Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL366006765M
Compliance #: HL366002660C

Date Concluded: August 14, 2023

Name, Address, and County of Licensee Investigated:
Suite Living Senior Care of Brooklyn Park
8500 Regent Avenue Nortr
Brooklyn Park, MN 55443
Hennepin County

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

Evaluator's Name: Lissa Lin, RN
Special Investigator

Finding: Inconclusive

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

Initial Investigation Allegation(s):
The facility neglected a resident when staff did not administer her prescribed medication for several days. The resident was hospitalized with abdominal pain and distention.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. Although the resident may not have received all her scheduled doses of a prescribed medication during approximately two weeks, there was conflicting staff member documentation on the medication's availability and administration. The facility had a process in place for unlicensed staff members to notify nurses when a medication was low and needed to be refilled. Nursing and unlicensed staff members gave conflicting information during interviews on when the nurse was notified about the medication needing to be refilled. The resident was hospitalized for one week for treatment of abdominal pain. In addition, the hospital physician and primary physician had conflicting causes of the resident's hospitalization.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the physician. The investigation included review of medical records, hospital records, policies and procedures, personnel files, and facility incident reports. Also, the investigator observed medication administration and the medication refill process.

The resident resided in an assisted living facility. The resident's diagnoses included cirrhosis of the liver (liver damage), diabetes and multiple sclerosis (MS). The resident's service plan included assistance with medication administration. The resident's assessment indicated she was able to make her needs known. The resident's medication management plan indicated facility staff was responsible for monitoring and ordering resident medications.

The resident's medication orders included an order for lactulose scheduled twice a day for cirrhosis of the liver. The resident's medication administration record (MAR) indicated over a two-week span of time the resident missed 17 out of 24 doses of lactulose. The staff indicated on the MAR drug "not available" as the reason why the medication was not given.

The resident's progress noted indicated the resident presented to the nurse crying and complaining of abdominal pain. The nurse assessed the resident, contacted the physician and sent the resident to the hospital for evaluation and treatment. The resident admitted to the hospital for about one week for treatment of neurogenic bowel (the loss of normal bowel function caused by a nerve problem) and then discharged back to the facility.

The resident's hospital record indicated the gastroenterologist (stomach/digestion doctor) reviewed the resident's bowel imaging, laboratory results and clinical presentation. The gastroenterologist indicated the neurogenic bowel was likely the complication of the resident's MS.

A few weeks later, the resident's physician contacted the resident's family member and the facility's nurse about the resident's hospitalization. The physician indicated the hospitalization most likely due to missed doses of her prescription lactulose. (Lactulose is a medication that increases bowel movements and lowers the body's ammonia production.)

During an interview, the nurse said when she was contacted by the resident's physician about the medication error, she was shocked because there was a process in place for staff to let her know if a medication was running low or out. Staff were to check the overstock storage first, and then let her know if a medication needed refilling by placing the empty medication package in specifically marked gray bins in the nursing office. The nurse checked the bins daily. The nurse said she never had any empty packaging or bottles of the resident's medications in the bins. The nurse checked the resident's medication records; there were days where staff

members documented the resident's lactulose was given at both scheduled times, days when staff documented it was not available during either scheduled time, and days when it was documented as given during one of the scheduled times, but not the other. The conflicting documentation involved experienced and newer staff members. The nurse said when she interviewed them about the medication, they had no clear explanations on what happened. The nurse said she increased her medication cart audits and reviewed the resident's medications and documentation process with staff members. One newer staff member was pulled from the medication cart for re-training. The nurse said she contacted the resident's family member about the incident.

During an investigative interview, an unlicensed staff member said she did not know when the resident's lactulose was out, but she did leave the nurse a note about needing it refilled. Other unlicensed staff members said the medication refill process worked well and were not aware of missed medications.

During an interview, a manager said the resident usually took any nursing concerns directly to the nurses.

During an interview, the resident said when she asked staff members where her medication was, they told her they left the nurse notes about reordering the medication. The resident said she had no reason not to believe them and did not think they neglected her. The resident said she asked the nurse about her medication but was not sure when. The resident said she recovered but it took her a long time to feel well again.

The resident's family member said the nurse called her when the resident was sent to the hospital for abdominal pain. A few weeks later, the physician told her the missed lactulose was a primary reason for the resident's hospitalization. The family member said the resident returned to her baseline health, but the family member still had concerns about the staff performing other cares and treatments. Therefore, the family member found a new facility for the resident.

In conclusion, the Minnesota Department of Health determined neglect was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
“Neglect” means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: Yes.

Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The nurse re-educated staff members on the resident's lactulose, documentation expectations and the refill process. The nurse increased her medication cart audits and ensured competency testing of unlicensed staff.

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

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

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

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

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36600	A. BUILDING: _____ B. WING _____	C 07/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING SR CARE OF BP	8500 REGENT AVENUE NORTH BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL366002660C/#HL366006765M On Juy 24, 2023, 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 21 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL366002660C/#HL366006765M, tag identification: 0620, 0730, 0750, 1760 and 3000.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 620 SS=D	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma	0 620		

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0 620	Continued From page 1 (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 record review and interview, the licensee failed to comply with the requirements for reporting maltreatment of vulnerable adults for one of one residents (R1) reviewed. Staff failed to report a medication error after R1's medical doctor (MD)-I informed them that R1 had missed multiple prescribed doses of lactulose. R1 was hospitalized for abdominal pain. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally Findings include: R1's record was reviewed. R1's diagnoses included type 2 diabetes, multiple sclerosis (MS)and cirrhosis of the liver (liver damage). R1's service agreement dated February 6, 2023, indicated R1 received medication set up and administration, blood glucose checks and safety checks. R1 required assist of 2 staff for transfers. R1's individualized medication management plan	0 620		

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0 620	Continued From page 2 (IMMP) dated May 12, 2023, indicated medication documentation would be maintained and verification of medications administered as prescribed or ordered would be maintained. The facility nurse was responsible for monitoring supplies and ordering refills on a timely basis. Unlicensed personnel (ULP) would contact the nurse 24 hours per day seven days per week with any questions or concerns about medication administration. R1's medication order summary indicated R1 received lactulose oral solution two times a day related to cirrhosis of liver. Order date and start date was February 6, 2023. R1's medication administration record (MAR) dated April and May 2023, indicated R1 received lactulose oral solution two times a day scheduled at 8:00 a.m. and 8:00 p.m. During April 24, 2023 through May 5, 2023, licensee staff documented R1's lactulose not available (code "11") for the 8:00 a.m. dose 10 out of 12 times. Licensee staff documented R1's lactulose not available for the 8:00 p.m. dose 7 out of 12 times. Staff documentation indicated R1 did not receive 17 out of 24 scheduled doses of her lactulose. A health status note by licensed practical nurse (LPN)-E dated May 5, 2023, at 10:17 a.m., indicated R1 reported increased abdominal pain, vaginal and bilateral leg pain. R1's abdomen was distended and hard with discomfort with touch. Staff administered pain medication with little or no effect. R1 cried and was unable to tolerate moving or touch. LPN-E updated MD-I and sent R1 to the hospital. R1's hospital discharge summary dated May 12, 2023, indicated R1's principal diagnosis was	0 620		

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0 620	Continued From page 3 abdominal pain due to neurogenic bowel. R1 typically took lactulose for hepatic encephalopathy (liver inflammation) but the licensee has been out of supply and not been giving her the lactulose for one week. An email from MD-I to family member (FM)-G on May 24, 2023, at 8:59 a.m., indicated R1 had not received her lactulose prior to her hospitalization. The hospital physician felt this was a reason for her hospitalization. An email from LPN-E to FM-G on May 30, 2023, at 10:19 a.m., indicated LPN-E apologized for the situation and she had changed the refill process since the incident. LPN-E indicated R1 only missed six days of lactulose, which was not acceptable, but it was not two weeks. During the entrance conference on July 24, 2023, at 9:05 a.m., the MDH surveyor requested copies of the Minnesota Adult Abuse Reporting Center (MAARC) reports. Management staff provided three MAARC reports, none were on R1's medication error. During an interview on July 24, 2023 at 2:38 p.m., licensed assisted living director (LALD)-B said they were informed of the medication error, it was the physician or hospital staff she could not recall. She did not know what the outcome was. Nurses handled reports and she was not aware if a MAARC report was filed. During an interview on August 8, 2023, at 10:30 a.m., R1 said she asked various staff members who passed medications about her lactulose when she did not get it some times, and they said they told the nurse or left the nurse a note about the medication. R1 said she did not see staff write	0 620		

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0 620	Continued From page 4 and leave notes to the nurses, but she had no reason to doubt them if they said they did that. R1 said she could not say staff members neglected her but she was in terrible pain and her stomach was rock hard when she went to the hospital. R1 said it took a long time to feel better. A policy titled Vulnerable Adult Maltreatment - Prevention and Reporting dated July 19, 2021, indicated staff were trained during orientation on the identification of incidents of maltreatment, including abuse, financial exploitation, and neglect. If the LALD or RN confirms the suspicion of maltreatment, they will contact the MAARC. Such a report must be made no later than 24 hours after the maltreatment was first suspected. TIME PERIOD TO CORRECT: Seven (7) Days	0 620		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives,	0 730		

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0 730	Continued From page 5 guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on record review, observation and interview, the licensee lacked documentation that the nurse refilled a prescription medication for one of one (R1) resident. R1 was hospitalized for abdominal pain and neurogenic bowel. 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	0 730		

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0 730	Continued From page 6 resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). Findings Include: R1's record was reviewed. R1's diagnoses included type 2 diabetes, multiple sclerosis (MS)and unspecified cirrhosis of the liver. R1's service agreement, dated February 6, 2023, indicated R1 received medication set up and administration, blood glucose checks and safety checks. R1 required assist of 2 staff for transfers. R1's individualized medication management plan (IMMP), dated May 12, 2023, indicated medication documentation would be maintained and verification of medications administered as prescribed or ordered would be maintained. The facility nurse was responsible for monitoring supplies and ordering refills on a timely basis. ULPs would contact the licensed nurse 24/7 with any questions or concerns with medication administration. R1's medication order summary indicated R1 received Lactulose oral solution 10 GM/15ML, 15 ml by mouth two times a day related to unspecified cirrhosis of liver. Order date and start date was February 6, 2023. During an interview and observation on July 24, 2023 at 1:48 p.m., LPN-E said she had no idea R1's lactulose prescription was out. Staff knew to place empty bottles or packaging into the gray refill bin in the nurses office. Staff were also	0 730		

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0 730	Continued From page 7 supposed to check the overstock storage area to make sure a prescription had not arrived and needed placement on the medication cart. LPN-E said with this specific incident she did not know why, who or how this happened. LPN-E said she audited the medication carts regularly and R1's medication was on a 28-day refill cycle. LPN-E attempted to access R1's electronic prescription history from the pharmacy to show the MDH surveyor when R1's prescriptions were filled, but could not access her records since R1 had discharged from the licensee and R1's electronic pharmacy records appeared blank. A policy titled Resident Record - Documentation, dated July 19, 2021, indicated staff will document in the resdient record for all medications, services, treatments and therapies for each resident. Staff will also document other important and pertinent information relating to each resident. TIME PERIOD TO CORRECT: Seven (7) Days	0 730		
0 750 SS=D	144G.43 Subd. 5 Record retention Following the resident's discharge or termination of services, an assisted living facility must retain a resident's record for at least five years or as otherwise required by state or federal regulations. Arrangements must be made for secure storage and retrieval of resident records if the facility ceases to operate. This MN Requirement is not met as evidenced by: Based on record review, observation and interview, the licensee lacked prescription medication refill records for one of one (R1)	0 750		

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0 750	Continued From page 8 resident. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1's record was reviewed. R1's diagnoses included type 2 diabetes, multiple sclerosis (MS)and cirrhosis of the liver (liver damage). R1's service agreement dated February 6, 2023, indicated R1 received medication set up and administration, blood glucose checks and safety checks. R1 required assist of two staff for transfers. R1's individualized medication management plan dated May 12, 2023, indicated medication documentation would be maintained and verification of medications administered as prescribed or ordered would be maintained. The facility nurse was responsible for monitoring supplies and ordering refills on a timely basis. R1's medication order summary indicated R1 received Lactulose oral solution two times a day related to cirrhosis of liver. Order date and start date was February 6, 2023. During an interview and observation on July 24, 2023, at 1:48 p.m., licensed practical nurse (LPN)-E said she had no idea R1's lactulose	0 750		

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0 750	Continued From page 9 prescription was out of supply during an incident. LPN-E said she audited the medication carts regularly and R1's medication was on a 28-day refill cycle. LPN-E attempted to access R1's electronic prescription history from the pharmacy to show the surveyor when R1's prescriptions were filled, but could not access her records since R1 had discharged from the licensee and R1's electronic pharmacy records appeared blank. A policy titled Resident Record - Documentation, dated July 19, 2021, indicated staff will document in the resident record for all medications, services, treatments and therapies for each resident. Staff will also document other important and pertinent information relating to each resident. TIME PERIOD TO CORRECT: Seven (7) Days	0 750		
01760 SS=G	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.	01760		

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01760	Continued From page 10 This MN Requirement is not met as evidenced by: Based on record review, observation and interview, the licensee failed to administer medications as ordered for one of one residents, (R1) reviewed. Staff members documented conflicting information on R1's prescribed lactulose as given or unavailable. R1 was hospitalized for one week with abdominal distention after not receiving several doses of her lactulose. 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: An article titled, "Why do we use Lactulose and Rifaximin for Hepatic Encephalopathy?" dated July 6, 2021, published by the American Association for the Study of Liver Disease, indicated Lactulose is prescribed as a standard prevention for liver inflammation for patients with cirrhosis by capturing toxic gases, balancing pH levels and excreting toxins out of the body via bowel movements acting as a laxative. R1's record was reviewed. R1's diagnoses included type 2 diabetes, multiple sclerosis (MS)and cirrhosis of the liver (liver damage). R1's service agreement dated February 6, 2023, indicated R1 received medication set up and	01760		

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	36600	A. BUILDING: _____ B. WING _____	C 07/24/2023

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01760	Continued From page 11 administration, blood glucose checks and safety checks. R1 required assist of 2 staff for transfers. R1's individualized medication management plan dated May 12, 2023, indicated medication documentation would be maintained and verification of medications administered as prescribed or ordered would be maintained. The facility nurse was responsible for monitoring supplies and ordering refills on a timely basis. Unlicensed personnel (ULP) would contact the nurse 24 hours per day seven days per week with any questions or concerns about medication administration. R1's medication order summary indicated R1 received lactulose oral solution two times a day related to cirrhosis of liver. Order date and start date was February 6, 2023. R1's medication administration record (MAR) dated April and May 2023, indicated R1 received lactulose oral solution two times a day scheduled at 8:00 a.m. and 8:00 p.m. During April 24, 2023 through May 5, 2023, licensee staff documented R1's lactulose not available (code "11") for the 8:00 a.m. dose 10 out of 12 times. Licensee staff documented R1's lactulose not available for the 8:00 p.m. dose 7 out of 12 times. R1 did not receive 17 out of 24 scheduled doses of her lactulose. A health status note by licensed practical nurse (LPN)-E dated May 5, 2023, at 10:17 a.m., indicated R1 reported increased abdominal pain, vaginal and bilateral leg pain. R1's abdomen was distended and hard with discomfort with touch. Staff administered pain medication with little or no effect. R1 cried and was unable to tolerate moving or touch. LPN-E updated MD-I and sent	01760		

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01760	Continued From page 12 R1 to the hospital. R1's hospital discharge summary dated May 12, 2023, indicated R1's principal diagnosis was abdominal pain due to neurogenic bowel. R1 typically took lactulose for hepatic encephalopathy (liver inflammation) but the licensee has been out of supply and not been giving her the lactulose for one week. An email from medical doctor (MD)-I to family member (FM)-G on May 24, 2023, at 8:59 a.m., indicated R1 had not received her lactulose prior to her hospitalization. The hospital physician felt this was a reason for her hospitalization. An email from LPN-E to FM-G on May 30, 2023, at 10:19 a.m., indicated LPN-E apologized for the situation and she had changed the refill process since the incident. LPN-E indicated R1 only missed six days of lactulose, which was not acceptable, but it was not two weeks. During an observation on July 24, 2023, at 11:00 a.m., the regional director of nursing (DON)-J showed the surveyor where staff placed medication refill requests. There were two gray bins on a counter in the nursing office, one marked "Medications to be filled" and the other marked "Medications to be filled from overstock". The bins were empty; LPN-E had collected the bins earlier and reviewed the medication refills. During an interview on July 24, 2023, at 9:30 a.m., ULP-C said if they run low or are out of a medication they tear off the top of the pill pack card and put it in the bin in the nurses' office. LPN-E reorders medications. ULP-C did not recall R1's lactulose being unavailable.	01760		

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01760	Continued From page 13 During an interview on July 24, 2023, at 1:03 p.m., ULP-A said she did not know the reason why R1 was out of her medication but she let the nurse, LPN-E, know. She could not recall if she filled out a form or wrote a note. ULP-A said there is a paper form to fill out for medication refills on the medication cart, but they were out of them today so she would just write a note to the nurse if any medications needed refills. ULP-A said to document on the MAR a medication was not available, they use "11", while a check mark meant it was given. During an interview on July 24, 2023, at 1:4 p.m., LPN-E said she had no idea R1's lactulose prescription was out. Staff knew to place empty bottles or packaging into the gray refill bin in the nurses office. LPN-E said with this specific incident she did not know why, who or how this happened. When MD-I told her about the missed lactulose, LPN-E said she was incredulous. LPN-E said she audited the medication carts regularly but after this incident increased the audits. LPN-E said staff did not tell her directly the medication was out and she had no notes from them. LPN-E said there were some experienced caregivers and newer caregivers who may have documented incorrectly. LPN-E said R1 stopped by her office to visit almost daily and she never said her lactulose was out or asked about her prescription. LPN-E said after the incident she reviewed R1's lactulose medication with all the staff who passed medications and reviewed the process for alerting her to medications that needed refills. LPN-E said one newer staff member was pulled from medication cart because of continued knowledge deficit and she had to successfully complete re education to pass medications in the future.	01760		

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01760	Continued From page 14 During an interview on August 7, 2023, at 10:34 a.m., FM-G said LPN-E called her when R1 was sent to the hospital with abdominal pain but no one was aware R1 had missed doses of her lactulose until weeks after R1's hospitalization when she received a message from MD-I around May 23, 2023 that the missed lactulose caused R1's abdominal pain and hospitalization. During an interview on August 8, 2023, at 10:30 a.m., R1 said she asked different staff members who passed medications about her lactulose and they said they told the nurse or left the nurse a note about the medication. R1 said she did not see staff write notes to the nurses about her medication, but she had no reason to doubt them if they said they would do that, so she can't say she was neglected. R1 said she was in terrible pain and her stomach was rock hard when she went to the hospital. R1 said she is healed but it took a long time to feel better. A policy titled Medication and Treatment Record - Documentation and Refusal, dated July 20, 2021, indicated the licensee will create and maintain a correct and accurate medication record for each resident receiving medication assistance or administration. If a medication was not completed as prescribed, documentation must include the reason why it was not completed and any follow up procedures that were provided. TIME PERIOD TO CORRECT: Seven (7) Days	01760		
03000 SS=D	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	03000		

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03000	Continued From page 15 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 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	03000		

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03000	Continued From page 16 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 record review and interview, the licensee failed to comply with the requirements for reporting maltreatment of vulnerable adults for one of one residents (R1) reviewed. Staff failed to report a medication error after R1's medical doctor (MD)-I informed them that R1 had missed multiple prescribed doses of lactulose. R1 was hospitalized for abdominal pain. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally Findings include: R1's record was reviewed. R1's diagnoses included type 2 diabetes, multiple sclerosis (MS)and cirrhosis of the liver (liver damage). R1's service agreement dated February 6, 2023, indicated R1 received medication set up and administration, blood glucose checks and safety checks. R1 required assist of 2 staff for transfers. R1's individualized medication management plan	03000		

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03000	Continued From page 17 (IMMP) dated May 12, 2023, indicated medication documentation would be maintained and verification of medications administered as prescribed or ordered would be maintained. The facility nurse was responsible for monitoring supplies and ordering refills on a timely basis. Unlicensed personnel (ULP) would contact the nurse 24 hours per day seven days per week with any questions or concerns about medication administration. R1's medication order summary indicated R1 received lactulose oral solution two times a day related to cirrhosis of liver. Order date and start date was February 6, 2023. R1's medication administration record (MAR) dated April and May 2023, indicated R1 received lactulose oral solution two times a day scheduled at 8:00 a.m. and 8:00 p.m. During April 24, 2023 through May 5, 2023, licensee staff documented R1's lactulose not available (code "11") for the 8:00 a.m. dose 10 out of 12 times. Licensee staff documented R1's lactulose not available for the 8:00 p.m. dose 7 out of 12 times. Staff documentation indicated R1 did not receive 17 out of 24 scheduled doses of her lactulose. A health status note by licensed practical nurse (LPN)-E dated May 5, 2023, at 10:17 a.m., indicated R1 reported increased abdominal pain, vaginal and bilateral leg pain. R1's abdomen was distended and hard with discomfort with touch. Staff administered pain medication with little or no effect. R1 cried and was unable to tolerate moving or touch. LPN-E updated MD-I and sent R1 to the hospital. R1's hospital discharge summary dated May 12, 2023, indicated R1's principal diagnosis was	03000		

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03000	Continued From page 18 abdominal pain due to neurogenic bowel. R1 typically took lactulose for hepatic encephalopathy (liver inflammation) but the licensee has been out of supply and not been giving her the lactulose for one week. An email from MD-I to family member (FM)-G on May 24, 2023, at 8:59 a.m., indicated R1 had not received her lactulose prior to her hospitalization. The hospital physician felt this was a reason for her hospitalization. An email from LPN-E to FM-G on May 30, 2023, at 10:19 a.m., indicated LPN-E apologized for the situation and she had changed the refill process since the incident. LPN-E indicated R1 only missed six days of lactulose, which was not acceptable, but it was not two weeks. During the entrance conference on July 24, 2023, at 9:05 a.m., the MDH surveyor requested copies of the Minnesota Adult Abuse Reporting Center (MAARC) reports. Management staff provided three MAARC reports, none were on R1's medication error. During an interview on July 24, 2023 at 2:38 p.m., licensed assisted living director (LALD)-B said they were informed of the medication error, it was the physician or hospital staff she could not recall. She did not know what the outcome was. Nurses handled reports and she was not aware if a MAARC report was filed. During an interview on August 8, 2023, at 10:30 a.m., R1 said she asked various staff members who passed medications about her lactulose when she did not get it some times, and they said they told the nurse or left the nurse a note about the medication. R1 said she did not see staff write	03000		

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03000	Continued From page 19 and leave notes to the nurses, but she had no reason to doubt them if they said they did that. R1 said she could not say staff members neglected her but she was in terrible pain and her stomach was rock hard when she went to the hospital. R1 said it took a long time to feel better. A policy titled Vulnerable Adult Maltreatment - Prevention and Reporting dated July 19, 2021, indicated staff were trained during orientation on the identification of incidents of maltreatment, including abuse, financial exploitation, and neglect. If the LALD or RN confirms the suspicion of maltreatment, they will contact the MAARC. Such a report must be made no later than 24 hours after the maltreatment was first suspected. TIME PERIOD TO CORRECT: Seven (7) Days	03000		