Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL391494921M
Compliance #: HL391496405C

Date Concluded: November 12, 2024

Name, Address, and County of Licensee Investigated:
Suite Living Senior Care of Prior Lake
5600 Credit River Road Southeast
Prior Lake, MN 55372
Scott County

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

Evaluator's Name: Lissa Lin, RN
Special Investigator

Finding: Substantiated, individual responsibility

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

Initial Investigation Allegation(s):
The AP abused the resident when she administered antipsychotic medications to him without a prescription and caused a chemical restraint. The resident was sedated, disoriented and fell.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. The AP gave the resident unprescribed medications even though hospice staff declined to add Haldol (an antipsychotic) and quetiapine (an antipsychotic) to the resident's medications. The AP, a registered nurse, intentionally placed antipsychotic medications, without a prescription, into the resident's morning medication cup and directed the unlicensed personnel (ULP) to administer them, as well directed the ULP to administer prescribed as needed medications to induce a chemical restraint. Additionally, a few hours later, the AP administered the resident prescribed as needed medications although the resident had been sleepy and drowsy. The AP told staff members she gave the unprescribed medications

to the resident because he was aggressive, and she did not want to deal with him. The resident took his morning medications, became disoriented, unsteady on his feet, displayed slurred speech, and fell.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family but was not able to schedule a timely interview. One family member provided a text message statement. The investigation included review of the resident records, pharmacy records, facility internal investigation, facility incident reports, video, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed staff administering resident medications and interacting with residents in their rooms and in common areas.

The resident resided in the assisted living. The resident's diagnoses included prostate and kidney cancer, kidney disease, Alzheimer's disease and depression. The resident's service plan included assistance with medication management and administration. The resident was a new admission to the memory care unit.

The resident's preadmission assessment, signed and dated by the AP, indicated the resident was alert but had cognitive impairment, orientation issues and forgetfulness. He displayed verbal and physical aggression, anxiety, agitation and wandering behavior. He was enrolled in hospice.

The resident's care plan directed management of behaviors included safety checks every two hours, monitoring whereabouts when wandering, provide orientation cues and reminders, and provide clear explanation of care activities prior to contact. If the resident was resistive to cares, the care plan directed staff to stop, ensure safety and then reapproach. The care plan directed to limit staff to one person at a time, two staff at most for one staff to provide care and the second staff to provide "pleasant" distraction. Additionally, the care plan indicated hospice provided pain management and staff were to monitor for any side effects of pain medications to report to the nurse. The resident was not able to walk safely and was at risk for falls.

On admission to the facility, the prescriber ordered the resident's prescribed Haldol, 1mg tablets, be discontinued and to start morphine (opiod pain medication), lorazepam (antianxiety medication) and Levsin (medication to reduce secretions). There were no prescriber orders to for quetiapine. The AP signed the prescriber orders and faxed the orders to the pharmacy. The next day, the AP received a telephone order to increase the resident's prescribed antipsychotic, olanzapine, dose.

The resident's progress notes indicated on the resident's fourth day of admission, the resident had behaviors of pacing, exit seeking, raised voice and redirection was ineffective. Hospice provided orders to increase the as needed (PRN) order for the resident's olanzapine, in addition to the scheduled doses. The AP received and transcribed the new orders. Progress notes indicated the next morning, the AP documented she received report the resident had restlessness, agitation, and wandering during the overnight shift. The overnight staff contacted

hospice, who indicated they would provide a visit to the resident that day. The AP indicated in the progress note at 7:07 a.m., the resident was asleep and waiting hospice staff to discuss medication adjustments.

The resident's electronic medication administration record (eMAR) indicated medications administered to the resident at 8:00 a.m. included scheduled olanzapine, an antidepressant, PRN lorazepam and PRN morphine.

The resident's progress notes, the same day, at 12:26 p.m., indicated the resident ate breakfast and was amenable to medication administration from the ULP. The resident was drowsy and sleeping. The AP documented hospice staff completed their visit and addressed concerns. The resident required two staff to assist him into his recliner. The resident had difficulty walking and slept awkwardly in his chair.

The resident's eMAR indicated at 12:30 p.m., the AP administered PRN morphine, PRN lorazepam and PRN olanzapine and documented the PRNs were ineffective, although he was sleeping and drowsy during her documented progress notes at 7:07 a.m. and 12:26 p.m.

The resident progress notes, the same day, at 2:00 p.m., indicated the AP received an order from hospice to scheduled morphine three times a day, in addition to the PRN order of morphine.

The resident's record lacked orders for Haldol and quetiapine.

Approximately a week later, the resident was discharged to the hospital for falls. He died in the hospital. The resident's death record indicated he died of acute kidney injury.

The ULP 1 provided a written statement to the facility. The ULP indicated that same morning, at the start of the day shift, the AP approached her to talk about how the resident was the previous night. The AP directed the ULP to provide the resident his scheduled morning medications, which included olanzapine, but to also add PRN morphine and lorazepam because she was "not dealing with this today." The ULP prepared the resident's 8:00 a.m. medications and the AP came back with Haldol "pills." The ULP administered the resident's scheduled medication, the PRN medications and the medications provided by the AP. The ULP stated she later learned there was no prescription for Hadol. At 12:30 p.m., the AP asked for the ULP's medication cart keys, prepared PRN morphine and lorazepam in a syringe and went to administer them to the resident. The AP returned from the resident's room, stated it was a failed attempt to give medications and crushed unknown pills into a medication cup, "slurried" them with orange juice and administered the mixture to the resident. Approximately 30 minutes later, ULP 1 heard a loud noise and found the resident hanging off the edge of his recliner. The resident slurred his words, tried standing and fell backwards into his chair, then collapsed into his wheelchair against a wall. ULP 1 wrote she expressed her concern over the resident's condition to the AP who told her to "let him fall" or leave him on the floor. At 2:00

p.m. shift change, ULP 1 wrote the AP reported to staff we “snowed” the resident, therefore hospice would provide a Broda chair (assisted positioning chair) and a mechanical lift because the resident was a “monkey & belongs in a zoo.”

A witness, ULP 2, emailed her concerns to the facility management staff that same day, around 2:00 p.m. ULP 2 indicated the AP told her directly she added two medications to the resident’s morning medication cup before ULP 1 administered them and told ULP 1 “you didn’t see me do that.” ULP 2 indicated the AP said she placed Haldol and quetiapine. ULP 2 indicated the AP said she hoped hospice would order those medications later in the day. ULP 2 indicated the AP said she wanted the resident “snowed” so he was not a “busy bee” or aggressive. ULP 2 wrote the AP became loud and upset when hospice did not order Haldol and quetiapine and said she would have to add those medication to his eMAR even though they were not ordered for him. ULP 2 indicated the resident was unsteady on his feet, unable to walk or hold his balance after administration and was walking fine prior. After the 12:30 p.m., medication administration, the resident was falling over and ULP 2 caught him. ULP 2 reported to the AP the resident was not stable walking and the AP responded to let him fall or put him on the floor to stay there.

The facility failed to immediately investigate the incident but did remove the AP from working after following up with staff who reported the incident. The AP no longer works for the facility.

Review of the AP's personnel file indicated she successfully completed on-line training modules on abuse prevention, assisted living bill of rights, attitude of care, customer service, multiple dementia topics, Medicaid fraud and abuse, person-centered care and professional boundaries.

During an interview, the ULP 1 said the overnight shift reported the resident had been a little agitated but did not need PRN medications. The resident was new to her, and she did not know all of his medications like other residents she worked with. The AP went into her office, came back out and dropped two pills into the resident’s medication cup. The AP said you did not see that. ULP 1 said she wanted to ask the AP what she meant about the two pills she added, but the resident walked up to the medication cart, so ULP 1 gave him his medications. He took all of the medications, including the two pills the AP added. ULP 1 said she believed the AP had a prescription and was following policies and procedures. ULP 1 said the two medications were Haldol and quetiapine. ULP 1 went to sign off on the resident’s eMAR that his medications were given. She did not see any new medications added to his eMAR. Later in the morning, ULP 2 asked ULP 1 if the resident received more than his “usual” medications because the AP told her that she “snowed” the resident with medications (Haldol and quetiapine) and laughed about it. ULP 1 said she felt sick when she heard that and knew she had to report the incident to management. She said she spent much of her shift providing one to one supervision with the resident because he was unsteady on his feet and unsafe. ULP 1 said ULP 2 came to help her with the resident. He tried standing, fell into his collapsed wheelchair against the wall and ULP 2 hurt herself trying to catch him. ULP 1 stated she felt the AP took advantage of her own vulnerability and used it to do what she wanted. ULP 1 stated the resident did not deserve what happened to him.

During an interview, a nurse manager said the AP asked hospice for Haldol and quetiapine but the hospice physician would not order the medications until the prescribed medications were tried first. The nurse manager said the AP took Haldol and quetiapine from the resident's back up hospice medications. Those medications were brought in by his family and should have been returned to them or destroyed. The AP told the nurse manager she only gave the unprescribed Haldol to the resident. The incident was the first they had with the AP, but it was serious, and she was no longer safe to work at the facility. The nurse manager said the facility conducted an internal investigation and the AP was no longer employed by the facility.

During an interview, the AP said she was the care manager for the facility's assisted living and memory care areas. Her job duties included resident assessments and ordering medications. The AP said the resident was more agitated and difficult to care for than his family indicated when he admitted to the facility. The resident had a "care package" of medications from his previous hospice, which was a different branch of the same hospice service. The hospice medication care package contained morphine, lorazepam Haldol, nausea medication, and a laxative. The AP said she asked hospice about getting a Haldol prescription but said each time she called, she spoke to a different nurse; some were offended that she asked for Haldol. The AP said there was one hospice nurse in favor of adding Haldol and she thought the hospice nurse said to give a dose. The AP said the resident was aggressive, he threw food and feces for days. He was not appropriate for their facility and not redirectable. Hospice and management did not listen to her concerns about the resident. Since his scheduled and PRN medications did not work on his aggression, she added Haldol pills into his morning medication cup and let the ULP give them to the resident. The AP said she did not give him quetiapine. The AP said she still hoped to get a prescription for the Haldol later that day, but hospice did not write one. Looking back, the AP said she would not have given the Haldol without first having a prescription.

The resident's family declined an interview, but provided a statement. The family member wrote the facility reported the resident was given a chemical restraint. The resident's spouse was with him that day and said he could not stand up or walk. The resident slept most of the day. The family member felt the resident never recovered from what he was given.

The hospice nurse was no longer with the hospice company and did not respond to phone calls and text message requests for an interview.

In conclusion, the Minnesota Department of Health determined abuse 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.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:

(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult; and

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

(1) The AP did not follow an erroneous order, direction or care plan with awareness and failure to take action.

The AP did direct an erroneous order, direction, or care plan.

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

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

The facility provided adequate staffing levels.

The AP failed to follow the facility directive and/or policies and procedures.

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

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

The maltreatment was not a sudden or foreseen event.

Vulnerable Adult interviewed: No, deceased.
Family/Responsible Party interviewed: Sent a written text statement, they were not available for a timely interview.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility conducted an internal investigation. The AP was no longer employed with the facility.

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

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

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

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

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

cc:

The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Scott County Attorney
Prior Lake City Attorney
Prior 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
	39149	A. BUILDING: _____ B. WING _____	C 10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING SENIOR CARE OF PRIOR LAKE	5600 CREDIT RIVER ROAD SE WHITE BEAR LAKE, MN 55110

(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: HL391496405C/HL391494921M On October 10, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 19 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for HL391496405C/HL391494921M, tag identification 0620, 1750, 2310 and 2360.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 620 SS=D	144G.42 Subd. 6 (a) / 626.557, Subd. 3 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. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.	0 620		

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0 620	Continued From page 2 (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to report maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC) immediately, no later than 24 hours, for one of one residents (R1), reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The Medicare State Operations Manual (SOM),	0 620		

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0 620	Continued From page 3 dated September 7, 2000, defined a chemical restraint as "any drug that is used for discipline or convenience and not required to treat medical symptoms." R1's diagnoses included Alzheimer's Disease, prostate cancer with metastasis to his kidneys and lungs, suicidal ideation and depression. R1's pre-admission assessment dated June 27, 2024, signed by registered nurse (RN)-G, indicated R1 had cognitive impairment, orientation issues, and forgetfulness but was alert. RN-G assessed him with verbal and physical aggression, anxiety, agitation and wandering. R1 was enrolled in hospice. R1's service agreement dated July 1, 2024, indicated R1 received medication administration. R1's physician admission orders, dated July 1, 2024, indicated a routine admission to hospice and included orders for schedule psychotropic medications to manage depression/anxiety and agitation. The physician orders directed to discontinue several medications, including haloperidol (antipsychotic). New prescribed orders included morphine every four hours PRN for pain/shortness of breath, and lorazepam (antianxiety) every four hours PRN for terminal agitation. RN-G signed the order form. R1's progress note dated July 5, 2024, at 7:07 a.m., by RN-G, indicated she received report this morning, last night around 8:50 p.m., R1 was in the dining room restless, flipping chairs, wandering, anxious, agitated, aggressive, took off shoes and socks and refused to put clothes back on per report of three separate unlicensed personnel (ULP) who tried to redirect or	0 620		

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0 620	Continued From page 4 administer medications. R1 only became more angry. Hospice notified for direction. Hospice indicated staff would visit R1. During last night's episode R1 sat on floor. Vital signs obtained. RN-G documented R1 was currently asleep and awaiting hospice staff to discuss medication adjustments. R1's electronic medication administration record (eMAR) dated July 2024, indicated on July 5, 2024, at 8:00 a.m., ULP-H administered scheduled olanzapine 10 mg, venlafaxine 150 mg, and PRN lorazepam 0.5 mg and morphine 5 mg to R1. ULP-H administered PRN medications, although RN-G documented an hour prior in a progress note he was sleeping. R1's progress note dated July 5, 2024, at 12:26 p.m., by RN-G, indicated R1 ate breakfast and amenable to medication administration from ULP. R1 was drowsy and sleeping. Hospice staff completed visit, addressed concerns with RN-G and R1's spouse. R1 assisted by two staff in recliner. R1 had difficulty walking and slept awkwardly in chair. R1's eMAR dated July 2024, indicated on July 5, 2024, at 12:30 p.m., RN-G administered all three PRN medications to R1: morphine 5 mg, lorazepam 0.5 mg and olanzapine 5 mg. RN-G documented all three medications were ineffective, although he was sleeping and drowsy during her progress notes at 7:07 a.m. and 12:26 p.m. R1's progress note dated July 5, 2024, at 2:00 p.m., by RN-G, indicated hospice ordered a scheduled dose of morphine three times a day. An email sent to management by activities	0 620		

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0 620	Continued From page 5 director (AD)-I, dated Friday, July 5, 2024, at 1:57 p.m., indicated RN-G told her directly she added two medications to R1's medication cup before ULP-H administered and told ULP-H "you just didn't see me do that." AD-I indicated ULP-H was under the assumption that the medications were new and just not put in the eMAR yet. AD-I indicated RN-G told her it was her hope that when hospice came later in the day, they would approve the medications RN-G wanted ordered; the two medications she administered. The two medications she added to the medication cup were haloperidol and quetiapine (an antipsychotic). AD-I wrote, RN-G stated she wanted R1 to be "snowed" so he was not a "busy bee" or "aggressive." The email indicated RN-G also told other staff what she had done. RN-G became loud when the hospice nurse arrived and did not agree to add the haloperidol and quetiapine to R1's orders. AD-I wrote RN-G was upset she did not get her way with hospice and order the medications. RN-G told AD-I she would have to add those two medications to R1's eMAR even though they were not ordered for him. AD-I noted R1 was unsteady on his feet this morning, unable to walk or hold his balance. AD-I wrote R1 was walking fine prior to the medication administration. AD-I stated after RN-G administered medications at 12:30 p.m., R1 was falling over and AD-I caught him in time. AD-I stated she told RN-G he was not stable and kept trying to walk, but falling over. AD-I indicated RN-G's response was to let him fall or put him on the floor, "he can stay there." R1 medical record did not have prescription orders for haloperidol nor quetiapine. An email from housing director (HD)-A to regional director (RD)-C and another regional director,	0 620		

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0 620	Continued From page 6 dated Monday July 8, 2024, at 10:45 a.m., indicated a report of RN-G providing a resident two medications that were not ordered for him, haloperidol and quetiapine, intentionally. HD-A indicated he became overmedicated, unsteady, and falling. On July 9, 2024, ULP-H submitted a written statement to the licensee about the medication incident on July 5, 2024. ULP-H wrote around 6:30 a.m. RN-G approached her to talk about R1 and how he was the previous night. RN-G told ULP-H to give R1 his scheduled Olanzapine and other scheduled medications but to add his prn morphine and lorazepam too, because "she was not dealing with this today." ULP-H prepared R1's 8:00 a.m. medications and RN-G came back to the medication cart with haloperidol "pills." ULP-H gave R1 his scheduled medications, the PRN medications as directed by RN-G and the haloperidol "medications." Later she learned there was no prescription for the haloperidol. At 12:30 p.m., RN-G asked for ULP-H's medication cart keys and prepared PRN morphine and lorazepam in a syringe. She returned from R1's room and told ULP-H it was a failed attempt to give the medications. RN-G then crushed unknown pills into a cup and "slurried" them with orange juice and gave it to R1. Approximately 30 minutes later, ULP-H heard a loud noise and found R1 hanging off the edge of his recliner in his room, his bedside tray tipped over and food spilled. Another ULP came to help ULP-H clean up and during that time observed R1 slur his words, try standing, falling back into his chair, and then collapsed into a wheelchair against a wall. ULP-H wrote that she expressed her concern over R1's condition and RN-G told her to let him fall or leave him on the floor. At 2:00 p.m. shift change RN-G told staff we "snowed" R1,	0 620		

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0 620	Continued From page 7 therefore hospice will provide a Broda chair and a hoyer lift because he was a "monkey & belongs in a zoo." An email sent to the licensee on October 10, 2024, at 11:04 a.m., requested records for RN-G, including termination of employment information. An email dated October 10, 2024, at 12:06 p.m., from RD-K to the MDH investigator indicated RN-G was no longer employed by the licensee on July 8, 2024. The licensee did not provide any document related to discipline or termination of employment of RN-G. An email dated October 16, 2024, 6:14 p.m., RD-C provided RN-G's schedule information and indicated RN-G worked on Thursday July 4, 2024, Friday July 5, 2024, Monday July 8, 2024, and Tuesday July 9, 2024. During an interview on October 10, 2024, at 2:25 p.m., RD-C said RN-G asked hospice for quetiapine and haloperidol for R1. The hospice physician said not until the prescribed medications listed were tried first. The medication incident happened on July 5, 2024. RD-C stated she was notified the following Monday, [July 8], but did not file a MAARC report because staff said they would. RD-C did not recall what staff member or members said they would file MAARC reports. During an interview on October 22, 2024, at 1:02 p.m., ULP-H said she and AD-I reported the incident to housing director (HD)-A and RD-C. ULP-H said normally when there is a medication error or incident the staff person is pulled from	0 620		

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0 620	Continued From page 8 giving medications, but RN-G was not removed from duty. ULP-H said told RD-C she would file a MAARC report but was discouraged from doing so by the hospice nurse and HD-A because management wanted to do an internal investigation first. The licensee failed to make a MAARC report regarding RN-G chemically restraining R1. A policy titled Vulnerable Adult Maltreatment - Prevention and Reporting, dated July 19, 2021, indicated the facility educated clients, family members, and staff (mandated reporters) on how to report suspected maltreatment internally and to MAARC. All facility staff are mandated reporters and have the right to report suspected maltreatment directly to MAARC. If the Assisted Living Director or RN confirms the suspicion of maltreatment, they will contact MAARC. Such report must be made no later than 24 hours after the maltreatment was first suspected. TIME PERIOD TO CORRECT: Seven (7) Days.	0 620		
01750 SS=F	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	01750		

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01750	Continued From page 9 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 provide instruction to unlicensed personnel (ULP) and ensure demonstrated competency on administering as needed (PRN) controlled medications when the same or similar medications are prescribed to be administered on a scheduled basis for one of one residents (R1) reviewed. This deficient practice had the potential to affect all residents. Several ULP administered PRN medications shortly before or after another controlled medication of the same or similar drug, not adhering to the PRN frequency. 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 is 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's diagnoses included Alzheimer's Disease, prostate cancer with metastasis to his kidneys and lungs, suicidal ideation and depression. R1's pre-admission assessment dated June 27, 2024, signed by registered nurse (RN)-G, indicated R1 had cognitive impairment, orientation issues, and forgetfulness but was alert. RN-G assessed him with verbal and physical aggression, anxiety, agitation and wandering. R1 was enrolled in hospice.	01750		

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01750	Continued From page 10 R1's service agreement dated July 1, 2024, indicated R1 received medication administration. R1's progress note dated July 1, 2024, at 11:56 p.m., by RN-G, indicated R1 was a new admission to memory care. RN-G faxed the signed medication list from the hospital to the pharmacy. R1's physician admission orders dated July 1, 2024, indicated a routine admission to hospice and included orders for olanzapine (antipsychotic) 2.5 milligram (mg) daily at bedtime, olanzapine 2.5 mg once daily PRN for agitation, and venlafaxine (antidepressant) 75 mg, three times per day. The physician orders directed to discontinue several medications, including haloperidol (antipsychotic). New prescribed orders included morphine every four hours PRN for pain/shortness of breath, and lorazepam (antianxiety) every four hours PRN for terminal agitation. RN-G signed the order form. R1's physician orders dated July 2 and 4, 2024, included changes to R1's olanzapine order, which included an order to schedule olanzapine 10 mg twice per day and an order to give olanzapine 5 mg twice per day PRN. A progress note dated July 5, 2024, indicated RN-G took a verbal order from hospice to schedule morphine 5 mg three times a day in addition to the PRN morphine order. R1's physician orders dated July 12, 2024, included an order to increase R1's morphine to 10 mg scheduled every six hours and 10 mg every three hours as needed. In addition, new orders included scheduled clonazepam	01750		

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01750	Continued From page 11 (antianxiety) 0.5 mg three times a day and an order for haloperidol 5 mg every four hours PRN. R1's electronic medication administration record (eMAR) dated July 2024, indicated R1 had transcribed orders for a scheduled antipsychotic (olanzapine), two PRN antipsychotics (olanzapine and haloperidol), scheduled morphine, PRN morphine, a scheduled benzodiazepine (clonazepam), and a PRN benzodiazepine (lorazepam). R1's eMAR failed to provide directions to ULP when to administer PRN morphine, antipsychotics, and benzodiazepines, in relation to the scheduled doses of the same medication or same drug class. MORPHINE R1's eMAR dated July 5 through 13, 2024, indicated morphine 5 mg was scheduled to administer at 4:00 a.m., 12:00 p.m. and 8:00 p.m. R1's eMAR lacked direction to ULP administration of PRN morphine 5 mg every fours, would be available for administration at 8:00 a.m., 4:00 p.m. and 12:00 a.m., four hours from the last scheduled dose. Additionally, R1's PRN morphine order was transcribed with inaccurate conflicting directions. PRN morphine 5 mg was transcribed with the directions, give one sublingual tab every four hours as needed for shortness of breath and/or pain and inaccurately also included instructions that read give one tablet under tongue every one hour as needed. On July 12, 2024, R1's morphine order change was transcribed correctly and indicated morphine 10 mg was scheduled to administer at 2:00 a.m., 8:00 a.m., 2:00 p.m. and 8:00 p.m. R1's eMAR continued to lack direction to ULP administration of PRN morphine 10 mg every three hours, would be available for administration at 5:00 a.m., 11:00 a.m., 5:00 p.m. and 11:00 p.m., three hours from	01750		

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01750	Continued From page 12 the last scheduled dose. R1's eMAR dated July 2024, ULP staffed administered morphine sooner than directed by the PRN order in relation to the schedule was on the following dates: July 9, 2024, at 2:07 p.m. (2 hours early) administered by ULP-L July 10, 2024, at 2:35 p.m. (1.5 hours early) administered by ULP-N July 10, 2024, at 10:56 p.m. (1 hour early) administered by ULP-O July 11, 2024, at 3:01 p.m. (1 hour early) administered by ULP-M ANTIPSYCHOTICS R1's eMAR dated July 2 through 13, 2024, indicated olanzapine 10 mg was scheduled to administer at 8:00 a.m. and 8:00 p.m. R1's eMAR lacked direction to ULP administration of PRN olanzapine 5 mg two times per day from the last scheduled dose. On July 12, 2024, the order for haloperidol 5 mg every four hours PRN was transcribed and lacked direction to ULP administration of haloperidol in relation to administration times of olanzapine. BENZODIAZEPINES R1's eMAR dated July 1 through 13, 2024, indicated PRN lorazepam 0.5 mg was transcribed with the directions, give one tab every four hours as needed for restlessness/agitation. On July 11, 2024, R1's clonazepam 0.5 mg order was scheduled to administer at 10:00 a.m. and 5:00 p.m. The licensee failed to updated R1's lorazepam orders with direction to ULP administration of PRN lorazepam in relation to scheduled administration times of clonazepam. R1's eMAR dated July 2024, indicated on July 13,	01750		

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01750	Continued From page 13 2024, ULP-H attempted to administer both clonazepam and lorazepam at 10:00 a.m., however R1 refused to take the medication. On July 9, 2024, ULP-H submitted a written statement about the medication incident on July 5, 2024. RN-G directed ULP-H on July 5, 2024, to give R1 his scheduled morning olanzapine and his PRN morphine and PRN lorazepam because she did not want to deal with his behaviors. ULP-H wrote over the past five months RN-G had said disparaging things about memory care residents. RN-G had directed to give a resident all of her PRNs so she can shut up. During an interview on October 10, 2024, at 2:25 p.m., regional director (RD)-C stated it was not unheard of for a nurse to get a verbal order and will make decisions right there looking at what PRNs someone has to direct ULP what medications to give. RD-C stated they investigated an incident that occurred on July 5, 2024 of overmedicating R1 and re-educated staff. During an interview on October 22, 2024, at 1:02 p.m., ULP-H said R1 was about 80% cognitive and about 20% confused. ULP-H said R1 could say what he wanted and when she administered medications he would tell her to be patient. ULP-H said R1 would lay out his pills on the table and take one at a time. ULP-H said on July 5, 2024, the overnight shift reported R1 was agitated on the evening shift, during the overnight shift they did not give R1 any PRNs because he did not need it. RN-G directed ULP-H to give PRNs on her shift. After the incident ULP-H said RD-C reviewed R1's medication list with when to do PRNs. ULP-H's personnel file was reviewed. ULP-H had	01750		

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01750	Continued From page 14 medication administration competency tested on January 23, 2024. ULP-H completed medication training and tests between January 25, 2024 through January 30, 2024. The only training ULP-H completed after July 2024 was training on dementia management and abuse prevention and emergency preparedness. ULP-H's record lacked demonstrated competency of medication administration after the medication concerns investigated with R1. The licensee policy titled PRN Medications, dated July 21, 2021, indicated trained and competency tested by the RN ULP can administer PRN medications. The policy indicated ULP will check the frequency of the PRN medication if given in the last 24 hours and whether it has been given the maximum number of times allowed for the day. The policy indicated the ULP will confirm whether the reason for administration of the medication matches the reason the medication is prescribed. Documentation included when the PRN was administered, why the PRN was given, any unusual reactions, follow up communication with the resident and report any side effects to the nurse. The licensee PRN procedure failed to include requiring documented specific instructions for staff to follow prior to administering PRN medications to an individual resident, including frequency of a PRN administration when the same or similar medication is administered on a schedule basis, observation of a resident's specific behavior to determine the PRN is appropriate to administer, and follow up instructions on to determine if the PRN was effective.	01750		

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01750	Continued From page 15 TIME PERIOD OF CORRECTION: Twenty-One (21) Days	01750		
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to ensure staff provided appropriate cares that met accepted medical and nursing care standards for one of one residents (R1). Registered nurse (RN)-G chemically restrained R1 when she set up antipsychotic medications to R1 without a physician's prescription and directed an unlicensed personnel (ULP) to administer. RN-G administered four hours later several sedating medications after R1 was already sleepy and drowsy. R1 was sedated, disoriented, and unsteady on his feet for hours afterwards and fell. 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:	02310		

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02310	Continued From page 16 The Medicare State Operations Manual (SOM), dated September 7, 2000, defined a chemical restraint as "any drug that is used for discipline or convenience and not required to treat medical symptoms." The National Health Institute, National Library of Medicine, article titled "Haloperidol," dated September 1, 2023, indicated haloperidol should not be used as a chemical restraint to address patient behavior or restrict patient mobility, as it is not a conventional or accepted treatment. This approach should be reserved for situations where the need to address potential violence is crucial to ensure staff and patient safety. R1's diagnoses included Alzheimer's Disease, prostate cancer with metastasis to his kidneys and lungs, suicidal ideation and depression. R1's pre-admission assessment dated June 27, 2024, signed by RN-G, indicated R1 had cognitive impairment, orientation issues, and forgetfulness but was alert. RN-G assessed him with verbal and physical aggression, anxiety, agitation and wandering. R1 was enrolled in hospice. R1's service agreement dated July 1, 2024, indicated R1 received medication administration. R1's care plan dated July 1, 2024, indicated R1 lived in memory care. R1 required assistance for medication administration, ordering of medications, communication with pharmacy, and hospice coordination. R1 demonstrated wandering and interventions included monitoring whereabouts while he was up and about. R1 was not oriented and required staff to provide cues	02310		

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02310	Continued From page 17 and reminders regarding orientation. R1 required safety checks every two hours. R1 had chronic conditions requiring hospice and pain management. Interventions included staff observation and report to the nurse any side effects of pain medication such as constipation, new onset of or increased agitation, restlessness, confusion, hallucinations, feeling "ill at ease," vomiting, dizziness and falls. Hospice would manage chronic conditions and comfort measures. R1 was not able to walk safely and was at risk for falls. R1 required staff to assist with mobility in a Broda chair (supportive positioning chair) and redirect R1 if he attempted to stand or walk. R1's behaviors included anxious/paranoia, obsessive/repetitive behaviors, agitation and in ability to follow directions. Interventions included giving clear explanation of care activities prior to contact; if resistive, stop and ensure safety, then reapproach; and limit staff to one at a time, two at most, while one staff provides care and the other offered "pleasant" distraction. R1's progress note dated July 1, 2024, at 11:56 p.m., by RN-G, indicated R1 was a new admission to memory care. RN-G faxed the signed medication list from the hospital to the pharmacy. R1's physician admission orders, dated July 1, 2024, indicated a routine admission to hospice and included orders for olanzapine (antipsychotic) 2.5 milligram (mg) daily at bedtime, olanzapine 2.5 mg once daily as needed (PRN) for agitation, and venlafaxine (antidepressant) 75 mg, three times per day. The physician orders directed to discontinue several medications, including haloperidol (antipsychotic). New prescribed orders included morphine every four hours PRN	02310		

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02310	Continued From page 18 for pain/shortness of breath, and lorazepam (antianxiety) every four hours PRN for terminal agitation. RN-G signed the order form. R1's progress note dated July 2, 2024, at 3:00 p.m., by RN-G, indicated hospice visited R1. R1 had agitation, was given PRN lorazepam in the morning with no effect and olanzapine 2.5 mg with minimal effectiveness. R1's physician orders dated July 2, 2024, directed to increase the dose of olanzapine to 10 mg at bedtime. RN-G signed and dated the telephone verbal order as completed. R1's progress note dated July 4, 2024, at 10:14 a.m., by RN-G, indicated R1 had behaviors. R1 paced, was exit seeking, and asked where wife was. R1 was unable to redirect, would not sit or lie down or watch TV. R1 had his brow furrowed, wringing hands, and raised voice. RN-G documented scheduled olanzapine 10 mg administered 2 hours ago, lorazepam 0.5 mg administered 20 minutes go, with very little change in behavior. Hospice contacted and will evaluate R1 before making any additional medication changes. R1's progress note dated July 4, 2024, at 12:30 p.m., by RN-G, indicated R1 continued to be agitated, restless, slightly improved with spouse present. New orders received from hospice. R1's physician orders dated July 4, 2024, directed increase PRN olanzapine to 5 mg by mouth twice daily as needed for agitation/restlessness. RN-G signed and dated the telephone order. R1's progress note dated July 4, 2024, at 1:08 p.m., by RN-G, indicated RN-G attempted to give	02310		

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	39149	A. BUILDING: _____ B. WING _____	C 10/10/2024

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02310	Continued From page 19 R1 medications per spouse request but R1 swatted at RN-G and spouse with a rolled newspaper and refused medications in applesauce despite a 30 minute attempt, spitting meds, and doubtful he received the complete dose. R1's progress note dated July 5, 2024, at 7:07 a.m., by RN-G, indicated she received report this morning, last night around 8:50 p.m., R1 was in the dining room restless, flipping chairs, wandering, anxious, agitated, aggressive, took off shoes and socks and refused to put clothes back on per report of three separate ULP who tried to redirect or administer medications. R1 only became more angry. Hospice notified for direction. Hospice indicated staff would visit R1. During last night's episode R1 sat on floor. Vital signs obtained. RN-G documented R1 was currently asleep and awaiting hospice staff to discuss medication adjustments. R1's electronic medication administration record (eMAR) dated July 2024, indicated on July 5, 2024, at 8:00 a.m., ULP-H administered scheduled olanzapine 10 mg, venlafaxine 150 mg, and PRN lorazepam 0.5 mg and morphine 5 mg to R1. ULP-H administered PRN medications, although RN-G documented an hour prior in a progress note he was sleeping. R1's progress note dated July 5, 2024, at 12:26 p.m., by RN-G, indicated R1 ate breakfast and amenable to medication administration from ULP. R1 was drowsy and sleeping. Hospice staff completed visit, addressed concerns with RN-G and R1's spouse. R1 assisted by two staff in recliner. R1 had difficulty walking and slept awkwardly in chair.	02310		

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02310	Continued From page 20 R1's eMAR dated July 2024, indicated on July 5, 2024, at 12:30 p.m., RN-G administered all three PRN medications to R1: morphine 5 mg, lorazepam 0.5 mg and olanzapine 5 mg. RN-G documented all three medications were ineffective, although he was sleeping and drowsy during her progress notes at 7:07 a.m. and 12:26 p.m. R1's progress note dated July 5, 2024, at 2:00 p.m., by RN-G, indicated hospice ordered a scheduled dose of morphine three times a day. R1's progress note dated July 5, 2024, at 3:02 p.m., by RN-G, indicated R1 bent over, then sat on floor in the hallway, picked at carpet and things he imagined were in the carpet. R1 took off his socks. R1 had no injuries or distress, and able to get himself back up. R1 appeared bored, moved furniture around, paced, punched code box, used busy boxes. RN-G documented R1 was toileted, given juice and a snack, which were thrown to the floor. An email sent to management by activities director (AD)-I, dated July 5, 2024, at 1:57 p.m., indicated RN-G told her directly she added two medications to R1's medication cup before ULP-H administered and told ULP-H "you just didn't see me do that." AD-I indicated ULP-H was under the assumption that the medications were new and just not put in the eMAR yet. AD-I indicated RN-G told her it was her hope that when hospice came later in the day, they would approve the medications RN-G wanted ordered; the two medications she administered. The two medications that she added to the medication cup were haloperidol and quetiapine (an antipsychotic). RN-G repeated to her a few times throughout the day what she did, what she said	02310		

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02310	Continued From page 21 and what her wishes were. AD-I wrote, RN-G stated she wanted R1 to be "snowed" so he was not a "busy bee" or aggressive. The email indicated RN-G also told other staff what she had done. RN-G became loud when the hospice nurse arrived and did not agree to add the haloperidol and quetiapine to R1's orders. AD-I wrote RN-G was upset she did not get her way with hospice and order the medications. RN-G told AD-I she would have to add those two medications to R1's eMAR even though they were not ordered for him. AD-I noted R1 was unsteady on his feet this morning, unable to walk or hold his balance. AD-I wrote R1 was walking fine prior to the medication administration. AD-I stated after RN-G administered medications at 12:30 p.m., R1 was falling over and AD-I caught him in time. AD-I stated she told RN-G he was not stable and kept trying to walk, but falling over. AD-I indicated RN-G's response was to let him fall or put him on the floor, "he can stay there." An email from housing director (HD)-A to regional director (RD)-C and another regional director, dated Monday July 8, 2024, at 10:45 a.m., indicated a report of RN-G providing a resident two medications that were not ordered for him, haloperidol and quetiapine, intentionally. HD-A indicated he became overmedicated, unsteady, and falling. On July 9, 2024, ULP-H submitted a written statement about the medication incident on July 5, 2024. ULP-H wrote around 6:30 a.m. RN-G approached her to talk about R1 and how he was the previous night. RN-G told ULP-H to give R1 his scheduled Olanzapine and other scheduled medications but to add his prn morphine and lorazepam too, because "she was not dealing with this today." ULP-H prepared R1's 8:00 a.m.	02310		

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02310	Continued From page 22 medications and RN-G came back to the medication cart with haloperidol "pills." ULP-H gave R1 his scheduled medications, the PRN medications as directed by RN-G and the haloperidol "medications." Later she learned there was no prescription for the haloperidol. At 12:30 p.m., RN-G asked for ULP-H's medication cart keys and prepared PRN morphine and lorazepam in a syringe. She returned from R1's room and told ULP-H it was a failed attempt to give the medications. RN-G then crushed unknown pills into a cup and "slurried" them with orange juice and gave it to R1. Approximately 30 minutes later, ULP-H heard a loud noise and found R1 hanging off the edge of his recliner in his room, his bedside tray tipped over and food spilled. Another ULP came to help ULP-H clean up and during that time observed R1 slur his words, try standing, falling back into his chair, and then collapsed into a wheelchair against a wall. ULP-H wrote that she expressed her concern over R1's condition and RN-G told her to let him fall or leave him on the floor. At 2:00 p.m. shift change RN-G told staff we "snowed" R1, therefore hospice will provide a Broda chair and a hoyer lift because he was a "monkey & belongs in a zoo." An email from AD-I to RD-C, dated July 9, 2024, at 12:01 p.m., indicated during a break that day [July 5, 2024], RN-G laughed about giving R1 extra medication and said she wondered which medication she gave got him so "snowed." RN-G made the comment after the hospice nurse visit. AD-I indicated she again verified with RN-G what the medications were, haloperidol and quetiapine. R1's record lacked an incident report on July 5, 2024 for the near miss fall into his chair as described by ULP-H and AD-I.	02310		

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02310	Continued From page 23 R1's incident reports after the incident on July 5, 2024, included falls on July 8, 2024, July 12, 2024 and several falls on July 13, 2024, resulting in R1 being transported to the hospital. R1's death record indicated R1 died on July 22, 2024, cause of death due to acute kidney injury within weeks of death. During an interview on October 10, 2024, at 2:25 p.m., RD-C said RN-G asked hospice for quetiapine and haloperidol for R1 but the hospice physician said not until the prescribed medications listed were tried first. RD-C said RN-G said she only gave the non-prescribed haloperidol which came from a bubble pack card backup medication. RD-C said the haloperidol should have been returned to the family or destroyed. During an interview on October 22, 2024, at 1:02 p.m., ULP-H said the medication incident with RN-G happened on the morning of July 5, 2024 in the memory care unit. ULP-H said the overnight shift reported R1 had been a little agitated but did not need PRN medications. RN-G told ULP-H "she was not going to deal that bullshit today, well give him something else." ULP-H said she thought R1 had a new prescribed medication. ULP-H said R1 was still new to her and she did not know all his medications like she did other residents. ULP-H had his 8:00 a.m. medications ready in a medication cup. RN-G went to her office, came out and dropped two pills into R1's medication cup and said "you didn't see that," to ULP-H. ULP-H was not sure what RN-G meant, and wanted to ask her what she said, but R1 came up to the medication cart and ULP-H gave R1 his medications. He took all of them. She	02310		

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02310	Continued From page 24 went to sign off on R1's medications in the eMAR. She did not see newly added prescribed or PRN medications and thought at first there was a delay in the eMAR updating because of the July 4th holiday. ULP-H said RN-G returned and asked her if R1 took all his medications. Later that morning, ULP-H said AD-I asked her if she gave R1 more than his regular medications because RN-G told staff what she had done, "gloating." ULP-H said she felt sick to her stomach when she heard that. ULP-H said during the rest of the day shift, R1 was disoriented and unsteady. He fell into a wheelchair and AD-I hurt herself trying to catch him. ULP-H said he was practically a one to one supervision for the rest of the shift and she worked alone in memory care. ULP-H said the two nonprescribed medications were quetiapine 25 mg and haloperidol. ULP-H did not recall the haloperidol dose amount. A policy titled Medication and Treatment Orders, dated July 20, 2021, indicated a current written prescriber's order must be obtained for any treatment or medication administration provided to a resident. Prescriptions or orders to be implemented must be received from an authorized prescriber. The RN is responsible for assuring that current, authorized prescriber orders for medications or treatments administered by the staff are kept on file in the resident's records. TIME PERIOD OF CORRECTION: Seven (7) Days	02310		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial	02360		

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02360	Continued From page 25 exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No plan of correction is required for this tag.	