Sodium chloride ophthalmic solution and Muro 128 ointment were used to draw water out of a swollen cornea. Moxifloxacin ophthalmic solution was an eye antibiotic used to treat infections of the eye. Restasis eyedrops were used to prevent inflammation of the cornea. Prenisolone ophthalmic solution was a corticosteroid used to help prevent inflammation and rejection of the transplanted cornea.	0 620		

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0 620	Continued From page 7 On April 4, 2021, at 11:00 a.m., family member (FM)-D stated R1 had six prescribed eyedrops she needed to have administered prior to her corneal transplant surgery. FM-D stated R1 would call FM-D stating eyedrops were not administered due to DON-B being unable to locate a prescribed eyedrop. FM-D stated on November 6, 2021, she received a phone call from FM-C stating R1 missed two days' worth of prednisolone ophthalmic solution, stating they were told it was the pharmacy's fault. FM-D stated at that point R1's family decided to move R1 into FM-C's home until another assisted living facility could be found. FM-D stated she documented and kept track of dates and times when R1 did not receive her medications, including insulin. (FM-D provided the document to the state investigator). On April 4, 2021, at 3:00 p.m., director of nursing (DON)-B stated she was in charge of ordering eye medications, insulin, and as needed (PRN) medications. On April 5, 2022, at 10:00 a.m., R1 stated she did not feel safe when she resided at the facility, stating DON-B always made excuses. R1 stated she required eye drops before and after her corneal transplant surgery to help prevent transplant rejection. R1 stated the night before her corneal transplant surgery, unlicensed personnel (ULP)-E gave her morning insulin pen instead of her nighttime insulin. R1 stated she dialed up the insulin pen and administered some of her morning insulin before realizing it was the wrong insulin. On April 5, 2022, at 1:00 p.m., unlicensed personnel (ULP)-E stated she was distracted	0 620		

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0 620	Continued From page 8 when R1 asked for her nighttime insulin. ULP-E stated she immediately called DON-B after R1 injected the wrong insulin. ULP-E stated DON-B told her to monitor R1 during the rest of her shift. ULP-E stated she and ULP-J monitored R1 and rechecked her blood sugars at least once after the medication error. ULP-E stated she did not complete an incident report. ULP-E stated staff had the option of charting "declined" or "unavailable," when medications were unavailable. The licensee policy titled, Vulnerable Adult Maltreatment-Prevention and Reporting, updated August 1, 2021, indicated the licensee trained all staff members on identifying incidents of maltreatment, including abuse, financial exploitation, and neglect, and any act that constituted maltreatment was prohibited. TIME PERIOD TO CORRECT: Seven (7) days.	0 620		
0 630 SS=F	144G.42 Subd. 6 Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced	0 630		

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KELLER LAKE COMMONS	655 NORWOOD LANE BIG LAKE, MN 55309

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0 630	Continued From page 9 by: Based on interview and record review, the licensee failed to address all areas of potential abuse and implement specific interventions to reduce the risk of abuse for three of three residents (R1, R2, R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings Include: R1 R1's medical record was reviewed. R1 admitted to the facility on August 27, 2021. R1's diagnoses included legal blindness, Type 1 diabetes, Fuchs' dystrophy (hereditary eye condition), macular degeneration, and glaucoma. R1's service plan dated August 28, 2021, indicated R1 received assistance with personal cares, four times daily blood glucose checks, meals, medication assistance, diabetic foot care, toileting (pericare), a wireless call pendant, laundry, and housekeeping. R1 used a walker for mobility. R1's registered nurse (RN) assessment dated September 10, 2021, completed by director of nursing (DON)-B, indicated R1 was unable to self-administer medications safely. R1 had partial or total blindness. R1 required staff assistance in the event of an emergency.	0 630		

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0 630	Continued From page 10 R1' individual abuse prevention plan (IAPP) dated November 9, 2021, indicated R1 was susceptible to being abused by another individual with a needed intervention of staff would identify risk factors, assess and monitor yearly with any suspected incident, and educate staff on identifying or treating possible abuse or neglect. R1's IAPP lacked evidence R1 was assessed for her susceptibility to being abused by other vulnerable adults, her risk of abusing other vulnerable adults, her risk for self-abuse, and statements of specific measures to be taken to minimize her risk of being abused. R2 R2's medical record was reviewed. R2 admitted to the facility on September 22, 2021. R2's diagnoses included, but were not limited to Type 2 Diabetes, diabetic neuropathy, chronic kidney disease (CKD) Stage 4, chronic obstructive pulmonary disease (COPD), and chronic heart failure (CHF). R2's RN assessment dated January 18, 2022, and completed by DON-B, indicated R2 used a walker or cane inside her apartment. R2 was able to safely self-administer topical ointments, creams, transdermal patches, inhalents, subcutaneous injections, and oxygen. Directly below these assessments was a contradicting summary indicating R2 was unable to self-administer medications safely. R2 required diabetic foot care. R2 was short-of-breath and used oxygen. R2 was independent in using her continuous positive airway pressure (CPAP) machine. R2's IAPP dated January 18, 2022, indicated R2 was susceptible to being abused by another	0 630		

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0 630	Continued From page 11 individual with a needed intervention of staff would identify risk factors, assess and monitor yearly with any suspected incident, and educate staff on identifying or treating possible abuse or neglect. R2's IAPP lacked specific measures to be taken to minimize her risk of being abused. R2's service plan dated February 1, 2022, indicated R2 received assistance with personal cares, two times daily blood glucose checks, meals, medication assistance, oxygen saturation, a wireless call pendant, laundry, and housekeeping. R2 used a four-wheeled walker for mobility. R3 R3's medical record was reviewed. R3 admitted to the facility on January 25, 2021, under the comprehensive home care license, and began receiving assisted living services on August 1, 2021. R3's diagnoses included, but were not limited to Type 2 Diabetes Mellitus with diabetic chronic kidney disease Stage 4, paroxysmal atrial fibrillation (Afib), and long-term use of anticoagulants. R3 used a manual wheelchair and walker for mobility and walked with staff assistance of one using a gait belt. R3's RN assessment dated July 7, 2021, and completed by DON-B, indicated R3 required staff assistance with medications. R3 was able to self-adminsiter inhalants and subcutaneous injections, but also indicated she was unable to self-administer her medications. R3 required a nurse to follow-up (F/U) on new orders as needed (PRN), and to schedule her lab and medical appointments.	0 630		

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0 630	Continued From page 12 R3's service plan dated August 1, 2021, indicated R3 received assistance with personal cares, behaviors, escorts, medication management, positioning, toileting, twice daily blood glucose monitoring, twice daily assistance with thrombo-embolus deterrent (TED) stockings, monthly RN supervision for TED hose, laundry, and housekeeping. R3's IAPP dated July 7, 2021, indicated R3 required a gait belt with staff assist of one when walking. R3 required assistance in the event of an emergency due to being unable to self-propel her manual wheelchair. R3 was vulnerable to being abused with needed interventions of a yearly fall risk assessment. Staff were to encouraged to transfer R3 on her strong side. R3's IAPP lacked evidence R3 was assessed for risk of being abused by another vulnerable adult, her risk of abusing other vulnerable adults, her risk for self-abuse, and statements of specific measures to be taken to minimize her risk of being abused. On February 1, 2022, at 2:04 p.m., DON-B stated resident's IAPPs were addressed in RN assessments and updated annually or whenever changes were made to their service plans. The licensee policy titled Individual Abuse Prevention Plan, updated August 1, 2021, indicated IAPPs were developed for each vulnerable adult. The IAPP would contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including: (a) other vulnerable adults; (b) the person's risk of abusing other vulnerable adults, and; (c) statements of the specific measure to be taken to minimize the risk of	0 630		

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0 630	Continued From page 13 abuse to that person and other vulnerable adults, including self-abuse. TIME PERIOD TO CORRECT: Seven (7) days.	0 630		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living	01470		

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01470	Continued From page 14 services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure unlicensed personnel (ULP) received orientation to include the required content for four of six ULPs (ULP-E, ULP-F, ULP-G, ULP-H) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	01470		

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01470	Continued From page 15 Findings Include: ULP-E ULP-E was hired on August 10, 2021 to provide direct care services to the licensee's residents. ULP-E's personnel record lacked evidence of up-to-date annual training to include: *Review of the assisted living (AL) bill of rights (BOR) *Principles of person-centered planning and service delivery *Handling of residents' complaints, reporting complaints, and where to report complaints *Consumer advocacy services of the Office of Ombudsman for Long-Term Care (OOLTC) *Review of the types of assisted living services the employee would be providing ULP-F ULP-F was hired on May 25, 2021 to provide direct care services to the licensee's residents. ULP-F's personnel record lacked evidence of up-to-date annual training to include: *Review of the assisted living (AL) bill of rights (BOR) *Principles of person-centered planning and service delivery *Handling of residents' complaints, reporting complaints, and where to report complaints *Consumer advocacy services of the Office of Ombudsman for Long-Term Care (OOLTC) *Review of the types of assisted living services the employee would be providing ULP-G ULP-G was hired on December 22, 2021 to provide direct care services to the licensee's	01470		

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01470	Continued From page 16 residents. ULP-G's personnel record lacked evidence of up-to-date annual training to include: *Review of the assisted living (AL) bill of rights (BOR) *Principles of person-centered planning and service delivery *Handling of residents' complaints, reporting complaints, and where to report complaints *Consumer advocacy services of the Office of Ombudsman for Long-Term Care (OOLTC) *Review of the types of assisted living services the employee would be providing ULP-H ULP-H was hired on April 19, 2021 to provide direct care services to the licensee's residents. ULP-H's personnel record lacked evidence of up-to-date annual training to include: *Principles of person-centered planning and service delivery *Handling of residents' complaints, reporting complaints, and where to report complaints *Consumer advocacy services of the Office of Ombudsman for Long-Term Care (OOLTC) *Review of the types of assisted living services the employee would be providing Request for additional employee orientation documents was not provided. On April 4, 2022, at 3:00 p.m., director of nursing (DON)-B stated ULPs must complete all orientation training prior to performing resident cares. The licensee policy titled, Orientation and Training, updated August 1, 2021, indicated all	01470		

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01470	Continued From page 17 staff of the facility must complete and orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. Orientation must be completed once for each staff person, and was not transferrable to another home care provider. TIME PERIOD TO CORRECT: Twenty-One (21) days.	01470		
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter;	01530		

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01530	Continued From page 18 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure three of six unlicensed personnel (ULP-E, ULP-F, ULP-H) received the required amount of dementia care training in the required time frame. This had the potential to affect all residents. 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The finding include: ULP-E ULP-E was hired on August 10, 2021, to provide direct care services to the licensee's residents. ULP-E's employee record did not indicated a total of eight hours of required dementia training was completed within 120 hours of ULP-E's start date. ULP-F ULP-F was hired on May 25, 2021 to provide direct care services to the licensee's residents. ULP-F's employee record did not indicated a total of eight hours of required dementia training was completed within 120 hours of ULP-F's start date. ULP-G ULP-G was hired on December 22, 2021 to provide direct care services to the licensee's	01530		

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01530	Continued From page 19 residents. ULP-G's employee record did not indicated a total of eight hours of required dementia training was completed within 120 hours of ULP-G's start date. On April 4, 2022, at 3:00 p.m., director of nursing (DON)-B stated ULPs must complete all orientation training prior to performing resident cares. Request for additional orientation training records was not provided. The licensee policy titled, Training Records, updated August 1, 2021, indicated the licensee maintained a record of staff training and competencies. TIME PERIOD TO CORRECT: Twenty-One (21) days.	01530		
01620 SS=G	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must	01620		

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01620	Continued From page 20 be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted reassessments for one of three residents (R1) with records reviewed. The RN did not perform a reassessment for R1 after unlicensed personnel (ULP) gave her the wrong insulin to self-administer. In addition, the RN did not reassess R1 after her corneal transplant surgery on October 13, 2021 or when she failed to receive required eye drops pertinent for pain control, infection prevention and rejection prevention after her surgery. 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). Findings Include: R1 R1's medical record was reviewed. R1 admitted	01620		

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01620	Continued From page 21 to the licensee on August 27, 2021. R1's diagnoses included Type 1 diabetes, legal blindness, Fuchs' dystrophy (hereditary eye condition), macular degeneration, and glaucoma. R1's service plan dated August 28, 2021, indicated R1 received assistance with medication assistance. R1's RN assessment dated September 10, 2021, indicated R1 was unable to read medication labels due to poor vision. R1 was able to dial the correct number of insulin units on her insulin pens by listening to the clicks on the pens which staff verified and supervision. R1 had partial or total blindness. R1's progress note dated October 13, 2021, at 12:13 p.m., indicated R1 returned to the facility after her corneal transplant surgery. R1's record lacked evidence R1 was reassessed after staff provided the wrong insulin for R1 to self administer and after her corneal transplant surgery. R1's medical administration records (MARs) dated October and November 2021, indicated R1 was prescribed the following insulin: Novolog (short-acting insulin) 8-12 Units, resident to self-administer three times per day (TID) (8:00 a.m., 11:30 a.m., 4:00 p.m.), staff to verify dose; Basaglar (long-acting insulin) 30 Units, resident to self-administer once daily (8:00 p.m.), staff to verify dose. R1's medical administration records (MARs) dated October and November 2021, indicated R1 was prescribed the following eye drops and	01620		

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01620	Continued From page 22 insulin: sodium chloride ophthalmic solution, 5%, instill one drop into right eye four times per day (QID). Must wait five minutes between drops; moxifloxacin ophthalmic solution, 0.5%, instill one drop into right eye two times per day (BID); prednisolone acetate ophthalmic solution 1%, instill one drop into right eye QID. Must wait five minutes between different drops; ketorolac 0.5%; instill one drop BID in post-operative eye for one week, then one drop daily for seven more weeks, begin drops three days before surgery on October 13, 2021; Muro 128 5% eye ointment, apply 1/2 inch ribbon to right eye daily, must be administered after last eye drop; Restasis, administer one drop into right eye daily novalog 8-12 Units, resident to self-administer three times per day (TID), staff to verify dose; basaglar (long-acting insulin) 30 Units, resident to self-administer once daily (8:00 p.m.), staff to verify dose. R1's September, October, and November 2021 Medication Administration Summary, indicated R1 did not receive her eye drops on the following dates: *September 1-16, 2021, 8:00 p.m.: Ketorolac ophthalmic solution-not administered due to no supply *September 30, 2021, 8:00 p.m.: Sodium chloride ophthalmic solution-not administered-high glucose *September 30, 2021, 8:00 p.m.: Muro 128 ophthalmic ointment-declined *October 6, 2021, 8:00 p.m.: Sodium chloride ophthalmic solution-declined *October 14, 2021, 4:00 p.m.: Sodium chloride ophthalmic solution-declined *October 15, 2021, 4:00 p.m.: Sodium chloride ophthalmic solution-not administered per RN *October 20, 2021, 4:00 p.m.: Sodium chloride	01620		

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KELLER LAKE COMMONS	655 NORWOOD LANE BIG LAKE, MN 55309

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01620	Continued From page 23 ophthalmic solution-declined *October 22, 2021, not on the list *October 30, 2021, 8:00 a.m.: Moxifloxacin ophthalmic solution-unavailable-waiting to receive from pharmacy. *October 30, 2021, 8:00 p.m.: Restasis eyedrops-need refill *November 4-5, 2021: Moxifloxacin ophthalmic solution- (3 missed doses)-no supply *November 5-6 2021: Prednisolone acetate ophthalmic solution (5 missed doses)-no supply The Mayo Clinic website, www.mayoclinic.org, indicated eyedrops immediately after cornea transplant surgery and during recovery helped control infection, rejection, swelling, and pain. The Mayo Clinic website indicated ketorolac ophthalmic solution was a non-steroidal anti-inflammatory drug (NSAID) used to treat pain, burning, and inflammation of the eye before and after eye surgeries. Sodium chloride ophthalmic solution and Muro 128 ointment were used to draw water out of a swollen cornea. Moxifloxacin ophthalmic solution was an eye antibiotic used to treat infections of the eye. Restasis eyedrops were used to prevent inflammation of the cornea. Prenisolone ophthalmic solution was a corticosteroid used to help prevent inflammation and rejection of the transplanted cornea. On April 5, 2022, at 10:00 a.m., R1 stated on October 12, 2021, at 8:00 p.m., she self-administered the wrong insulin after ULP-E handed her the wrong insulin pen. R1 stated she self-administered 12 Units of Novolog before she realized it was the wrong insulin. On April 5, 2022, at 1:00 p.m., unlicensed personnel (ULP)-E stated on October 12, 2021,	01620		

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01620	Continued From page 24 she was distracted when R1 asked for her nighttime insulin. ULP-E stated she immediately called DON-B after R1 injected the wrong insulin. ULP-E stated DON-B told her to monitor R1 during the rest of her shift. ULP-E stated she and ULP-J monitored R1 and rechecked her blood sugars at least once after the medication error. ULP-E stated she did not complete an incident or medication error report. On February 1, 2022, at 2:04 p.m., DON-B stated she performed change in condition assessments or when a resident returned from the hospital. DON-B confirmed she did not perform reassessment for R1. The licensee policy titled Assessments, Reviews, and Monitoring, updated August 1, 2021, indicated the RN conducted reassessments based on the changes and needs of the resident and would not exceed 90 calendar days from the date of the last assessment. TIME PERIOD TO CORRECT: Seven (7) days.	01620		
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident	01640		

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01640	Continued From page 25 about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure all services were provided and implemented as directed in the current service plans for two of three residents (R1, R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1's medical record was reviewed. R1 admitted to the licensee on August 27, 2021. R1's diagnoses included legal blindness, Type 1 diabetes, Fuchs' dystrophy (hereditary eye condition), macular degeneration, and glaucoma.	01640		

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01640	Continued From page 26 R1's service plan dated August 28, 2021, indicated R1 received assistance with personal cares, four times daily blood glucose checks, meals, medication assistance, nail care as needed (PRN), toileting (pericare), a call pendant, laundry, and housekeeping. R1's RN assessment dated September 10, 2021, indicated R1 required supervision with bathing, and stand-by assistance with mobility. R1 required twice weekly diabetic foot soaks with staff assistance. R1's service delivery record dated August 28, 2021-October 31, 2021, lacked evidence R1 received stand-by assistance with mobility, twice weekly diabetic foot soaks, or PRN diabetic nail care. R2 R2's medical record was reviewed. R2 admitted to the licensee on September 22, 2021. R2's diagnoses included, but were not limited to Type 2 Diabetes, diabetic neuropathy, chronic kidney disease (CKD) Stage 4, chronic obstructive pulmonary disease (COPD), and chronic heart failure (CHF). R2's RN assessment dated January 18, 2022, and completed by DON-B, indicated R2 required diabetic foot care. R2's service plan dated February 1, 2022, indicated R2 received assistance with personal cares, two times daily blood glucose checks, meals, medication assistance, oxygen saturation, a wireless call pendant, laundry, and housekeeping.	01640		

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01640	Continued From page 27 R2's service plan failed to include a service for diabetic foot care. R2's service delivery record dated October 1, 2021-February 1, 2022, lacked documentation R2 received all of her services that were to be provided in her service plan. R3 R3's medical record was reviewed. R3 admitted to the licensee on January 25, 2021, under the comprehensive home care license, and began receiving assisted living services on August 1, 2021. R3's diagnoses included, but were not limited to Type 2 Diabetes Mellitus with diabetic chronic kidney disease Stage 4, paroxysmal atrial fibrillation (Afib), and long-term use of anticoagulants (Coumadin). R3 used a manual wheelchair and walker for mobility and walked with staff assistance of one using a gait belt. R3's RN assessment dated July 7, 2021, and completed by DON-B, indicated R3 required a nurse to follow-up on new orders as needed, schedule her lab and medical appointments. R3's service plan dated August 1, 2021, indicated R3 received assistance twice daily blood glucose monitoring, twice daily assistance with thrombo-embolus deterrent (TED) stockings, and monthly registered nurse (RN) supervision for the TED hose. R3's service plan did not include R3's nursing staff's managment of R3's International Normalized Ratio (INR). R3's progress note dated August 28, 2021, at 10:27 a.m., and written by director of nursing (DON)-B, indicated she obtained R3's INR	01640		

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01640	Continued From page 28 results. DON-B updated R3's provider with her INR results. On April 7, 2022, at 11:04 a.m., DON-B stated nursing staff obtained R3's INR from an INR machine that R3 had. DON-B stated R3's provider would adjust R3's Coumadin based upon her INR results. On February 1, 2022, at 2:00 p.m., DON-B stated service plans were revised annually or when there was a change in the resident's condition. DON-B stated her job duties included ensuring service plans were up-to-date and accurate. DON-B stated service plans described all the services staff provided for the residents. On April 1, 2022, at 11:10 a.m., R2 stated her scheduled services did not start until the end of October. R2 stated she was confused after she was admitted on September 22, 2021, stating, "nothing was happening." R2 stated on October 20, 2021, she and her family had a meeting with licensed assisted living director (LALD)-I and DON-B to discuss her services she never received. R2 stated she started receiving her services after her meeting with LALD-I and DON-B. The licensee policy titled, Service Plan, updated August 1, 2021, indicated service plans were written plans between a resident or resident's designated representative and the facility about the services that would be provided to the resident. Service plans were revised, if needed, based on resident reassessments and monitorin. TIME PERIOD TO CORRECT: Seven (7) days.	01640		

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01730	Continued From page 29	01730		
01730 SS=I	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any	01730		

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01730	Continued From page 30 changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure medication refills were ordered in a timely basis as required in the medication management plan for three of three residents (R1, R2, R3) with records reviewed. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings Include: R1 R1's medical record was reviewed. R1 admitted to the licensee on August 27, 2021. R1's diagnoses included, but were not limited to, legal blindness, Type 1 diabetes, Fuchs' dystrophy (hereditary eye condition), macular degeneration, and glaucoma. R1's service plan dated August 28, 2021, indicated R1 received medication assistance four times per day. R1's registered nurse (RN) assessment dated September 10, 2021, indicated R1 was able to	01730		

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01730	Continued From page 31 dial the correct number of insulin units on her insulin pens by listening to the clicks on the pens which staff verified and supervised. R1's prescriber's initial home visit dated September 16, 2021, indicated staff were to continue to assist R1 with her eye drop administration. R1's individual abuse prevention plan (IAPP) dated November 9, 2021, indicated R1 required assistance with medication administration due to partial or total blindness. R1's medical administration records (MARs) dated August 27, 2021 to November 6, 2021, indicated R1 was prescribed the following medications: a thyroid pill, allergy tablet, aspirin, two different steroid creams for her skin, two different antibiotic tablets, a stool softener tablet, three different blood pressure pills, fiber powder for constipation, two different types of insulin (short-acting and long-acting), cholesterol medication, vitamins, and six different eye drops and one eye ointment prescribed before and after her corneal transplant surgery to prevent rejection of her transplanted cornea. R1's August-November 2021 MARs indicated R1 was not administered the following medications, eye drops, and eye ointment due to no supply: August 2021: 5 doses of medications, 1 dose of insulin, 3 doses of eye drops, and 1 dose of eye ointment. September 2021: 20 doses of medications, 12 doses of eye medications, and 1 dose of eye ointment. October 2021: 12 doses of medications, 7 doses of eye drops, and 1 dose of eye ointment. November 2021: 8 doses of eye drops.	01730		

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01730	Continued From page 32 R2 R2's medical record was reviewed. R2 admitted to the licensee on September 22, 2021. R2's diagnoses included, but were not limited to Type 2 Diabetes, diabetic neuropathy, chronic kidney disease (CKD) Stage 4, chronic obstructive pulmonary disease (COPD), and chronic heart failure (CHF). R2's RN assessment dated January 18, 2022, and completed by DON-B, indicated R2 was able to safely self-administer topical ointments, creams, transdermal patches, inhalants, subcutaneous injections, and oxygen. Directly below these assessments was a contridictory summary indicating R2 was unable to self-administer medications safely. R2's IAPP dated January 18, 2022, indicated R2 required assistance in medication administration. R2's service plan dated January 18, 2022, indicated R2 received medication assistance. R2's MARs dated October 2021-January 2022, indicated R2 was prescribed the following medications: a thyroid pill, gout tablet, aspirin, two different types of antidepressants, a water pill, two different types of insulin (fast-acting and intermediate-acting), vitamins, two different types of blood pressure tablets, cholesterol tablet, and a tablet to reduce stomach acid. R2's record indicated R2 was not administered the following medications due to no supply: October 2021: 1 dose of medication. November 2021: 1 insulin dose. December 2021: 2 doses of medication.	01730		

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01730	Continued From page 33 R3 R3's medical record was reviewed. R3 admitted to the licensee on February 18, 2020. R3's diagnoses included, but were not limited to Diabetes Mellitus Type 2, CKD Stage 4 (severe), CHF, and hyperlipidemia (high cholesterol). R3's RN assessment dated September 30, 2021, and completed by DON-B, indicated R3 had a complicated medication regimen and required assistance with medication management and administration. R3's service plan dated February 1, 2022, indicated R3 received assistance with medication management, medication set-up, and medication assistance. R3's MARs dated August 2021-September 2021, indicated R3 was prescribed the following medications: a lotion used for rash, a long-acting insulin, an oral diabetic tablet, anti-fungal powder, stool softener, narcotic pain pill, vitamins, two different types of antibiotics, a water pill, one blood pressure tablet, two different types of steroid creams, oral potassium packets mixed with water, oral steroid tablet, and an anticoagulant (Coumadin). R3's record indicated R3 was not administered the following medications due to no supply: August 2021: 9 doses of Coumadin medication, 2 doses of insulin (no needle supply). September 2021: 2 doses Coumadin medication, 7 doses of other medications, 2 doses on insulin and 1 dose of topical cream. R3's nurse progress note dated August 5, 2021, at 3:13 p.m., indicated R3's international normalized ratio (INR) was 1.6. The note	01730		

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01730	Continued From page 34 indicated a new Coumadin order, giving R3 1 mg every Monday and 2 mg the rest of the week. Nurses were to recheck R3's INR in one week. R3's medication error report dated August 6-8, 2021, at 4:30 p.m., indicated R3 was not administered three days' of Coumadin, 25 milligrams (mg). The report indicated the error was due to an omission that occurred during an evening shift. The report indicated, "staff documented as no supply, did not follow protocol and update on-call nurse." The report indicated R3's prescriber was notified. 911 was not called. The report was reported and reviewed by the director of nursing (DON)-B on August 18, 2021, at 2:29 p.m. R3's nurse progress note dated August 16, 2021, at 6:14 p.m., indicated R3's INR was 1.3. A new order was prescribed increasing R3's Coumadin to 2 mg daily. Nurses were to recheck R3's INR in one week. R3's nurse progress note dated September 13, 2021, at 12:40 p.m., indicated R3's INR was 1.3. Nurses were to administer 2 mg of Coumadin daily recheck her INR in one week. On April 4, 2022, at 3:00 p.m., DON-B stated most medications were ordered on a cycle-fill and shipped automatically. DON-B stated staff notified her five to seven days before a medication runs out. DON-B stated medications usually arrived the same day once she put the order in to pharmacy. On April 5, 2021, at 10:00 a.m., R1 stated she moved into the facility in August 2021 because she required daily assistance with her eye drop regimen. R1 stated her corneal transplant surgery	01730		

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01730	Continued From page 35 was October 13, 2021. R1 stated she was prescribed several different eye drops before and after her surgery to prevent corneal transplant rejection. R1 stated on November 6, 2021, her family moved her out of the facility after the facility ran out of her eye drops for two days, stating she missed several doses. R1 stated her corneal transplant surgery did not go well, stating her eyesight was, "very poor." On April 5, 2021, at 1:00 p.m., unlicensed personnel (ULP)-E stated ULP had the option to document either unavailable or declined when they ran out of medications. ULP-E stated ULP were supposed to alert the nurses whenever resident's medications were running low, otherwise, ULP-E stated, the nurses would not know a resident ran out of their medications. ULP-E stated ULP could alert nurses by sending them a message from their work phone, or peel off a medication label and apply it to a note pad that was used for re-ordering medications. On April 7, 2021, at 12:00 p.m., ULP-G stated sometimes the pharmacy took a long time to send the medications. On February 1, 2022, the director of nursing (DON)-B stated she was responsible for ensuring the resident's service plans were up-to-date and accurate. DON-B stated the resident's service agreement was everything staff did for the residents, every care they provide, and the medications they need. DON-B stated, "it documents everything." The licensee policy titled Medication Management Individualized Plan, updated August 1, 2021, indicated the licensee would prepare and include in the resident's service plan a written statement	01730		

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01730	Continued From page 36 of the medication management services that would be provided to the resident. TIME PERIOD TO CORRECT: Seven (7) days.	01730		
01750 SS=I	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure five unlicensed personnel (ULP-A, ULP-E, ULP-F, ULP-G, ULP-J) demonstrated competency for administering medications. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	01750		

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01750	Continued From page 37 The findings included: ULP-A ULP-A was hired on July 9, 2020 to provide direct care services to the licensee's residents. ULP-E ULP-E was hired on August 10, 2021 to provide direct care services to the licensee's residents. ULP-F ULP-F was hired on May 25, 2021 to provide direct care services to the licensee's residents. ULP-G ULP-G was hired on December 22, 2021 to provide direct care services to the licensee's residents. ULP-J ULP-J was hired on June 7, 2021 to provide direct care services to the licensee's residents. Review of facility records indicated between August 6, 2021 and January 23, 2022, 64 medication errors were made by unlicensed personnel (ULP). Out of the 64 medication errors, the following ULP's had several medication errors: *ULP-A; November 23, 2021-January 18, 2022-13 medication errors. *ULP-E: December 7, 2021-December 16, 2021-2 medication errors *ULP-F; August 16, 2021-January 16, 2022-19 medication errors. *ULP-G; December 28, 2021-January 16, 2022-3 medication errors. *ULP-J; November 23, 2021-December 30, 2021-6 medication errors.	01750		

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01750	Continued From page 38 ULP-A, ULP-E, ULP-F, ULP-G, and ULP-J's employee records lacked evidence the ULP demonstrated competency in medication administration. Review of ULP-F's employee record dated September 21, 2021, indicated ULP-F was disciplined due to continued medication errors, giving incorrect medication doses, and documenting "no supply" when supply was in cabinet. ULP-F was assigned to complete all online training modules, and three medication administration observations with a nurse by September 25, 2021. Review of ULP-F's training record, indicated ULP-F completed her online retraining for medication administration on December 20, 2021 and February 6, 2022. ULP-F's employee records indicated ULP-F never completed retraining on medication administration competencies. Review of ULP-F's medication error reports indicated ULP-F had an additional 13 medication errors between November 25, 2021 and January 16, 2022. On April 4, 2022, at 3:00 p.m., DON-B stated majority of medications were ordered on a cycle fill and delivered automatically from the pharmacy. DON-B stated she was in charge of ordering eye drops, ointments, Coumadin, steroid creams, insulin, and as needed (PRN) narcotic pain medications. DON-B stated pharmacy delivered medications the same day. DON-B stated ULP who had more than two or three medication errors within a one month period were required to do retraining on medication administration. DON-B stated retraining included	01750		

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01750	Continued From page 39 both online and competency training on medication administration. DON-B was unable to explain the 64 medication error reports, stating, "I've been working with them consistently." Review of ULP-A, ULP-G, and ULP-J's employee records, indicated they were not retrained on medication administration. On April 4, 2022, at 3:00 p.m., DON-B stated ULP who had more than two or three medication errors within a one month period were required to do retraining on medication administration. DON-B stated retraining included both online and competency training on medication administration. DON-B was unable to explain the 64 medication error reports, stating, "I've been working with them consistently." The licensee policy titled Staff Competency, dated August 1, 2021, indicated all residents would receive quality service delivered by staff who were educated and competent in the delivery of assisted living services. The registered nurse (RN) was responsible for the overall competency evaluation program. TIME PERIOD TO CORRECT: Seven (7) days.	01750		
01760 SS=I	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	01760		

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01760	Continued From page 40 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 each medication administered by the assisted living facility was documented in the record and when not administered as prescribed, documenting that included the reason why, and follow-up procedures were provided to meet the resident's needs for three of three residents (R1, R2, R3) with records reviewed. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings Include: R1 R1's medical record was reviewed. R1 was admitted to the facility on August 27, 2021. R1's diagnoses included, but were not limited to, legal blindness, Type 1 diabetes, Fuchs' dystrophy (hereditary eye condition), macular degeneration,	01760		

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01760	Continued From page 41 and glaucoma. R1's service plan dated August 28, 2021, indicated R1 received medication assistance four times per day. R1's registered nurse (RN) assessment dated September 10, 2021, indicated R1 wa able to dial the correct number of insulin units on her insulin pens by listening to the clicks on the pens which staff verified. R1's assessment indicated R1 was unable to self-administer medication safely. R1's prescriber's initial home visit dated September 16, 2021, indicated R1 was prescribed the following eye drops: moxifloxacin 0.5% eye drops, one drop into right eye (OD) four times daily (QID); prednisolone 1%-gatifloxacin 0.5%-bromfenac 0.078% eye drops, one drop into OD QID; ketoroloca 0.5% eye drop, one drop into both eyes every night at bedtime (QHS); Systane 0.4%-0.3%, instill one drop into both eyes QHS. R1's preopeative prescriber home visit dated October 4, 2021, indicated R1 had no changes to her eye medications. R1 told her prescriber she looked forward to her corneal transplant surgery but was not sure she could trust staff to instill the correct eye drops or administer the drops at the correct times. R1' individual abuse prevention plan (IAPP) dated November 9, 2021, indicated R1 needed assistance with medication administration due to partial or total blindness. R1's prescriber orders dated, August-October 2021, included, but were not limited to, a cholesterol tablet, blood pressure tablets, a	01760		

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01760	Continued From page 42 steroid cream, stool softener, six different eye drops, eye drop ointment, antibiotic tablets, vitamins, allergy tablets, and rapid and long-acting insulin. R1's August-November 2021 MARs indicated R1 was not administered her eye drops and eye ointment on the following dates due to no supply: August *August 28, 2021 at 8:00 p.m. *August, 29-30, 2021 at 8:00 p.m. *August 31, 2021 at 8:00 p.m. September *September 1-3, 2021 at 8:00 p.m. *September 6, 2021 at 8:00 p.m. *September 9, 10, 2021 at8:00 p.m. *September 5, 2021 at 8:00 p.m. *September 11 through 14, 2021 at 8:00 p.m. *September 16, 2021 at 8:00 p.m. *September 30, 2021 at 8:00 p.m. October *October 6, 2021 at 8:00 p.m. *October 16, 2021 at 8:00 p.m. *October 19, 2021 at 4:00 p.m. *October 22, 2021 at 8:00 p.m. *October 29-30, 2021 at 8:00 p.m. *October 24, 2021 at 8:00 p.m. November November 4, 2021 at 8:00 p.m. November 5, 2021 at 7:00 a.m., 11:00 a.m., 5:00 p.m., 8:00 p.m. November 6, 2021 at 7:00 a.m., 11:00 a.m., 4:00 p.m. In addition, R1's August -November 2021 MARs indicated R1 was not adminstered the following	01760		

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01760	Continued From page 43 medications due to no supply: *August 29, 2021-8:00 a.m.: Cholesterol tablet *August 29, 2021-8:00 p.m.: Blood pressure tablet *August 31, 2021-8:00 p.m.: Stool softener, long-acting insulin (Lantus), and steroid cream *September 9-14, 16, 20, 23, 25,27-29, 2021-8:00 p.m.: Steroid cream *September 5-8, 2021-8:00 a.m.: Allergy and cholesterol tablets *September 6, 2021-8:00 p.m.: Antibiotic tablet *October 1-3, 2021-8:00 a.m. and 8:00 p.m.: Steroid cream *October 9-10, 2021-8:00 a.m.: Stool softener *October 28, 2021-8:00 a.m.: Allergy tablet R1's MARs lacked evidence the facility performed any follow-up procedures to meet R1's needs after they failed to administer R1's medications as prescribed by her provider. R2 R2's medical record was reviewed. R2 was admitted to the facility on September 22, 2021. R2's diagnoses included, but were not limited to Type 2 Diabetes, diabetic neuropathy, chronic kidney disease (CKD) Stage 4, chronic obstructive pulmonary disease (COPD), and chronic heart failure (CHF). R2's RN assessment dated January 18, 2022, and completed by DON-B, indicated R2 was able to safely self-administer topical ointments, creams, transdermal patches, inhalants, subcutaneous injections, and oxygen (02). Directly below these assessments was a summary indicating R2 was unable to self-administer medications safely.	01760		

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01760	Continued From page 44 R2's IAPP dated January 18, 2022, indicated R2 required assistance in medication administration. R2's service plan dated January 18, 2022, indicated R2 received medication assistance. R2's prescriber orders indicated staff were to administer Regular insulin (short-acting), 40 Units two times per day (BID) (11:00 a.m., 6:00 p.m.), and Novolin 70/30 (intermediate-acting), 20 Units at bedtime (HS) (10:30 p.m.) to R2. R2's October 2021 MAR indicated on November 14, 2021, at 10:14 p.m., R1 was not administered her intermediate-acting insulin due to no needles. On November 9, 15, and 23, 2021, at 10:30 p.m., staff never documented R1 was administered her intermediate-acting insulin. R2's December 2021 MAR indicated on December 10, 2021, at 11:00 a.m., R2 was not administered her antidepressants due to staff documenting "no supply." R2's MARs lacked evidence the facility performed any follow-up procedures to meet R2's needs after they failed to administer medications as prescribed by her provider. R3 R3's medical record was reviewed. R3 was admitted to the facility on February 18, 2020. R3's diagnoses included, but were not limited to Diabetes Mellitus Type 2, CKD Stage 4 (severe), CHF, and hyperlipidemia (high cholesterol). R3's IAPP dated August 2, 2021, indicated R3 required assistance with medication administration.	01760		

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01760	Continued From page 45 R3's RN assessment dated September 30, 2021, and completed by DON-B, indicated R3 had a complicated medication regimen and required assistance with medication management and administration. R3's service plan dated February 1, 2022, indicated R3 received assistance with medication management, medication set-up, and medication assistance. R3's August and September 2021 MARs indicated R3 was not administered Coumadin on the following dates due to no supply: *August 6-8, 2021-4:30 p.m. *August 13-15, 2021-4:30 p.m.: *August 18, 2021-4:30 p.m. *August 27-28, 2021-4:30 p.m. *September 10, 2021-4:30 p.m. *September 23, 2021- 4:30 p.m. R3's medication error report dated August 6-8, 2021, at 4:30 p.m., indicated R3 was not administered her Coumadin, 25 milligrams (mg) by mouth (PO). The report indicated the error was due to an "omission" that occurred during an evening shift. The report indicated, "staff documented as no supply, did not follow protocol and update on-call nurse." The report indicated R3's prescriber was notified. 911 was not called. The report was reported and reviewed by the director of nursing (DON)-B on August 18, 2021, at 2:29 p.m. R3's nurse progress note dated August 13, 2021, at 12:40 p.m., indicated R3's international normalized ratio (INR) was 1.3. R3's record indicated R3's INR therapeutic range	01760		

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01760	Continued From page 46 was 2.0-3.0. The Mayo Clinic website, www.mayoclinic.org, copyrighted 1998-2022, indicated Coumadin must be taken exactly as directed to work safely and effectively. Taking too little of Coumadin may not be effective. In addition, R3's MAR indicated R3 was not adminsitered the following medications due to no supply: *September 8-9, 2021-8:00 a.m.: Long-acting insulin (Lantus-no needles) *September 9-13, 2021-4:30 p.m.: potassium *September 9, 2021-4:30 p.m.: antibiotic *September 23, 2021-4:30 p.m.: antibiotic. *September 23, 2021- 8:00 a.m.: steroid cream R3's MARs lacked evidence the facility performed any follow-up procedures to meet R3's needs after they failed to administer medications as prescribed by her provider. On February 1, 2022, at 2:00 p.m. director of nursing (DON)-B stated staff updated her through work phone text message or through a medication reorder form. DON-B stated medication reorder forms were checked daily. On April 4, 2022, at 3:00 p.m., DON-B stated majority of medications were ordered on a cycle fill and delivered automatically from the pharmacy. DON-B stated she was in charge of ordering eye drops, ointments, Coumadin, steroid creams, insulin, and as needed (PRN) narcotic pain medications. DON-B stated pharmacy delivered medications the same day. On April 4, 2022, at 9:00 a.m., family member	01760		

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01760	Continued From page 47 (FM)-C stated R1 ws mentally intact and had been a Type 1 diabetic for years and knew her medication regimen well. FM-C stated shortly after the resident moved into the facility, the facility changed R1's insulin needles to retractable, which had a cap at the end. FM-C stated staff did not tell R1 there was a cap at the end, and R1 ended up not getting her insulin. FM-C stated R1 called her stating she never felt the insulin gong into her. FM-C after that, R1's blood sugar shot up to almost 500 milligrams per deciliter (mg/dL). On April 4, 2022, at 11:00 a.m., FM-D stated she kept a log with dates and times, documenting when R1 was not administered her insulin, eye, and other medications. On April 5, 2022, at 10:00 a.m., R1 stated she moved into the facility because she required daily assistance with her complicated eye medication regimen. R1 stated she was prescribed several different eye drops and eye ointment before and after her corneal transplant surgery to prevent rejection of the transplanted cornea. R1 stated on October 12, 2021, the night before her eye surgery, ULP-E gave her the wrong insulin to self-administer. R1 stated she stopped injecting the insulin after she realized it was the wrong insulin, but stated she still ended up injecting several Units of insulin. R1 stated she was up most of the night eating carbohydrates in order to prevent her blood sugar levels from dropping too low. R1 stated on November 6, 2021, her family moved her out of the facility after the facility ran out of her eye drops for two days, stating she missed several doses. R1 stated her corneal transplant surgery did not go well, stating her eyesight was, "very poor."	01760		

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01760	Continued From page 48 On April 5, 2021, at 1:00 p.m., ULP-E stated ULP had the option to document unavailable or declined when they ran out of medications. ULP-E stated on October 12, 2021, she was distracted when R1 asked for her nighttime insulin. ULP-E stated she immediately called DON-B after R1 injected the wrong insulin. ULP-E stated DON-B told her to monitor R1 during the rest of her shift. ULP-E stated she and ULP-J monitored R1 and rechecked her blood sugars at least once after the medication error. ULP-E stated she did not complete an incident or medication error report. On April 7, 2022, at 12:00 p.m., ULP-F stated R1 expected her medications to be administered on time and would worry if she did not get them. ULP-F stated R1 complained if the facility was out of her eye drops for "a while," stating, "she knew the eye drops she was supposed to get for her eye surgery." ULP-F stated R1 became unhappy if the facility ran out of one of her eye drops and the next dose was missed because of no supply. ULP-F stated, "it wasn't all of her eye drops that were out at the same time, but I'm not sure." The licensee policy titled, Medication and Supplies-Reordering, updated August 1, 2021, indicated facility nursing staff would ensure resident's medications and supplies were ordered and available as needed. TIME PERIOD TO CORRECT: Seven (7) days.	01760		
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy	01940		

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01940	Continued From page 49 services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individualized treatment or therapy management plan was developed and maintained for three of three residents (R1, R2, R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01940		

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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
01940	Continued From page 50 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1's medical record was reviewed. R1 admitted to the licensee on August 27, 2021. R1's diagnoses included, but were not limited to, legal blindness, Type 1 diabetes, Fuchs' dystrophy (hereditary eye condition), macular degeneration, and glaucoma. R1's service plan dated August 28, 2021, indicated R1 received assistance with four times daily blood glucose checks and as needed (PRN) diabetic nail care from licensed staff. R1's registered nurse (RN) assessment dated January 18, 2022, and completed by director of nursing (DON)-B, indicated R1 required twice weekly diabetic foot soaks performed by licensed staff. R1's service record failed to include twice weekly diabetic foot soaks. R1's record lacked an individualized treatment and therapy plan that included the following required content: (1) a statement of the type of specific services that would be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that would be delegated to unlicensed personnel (ULP); (4) procedures for notifying a registered	01940		

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	34175	A. BUILDING: _____ B. WING _____	C 02/01/2022

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01940	Continued From page 51 nurse (RN) or appropriate licensed health professional when a problem arose with treatments or therapy services, and; (5) any resident specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be kept current and updated whenever there were changes. R2 R2's medical record was reviewed. R2 admitted to the licensee on September 22, 2021. R2's diagnoses included Type 2 Diabetes, diabetic neuropathy, chronic kidney disease (CKD) Stage 4, chronic obstructive pulmonary disease (COPD), and chronic heart failure (CHF). R2's RN assessment dated January 18, 2022, and completed by DON-B, indicated R2 required diabetic foot care. R2 required oxygen during activities and was independent in using oxygen and her continuous positive airway pressure (CPAP) machine. R2's service plan dated February 1, 2022, indicated R2 received assistance with twice daily blood glucose checks. R2's record lacked an individualized treatment and therapy plan that included the following required content: (1) a statement of the type of specific services that would be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that	01940		

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01940	Continued From page 52 would be delegated to unlicensed personnel (ULP); (4) procedures for notifying a registered nurse (RN) or appropriate licensed health professional when a problem arose with treatments or therapy services, and; (5) any resident specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be kept current and updated whenever there were changes. R3 R3's medical record was reviewed. R3 admitted to the licensee on January 25, 2021, under the comprehensive home care license, and began receiving assisted living services on August 1, 2021. R3's diagnoses included, but were not limited to Type 2 Diabetes Mellitus with diabetic chronic kidney disease Stage 4, paroxysmal atrial fibrillation (Afib), and long-term use of anticoagulants (Coumadin). R3 used a manual wheelchair and walker for mobility and walked with staff assistance of one using a gait belt. R3's RN assessment dated July 7, 2021, and completed by DON-B, indicated R3 required a nurse to follow-up on new orders as needed, schedule her lab and medical appointments. R3's service plan dated August 1, 2021, indicated R3 received assistance twice daily blood glucose monitoring, twice daily assistance with thrombo-embolus deterrent (TED) stockings, and monthly registered nurse (RN) supervision for the TED hose.	01940		

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01940	Continued From page 53 R3's service plan did not include R3's nursing staff's managment of R3's International Normalized Ratio (INR). R3's progress note dated August 28, 2021, at 10:27 a.m., and written by director of nursing (DON)-B, indicated she obtained R3's INR results. DON-B updated R3's provider with her INR results. R3's record lacked an individualized treatment and therapy plan that included the following required content: (1) a statement of the type of specific services that would be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that would be delegated to unlicensed personnel (ULP); (4) procedures for notifying a registered nurse (RN) or appropriate licensed health professional when a problem arose with treatments or therapy services, and; (5) any resident specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be kept current and updated whenever there were changes. Request for R3's prescribed order for TED hose was not provided. On April 7, 2022, at 11:04 a.m., DON-B stated nursing staff obtained R3's INR from an INR machine that R3 had. DON-B stated R3's provider would adjust R3's Coumadin based upon her INR results.	01940		

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01940	Continued From page 54 In an email dated March 31, 2022, at 11:42 a.m.., the surveyor requested R1, R2 and R3's treatment and therapy plans. In an email dated March 31, 2022, at 2:12 p.m., DON-B indicated resident treatment and therapy plans were addressed in their service plans, and confirmed in the email the residents did not have individualized treatment or therapy management plans. TIME PERIOD TO CORRECT: Seven (7) Days	01940		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: Based on observations, interviews, and document review, the facility failed to ensure one of three residents reviewed (R1) was free from maltreatment. R1 was neglected. Findings include: On May 6, 2021, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	

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03000	Continued From page 55	03000		
03000 SS=G	626.557 Subd. 3 Timing of report (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. (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	03000		

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03000	Continued From page 56 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 comply with the requirements for reporting to Minneosta Adult Abuse Reporting Center (MAARC) significant medication errors within 24 hours for one of three residents (R1) with records reviewed. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at 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 R1's medical record was reviewed. R1 admitted to the licensee on August 27, 2021. R1's diagnoses included Type 1 diabetes, legal blindness, Fuchs' dystrophy (hereditary eye condition), macular degeneration, and glaucoma.	03000		

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03000	Continued From page 57 R1's service plan dated August 28, 2021, indicated R1 received assistance with personal cares, four times daily blood glucose checks, meals, medication assistance, diabetic foot care, toileting (pericare), and housekeeping. R1 used a walker for mobility. R1's registered nurse (RN) assessment dated September 10, 2021, indicated R1 required supervision with bathing, and stand-by assistance with mobility. R1 was unable to read medication labels due to poor vision. R1 was able to dial the correct number of insulin units on her insulin pens by listening to the clicks on the pens which staff verified and supervised. R1 had partial or total blindness. R1 was assessed as required staff assistance in the event of an emergency. R1' individual abuse prevention plan (IAPP) dated November 9, 2021, indicated R1 needed assistance with medication administration due to partial or total blindness. R1's medical administration records (MARs) dated October and November 2021, indicated R1 was prescribed the following eye drops and insulin: sodium chloride ophthalmic solution, 5%, instill one drop into right eye four times per day (QID). Must wait five minutes between drops; moxifloxacin ophthalmic solution, 0.5%, instill one drop into right eye two times per day (BID); prednisolone acetate ophthalmic solution 1%, instill one drop into right eye QID. Must wait five minutes between different drops; ketorolac 0.5%; instill one drop BID in post-operative eye for one week, then one drop daily for seven more weeks, begin drops three days before surgery on October 13, 2021; Muro 128 5% eye ointment, apply 1/2 inch ribbon to right eye daily, must be administered after last eye drop; Restasis,	03000		

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03000	Continued From page 58 administer one drop into right eye daily novalog 8-12 Units, resident to self-administer three times per day (TID), staff to verify dose; basaglar (long-acting insulin) 30 Units, resident to self-administer once daily (8:00 p.m.), staff to verify dose. R1's September, October, and November 2021 Medication Administration Summary, indicated R1 did not receive her eye drops on the following dates: *September 1-16, 2021, 8:00 p.m.: Ketorolac ophthalmic solution-not administered due to no supply *September 30, 2021, 8:00 p.m.: Sodium chloride ophthalmic solution-not administered-high glucose *September 30, 2021, 8:00 p.m.: Muro 128 ophthalmic ointment-declined *October 6, 2021, 8:00 p.m.: Sodium chloride ophthalmic solution-declined *October 14, 2021, 4:00 p.m.: Sodium chloride ophthalmic solution-declined *October 15, 2021, 4:00 p.m.: Sodium chloride ophthalmic solution-not administered per RN *October 20, 2021, 4:00 p.m.: Sodium chloride ophthalmic solution-declined *October 22, 2021, not on the list *October 30, 2021, 8:00 a.m.: Moxifloxacin ophthalmic solution-unavailable-waiting to receive from pharmacy. *October 30, 2021, 8:00 p.m.: Restasis eyedrops-need refill *November 4-5, 2021: Moxifloxacin ophthalmic solution- (3 missed doses)-no supply *November 5-6 2021: Prednisolone acetate ophthalmic solution (5 missed doses)-no supply The Mayo Clinic website, www.mayoclinic.org, indicated eyedrops immediately after cornea	03000		

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03000	Continued From page 59 transplant surgery and during recovery helped control infection, rejection, swelling, and pain. The Mayo Clinic website indicated ketorolac ophthalmic solution was a non-steroidal anti-inflammatory drug (NSAID) used to treat pain, burning, and inflammation of the eye before and after eye surgeries. Sodium chloride ophthalmic solution and Muro 128 ointment were used to draw water out of a swollen cornea. Moxifloxacin ophthalmic solution was an eye antibiotic used to treat infections of the eye. Restasis eyedrops were used to prevent inflammation of the cornea. Prenisolone ophthalmic solution was a corticosteroid used to help prevent inflammation and rejection of the transplanted cornea. On April 4, 2021, at 11:00 a.m., family member (FM)-D stated R1 had six prescribed eyedrops she needed to have administered prior to her corneal transplant surgery. FM-D stated R1 would call FM-D stating eyedrops were not administered due to DON-B being unable to locate a prescribed eyedrop. FM-D stated on November 6, 2021, she received a phone call from FM-C stating R1 missed two days' worth of prednisolone ophthalmic solution, stating they were told it was the pharmacy's fault. FM-D stated at that point R1's family decided to move R1 into FM-C's home until another assisted living facility could be found. FM-D stated she documented and kept track of dates and times when R1 did not receive her medications, including insulin. FM-D provided the document to the state investigator). On April 4, 2021, at 3:00 p.m., director of nursing (DON)-B stated she was in charge of ordering eye medications, insulin, and as needed (PRN) medications.	03000		

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03000	Continued From page 60 On April 5, 2022, at 10:00 a.m., R1 stated she did not feel safe when she resided at the facility, stating DON-B always made excuses. R1 stated she required eye drops before and after her corneal transplant surgery to help prevent transplant rejection. R1 stated the night before her corneal transplant surgery, unlicensed personnel (ULP)-E gave her morning insulin pen instead of her nighttime insulin. R1 stated she dialed up the insulin pen and administered some of her morning insulin before realizing it was the wrong insulin. On April 5, 2022, at 1:00 p.m., unlicensed personnel (ULP)-E stated she was distracted when R1 asked for her nighttime insulin. ULP-E stated she immediately called DON-B after R1 injected the wrong insulin. ULP-E stated DON-B told her to monitor R1 during the rest of her shift. ULP-E stated she and ULP-J monitored R1 and rechecked her blood sugars at least once after the medication error. ULP-E stated she did not complete an incident report. ULP-E stated staff had the option of charting "declined" or "unavailable," when medications were unavailable. The licensee policy titled, Vulnerable Adult Maltreatment-Prevention and Reporting, updated August 1, 2021, indicated the licensee trained all staff members on identifying incidents of maltreatment, including abuse, financial exploitation, and neglect, and any act that constituted maltreatment was prohibited. TIME PERIOD TO CORRECT: Seven (7) days.	03000		