Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL201724721M
Compliance #: HL201726201C

Date Concluded: August 19, 202

Name, Address, and County of Licensee Investigated:
Harmony House of Pierz
26886 143rd Street
Pierz, MN 56364
Morrison County

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

Evaluator's Name:
Jana Wegener, RN, Special Investigator

Finding: Substantiated, facility responsibility

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

Initial Investigation Allegation(s):
The resident was neglected when the facility failed to ensure the resident had morphine available for shortness of breath and pain as scheduled/prescribed for end-of-life care. The resident went without scheduled morphine resulting in increased pain and withdrawal symptoms.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The resident did not receive the scheduled dose of morphine eight times over a 2-day time period. The resident had increased pain and withdrawal symptoms.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's pharmacy, hospice, and family. The investigation included review of the resident record(s), pharmacy records, and

related facility policy and procedures. Also, the investigator observed the resident and staff in the facility.

The resident resided in an assisted living memory care unit with diagnoses including Alzheimer's disease without behavioral disturbance, and chronic obstructive pulmonary disease (COPD) exacerbation.

The resident’s quarterly assessment indicated the resident received medication management services and a licensed nurse would monitor the resident’s medication supplies and reorder them as needed on a timely basis.

Approximately 2 months later, a hospice admission document indicated the resident was admitted to hospice for end-of-life care related to acute exacerbation of COPD. The hospice admission included orders for the resident to receive morphine solutab, 5 mg hourly as needed (PRN) for shortness of breath and pain.

The resident’s medication administration record (MAR) for June 2024, included no scheduled orders for morphine, and indicated the resident utilized the PRN morphine only 1 time that month for shortness of breath with relief noted. 19 days after the resident was admitted to hospice the resident’s morphine order was scheduled every 6 hours for pain and shortness of breath, and hourly PRN.

One week later a registered nurse (RN) progress note indicated staff updated the RN the resident would run out of morphine. The note indicated the RN instructed staff (unknown) to contact hospice and re-order the medication. The note indicated the RN would continue to monitor the situation, however there was no indication the RN followed up with staff or hospice to ensure the resident had morphine available.

The resident’s narcotic tracking log indicated the facility received 6 tablets of morphine later that day. The medication was received and logged into the resident’s narcotic tracking log by 2 unlicensed staff at 4:57 p.m. and indicated the resident had 11 tablets available for administration. The record failed to indicate staff notified facility nursing or hospice the resident had only received 6 tablets of morphine and would run out of the medication.

A pharmacy fax indicated the resident had no refills of morphine available, and the provider was contacted. There was no indication the facility followed up with the resident’s pharmacy, provider, or hospice to ensure the resident received her scheduled morphine as ordered.

The following day two staff documented the resident’s morphine count as 0 available to administer. There was no indication staff notified facility nursing or hospice the resident had no morphine available. The resident’s MAR indicated at 10:22 a.m., 5:00 p.m., and 11:00 p.m. that day multiple staff documented they were unable to administer the resident’s morphine because none was available.

A review of hospice triage notes indicated staff failed to inform hospice the resident would run out of morphine, and failed to notify hospice when the resident had no morphine available to administer. One hospice triage note indicated staff reported the resident had fallen. A hospice post fall visit note indicated a hospice nurse was onsite around 7:00 p.m. (the day the resident ran out of morphine) to assess the resident's injuries post fall and the resident denied any pain at that time. There was no indication staff notified the hospice nurse the resident had no morphine available to administer.

The following day at 5:00 a.m., 11:00 a.m. 5:00 p.m., and 11:00 p.m. multiple staff documented they were unable to administer the resident's morphine because none was available. There was no indication staff notified hospice or nursing the resident had no morphine to administer.

The next day at 11:00 a.m. staff documented they were unable to administer the resident's morphine because none was available. There was no indication staff notified hospice or nursing the resident had no morphine to administer.

The same day, at 11:24 a.m. the facility RN documented the resident was suffering withdrawal symptoms, was diaphoretic (sweating), vomiting, and had high blood pressure from not receiving the scheduled morphine. The note indicated the facility RN contacted hospice who delivered morphine to the resident stat (immediately).

The resident's MAR and administration notes indicated the resident utilized 4 doses of as needed (PRN) morphine for pain in addition to the scheduled doses administered after the medication was delivered to the facility. Prior to that day the resident had only utilized 1 PRN dose of morphine.

When interviewed a hospice RN stated she had sent a refill request for the resident's morphine prior to the incident but entered a quantity of 6 tablets instead of 60 by mistake. The RN stated she was unaware the resident had only received 6 tablets and would run out. The RN verified no one from the facility alerted her that the resident would run out of the morphine, and no one reported the resident had no medication available to administer until 2 days later after the resident suffered withdrawal symptoms. The RN stated she was onsite daily, but staff failed to report any concern with the resident not having morphine. The RN stated when she arrived on site to assess the resident after the concern was reported 2 days later the resident was in severe pain, had elevated pulse, elevated blood pressure, tremors, was shaking, had increased anxiety/restlessness, was vomiting, and sweating. The RN stated the resident begged and pleaded for help to feel better. The RN stated the incident could have been prevented if facility staff had communicated the resident had no morphine available. The RN stated the resident had not fully recovered from the incident and had declined drastically since the incident occurred.

When interviewed the facility RN stated no staff at the facility notified her the resident only received 6 tablets, then ran out of morphine, and no one notified her when there was no morphine available during change of shift medication counts, or with 8 missed doses of scheduled morphine over 2 days. The RN stated she became aware of the concern 2 days later when the resident aspirated while suffering withdrawal symptoms and verified no concerns were identified or reported prior to that. The RN stated staff were to call any time a narcotic was delivered to the facility so it could be checked in by a nurse but indicated that did not occur.

When interviewed the resident's family member indicated they were aware of the morphine incident, and stated the resident had progressively declined since the incident.

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

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

Neglect: Minnesota Statutes, section 260E.03, Subd. 15
"Neglect" means the commission or omission of any of the acts specified under clauses (1) to (8), other than by accidental means:
(1) failure by a person responsible for a child's care to supply a child with necessary food, clothing, shelter, health, medical, or other care required for the child's physical or mental health when reasonably able to do so;
(2) failure to protect a child from conditions or actions that seriously endanger the child's physical or mental health when reasonably able to do so, including a growth delay, which may be referred to as a failure to thrive, that has been diagnosed by a physician and is due to parental neglect;
(3) failure to provide for necessary supervision or child care arrangements appropriate for a child after considering factors as the child's age, mental ability, physical condition, length of absence, or environment, when the child is unable to care for the child's own basic needs or safety, or the basic needs or safety of another child in their care.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: N/A

Action taken by facility:
No action taken.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

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

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

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

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

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Morrison County Attorney
Pirez City Attorney
Pierz Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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HARMONY HOUSE OF PIERZ	26886 143RD STREET PIERZ, MN 56364

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0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, 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: #HL201723241M/ #HL201723352C #HL201724721M/ #HL201726201C On June 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 20 residents receiving services under the provider's Assisted Living with Dementia care license. The following correction orders were issued for #HL201723241M/ #HL201723352C, tag identification 1620, 1650, 2310, and 2360. The following correction orders were issued for # HL201724721M/ #HL201726201C, tag identification 1620, 1760, 1910, 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.	
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring	01620		

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01620	Continued From page 1 (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure a registered nurse (RN) completed and/or documented a comprehensive assessment for a change in condition, wound monitoring, emergency room (ER) visits, hospice admissions, readmission following hospitalization, and failed to assess and monitor risk for falls and fall interventions to reduce the risk of falls for two of two residents (R1, R2) 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	01620		

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01620	Continued From page 2 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: R1 was admitted to the licensee on November 8, 2023, with diagnoses including Parkinson's disease, aspiration pneumonia, dysphagia (difficulty swallowing), and dementia. R1's admission assessment dated November 8, 2023, indicated the resident was admitted to the facility due to frequent falls. The admission assessment indicated R1 had 10 or more falls in the last 3 months, with 4 falls in the last week prior to admission. The assessment and care plan indicated R1 was cognitively impaired with memory loss/confusion related to dementia and Parkinson's Disease. The assessment identified R1 was at a risk for falls related to gait and balance problems, decreased strength/endurance due to physical decline, syncope, inability to communicate his needs, tremors causing decreased muscular coordination, unsteady staggered motion when turning, and impaired judgment. The assessment indicated R1 required assistance every 2 to 3 hours with toileting and incontinence care. The assessment indicated staff should check on R1 frequently and provide 24 hour supervision and monitoring. On November 8, 2023, at 4:07 p.m. an admission progress note indicated R1 was admitted due to frequent falls at home. The note indicated R1 was non-verbal and required 1 staff assistance with	01620		

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01620	Continued From page 3 transfers and toileting. On November 9, 2023, R1's hospice admission paper work indicated he was admitted to hospice for end of life care related to Parkinson's disease, the admission documentation indicated R1 had a decline in function, was disoriented, and required fall precautions. A change of condition assessment was requested none was provided. On November 9, 2023, at 4:35 p.m. a fall incident report indicated R1's first fall occurred the day after admission. The incident report indicated R1 had an unwitnessed fall, and indicated immediate action taken to prevent recurrence was to watch R1 more closely. At 4:47 p.m. licensed practical nurse (LPN)-B documented no injury was noted, however, there was no indication any action was taken to prevent recurrence. On November 10, 2023, at 12:30 a.m. a fall incident report indicated R1 had an unwitnessed fall in the hallway from his wheelchair. The report identified R1 was incontinent of bladder and was toileted last at 7:30 p.m. (7 hours prior to the fall). The incident report indicated R1 had a head strike with a small laceration to the back of his head that was bleeding. The incident report indicated R1 had not received toileting services, or safety checks as indicated in his assessment and care plan. There was no indication any action was taken to prevent recurrence. On November 10, 2023, at 5:43 a.m. a fall incident report indicated R1 had an unwitnessed fall and was found in his room by his dresser resulting in a head strike and R1's previous head laceration was bigger and bleeding. The incident report indicated the immediate intervention was to check on R1 more frequently. However, there	01620		

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01620	Continued From page 4 was no indication safety checks were implemented, and no action was taken to prevent recurrence. On November 11, 2023, at 6:30 a.m. a fall incident report indicated R1 had an unwitnessed fall. The report indicated R1's alarm was in use but did not sound. The incident report indicated the immediate intervention was to check on R1 more frequently. However, there was no indication safety checks were implemented, and no action was taken to prevent recurrence. On November 23, 2023, at 6:37 p.m. a fall incident report indicated R1 had an unwitnessed fall, his alarm sounded, and he was found face down between his bed and rocking chair with a head strike causing a small goose egg. R1 was incontinent of bladder at the time the fall occurred. The immediate intervention to prevent recurrence was to provide every 2-hour safety checks. However, no action was taken to prevent recurrence, and there was no indication every 2-hour safety checks were implemented. On December 6, 2023, at 8:44 p.m. a fall incident note indicated R1 called for assistance and staff found R1 on the floor. The note indicated R1's alarm was under the bed not attached to R1, and indicated the adhesive part was no longer sticking. No incident report was completed, and there was no indication any action was taken to ensure R1 safety and prevent recurrence. On December 11, 2023, at 5:46 p.m. a fall incident note indicated R1 was found on the floor, with his alarm unattached laying on his pillow. No incident report was completed. On December 12, 2023, at 12:13 a.m. ULP care	01620		

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01620	Continued From page 5 note indicated R1 had bruising on his right elbow, and left hip. On December 18, 2023, at 7:00 a.m. a fall incident report indicated R1 had an unwitnessed fall. The report indicated no alarm was in use at the time the incident occurred. The immediate action to prevent recurrence was to implement a bed alarm. The incident report indicated it was reviewed by the facility registered nurse (RN) who indicated R1's care plan was followed at the time the incident occurred despite R1's alarm not being utilized, and no safety checks had been implemented as indicated in R1's assessment and plan of care. There was no indication any action was taken to prevent recurrence. On December 28, 2023, at 8:55 a.m. a fall incident report indicated R1 had an unwitnessed fall, resulting in a head strike with a laceration that was bleeding. The report indicated R1's alarm was not in use at the time the incident occurred. The incident report reviewed by the facility RN who indicated R1's care plan was followed at the time of the incident despite R1's alarm not being utilized at the time, and no safety checks had been implemented as indicated in R1's assessment and plan of care. There was no indication any action was taken to prevent recurrence. A hospital discharge summary indicated R1 was admitted to the hospital on January 1, 2024, and re-admitted to the licensee on January 5, 2024. The summary indicated R1 was admitted for aspiration pneumonia, related to Parkinson's disease, oropharyngeal dysphagia, resulting in severe sepsis, underlying dementia, and acute respiratory failure with hypoxia. A hospital re-admission assessment was requested, none	01620		

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01620	Continued From page 6 was provided. On January 6, 2024, at 2:51 a.m. a fall progress note indicated R1 was found on the floor. The note failed to indicate R1 had any injuries. No incident report was completed. On January 6, 2024, at 7:39 a.m. another progress note indicated R1 was found in bed with blood on the floor, his hands, bedding, and staff noted R1 had a laceration on the back left side of his head. The note indicated R1 required 9 staples at the hospital to repair the injury and returned to the facility later that day. R1's after visit summary dated January 6, 2024, indicated R1 was seen in the ED for a fall with closed head injury requiring laceration repair. A re-admission assessment was requested, none was provided. The investigator requested post fall risk assessments and wound/skin monitoring for R1's injuries. A single undated wound assessment was provided for an abrasion on the back of R1's head, no other skin/wound monitoring was provided for the injuries R1 had sustained after falls. No post fall risk assessments for any of the incidents were provided. On July 15, 2024, at 11:52 a.m. the licensed assisted living director (LALD)-A and LPN-B stated things were missed and not implemented with R1 to ensure his safety and prevent recurring falls and injury. The LALD indicated the staff who failed to complete an incident report when R1 fell and required staples was terminated for noncompliance with facility procedure. However, a review of personnel files provided by the facility indicated the ULP was terminated 3 months after	01620		

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01620	Continued From page 7 the incident with R1 and was not the same staff who documented the fall incident when R1 required staples. In addition, R1's record indicated multiple staff failed to complete incident reports for fall incident that occurred. LALD-A and LPN-B indicated they had difficulty getting the previous RN at the time of R1's admission in the building, and indicated since the current RN started they had no issues with falls or assessments. Records were requested for R2 to review to determine if concerns with falls and assessments were ongoing. R2: R2 was admitted on December 17, 2021, with diagnoses including late onset Alzheimer's disease, and chronic obstructive pulmonary disease (COPD). R2's 90-day assessment on April 1, 2024, indicated R2 was occasionally disoriented, needed assistance getting in and out of bed, was independent with ambulation but became visibly short of breath (SOB) when ambulating, and had chronic pain. On June 20, 2024, R2's hospice admission documentation indicated she was admitted to hospice for end of life care related to exacerbation of COPD. No change of condition assessment was completed when R2 was admitted to hospice to identify changes in the resident's needs. On 6/20/2024, at 10:51 p.m. a fall nurses note indicated R2 had an unwitnessed fall when transferring bed to recliner, R2 had a head strike, and elbow scrape. The note indicated staff were instructed to complete an incident report and start neuro checks. However, no incident report or	01620		

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01620	Continued From page 8 neuro checks were completed, and there was no indication any action was taken to prevent recurrence. On June 27, 2024, a routine 90-day assessment was completed (7 days after R2 was admitted to hospice). The assessment indicated R2 short of breath with ambulation, had pain, and utilized hospice. On June 23, 2024, at 10:20 p.m. a fall incident report indicated R2 had an unwitnessed fall in her room between table and chair in front of the TV. R2 was unable to reach her call light to ring for assistance. Staff heard a loud noise and R2 calling for help. R2 had no pendant call light on, and her elbow was bleeding. The report indicated R2 had gripper socks on, hit her head, and scraped her right elbow and left hip by buttocks with swelling red raised area reopened and scab on left leg below calf. The note indicated neuro checks were complete and the incident was reviewed by the RN. However, there was no indication R2's care plan or risk for falls was reviewed, and no indication any action was taken to prevent recurrence. On July 17, 2024, a fall incident report indicated R2 had an unwitnessed fall resulting in a head strike and skin tear. Although the incident report was reviewed by the RN, and a post incident progress note about the incident was completed. However, there was no indication R2 care plan or risk for falls was reviewed, and no indication any action was taken to prevent recurrence. The facility policy titled "Fall Prevention & Management" dated June 15, 2024, indicated the Registered Nurse (RN) would assess each resident for his/her risk for falls, design a service	01620		

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01620	Continued From page 9 plan, and implement procedures to minimize falls and/or injury. The policy defined a fall as an unintended landing on a floor or lower position not caused by a sudden major health event such as a stroke. A fall can be inferred if the fall is witnessed, if the resident is found on the floor, or if the resident states that a fall has occurred. Section A. indicated a fall risk assessment was completed on each resident on admission, annually, upon change of condition, and reviewed following a fall. The policy indicated possible prevention general safety precautions and interventions should be used for all residents and including providing call system that is within easy reach and secured, use of alert wristband or necklace, use of non-slip footwear, awareness of medication side effects, providing adequate light in all rooms and common areas, using nightlight's, keeping the resident's environment free of obstacles. High risk to fall prevention strategies included evaluate resident for placement to a higher level of care, verifying that frequently used resident items are within reach, offering toileting to the resident every two hours while awake and every four hours during the night (less than four hours of rest at night increases the risk of acute confusion due to sleep deprivation), conducting resident safety checks more frequently, every 2 hours and PRN (pro re or as needed), utilizing chair and bed alarms for residents with impulsive, and napping and toileting schedules. The policy indicated if a resident falls, the following steps should be taken assess the resident post fall including vital signs (pulse, temperature, respirations, and blood pressure), inspection for bruises, swelling, and lacerations, notify RN or on-call in accordance with site guidelines, complete Head Strike Protocol as directed in RTasks if head hit during fall. The policy indicated nursing was to review	01620		

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01620	Continued From page 10 and update the resident's service plan as applicable for an injured resident, complete incident report in RTasks. Section B. Risk Management Review indicated the Registered Nurse evaluates fall data to measure and analyze falls and reviews potential contributing factors and follow-up actions, based on compiled incident report data, a periodic trend summary should be provided and discussed as a team to enhance quality management/risk management. A facility policy and procedure titled "Assessment, Reviews, and Monitoring" effective August 1, 2021, Section 3. ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. Section 6. the licensee would conduct a nursing assessment during a holiday, and the weekend for a resident who is ready to be discharged from the hospital and return to the facility, and this may be completed virtually. A facility policy and procedure titled "Resident Change in Condition or Need" effective August 1, 2021, indicated the licensee would conduct initial reviews and scheduled assessments and monitoring as required. When changes in condition or need are identified, a Registered Nurse (RN) will initiate a change in condition assessment. The assessment may be limited to only those issues where a change has been identified. Section 3. indicated an change of condition assessments will also be initiated after every resident readmission to the site from the hospital, emergency department or other medical/treatment stay. No further information was provided.	01620		

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01620	Continued From page 11 TIME PERIOD FOR CORRECTION: Fourteen (14) days.	01620		
01650 SS=G	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review the	01650		

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01650	Continued From page 12 licensee failed to ensure the resident's service plan had the required information for one of one resident's (R1) reviewed. R1 was harmed when the facility failed to ensure interventions were implemented to reduce the resident's risk for recurring falls, R1 had a fall and sustained a head injury laceration requiring 9 staples. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted to the licensee on November 8, 2023, with diagnoses including Parkinson's disease, aspiration pneumonia, dysphagia (difficulty swallowing), and dementia. R1's admission assessment dated November 8, 2023, indicated the resident was admitted to the facility due to frequent falls. The admission assessment identified R1 had 10 or more falls in the last 3 months, with 4 falls in the last week prior to admission. The assessment and care plan indicated R1 was cognitively impaired with memory loss/confusion related to dementia and Parkinson's Disease. The assessment identified R1 was at a risk for falls related to gait and balance problems, decreased strength/endurance due to physical decline, syncope, inability to communicate his needs, tremors causing decreased muscular coordination, unsteady staggered motion when turning, and impaired	01650		

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01650	Continued From page 13 judgment. The assessment indicated R1 required assistance every 2 to 3 hours with toileting and incontinence care. The assessment indicated staff should check on R1 frequently and provide 24-hour supervision and monitoring. R1's signed service plan dated November 8, 2023, indicated staff were to provide toileting assistance 3 times daily. The service plan failed to include interventions to reduce R1's risk for falls including toileting and incontinence care every 2-3 hours, or safety checks and the frequency. On November 8, 2023, at 4:07 p.m. an admission progress note indicated R1 was admitted due to frequent falls at home. The note indicated R1 was non-verbal and required 1 staff assistance with transfers and toileting. On November 9, 2023, R1's hospice admission paperwork indicated he was admitted to hospice for end-of-life care related to Parkinson's disease, the admission documentation indicated R1 had a decline in function, was disoriented, and required fall precautions. R1's care plan updated November 22, 2023, indicated R1 was dependent on staff assistance with toileting and incontinence care every 2-3 hours. The care plans fall interventions included offer assistance as needed, assure appropriate lighting, provide frequent wellbeing safety checks, and indicated R1 utilized a bed and chair alarm to alert staff of attempts to self-transfer. R1's service delivery of care report for the resident's bed/chair alarm implemented on November 15, 2023, indicated staff were to check R1's tabs alert system, and ensure it was working	01650		

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01650	Continued From page 14 and attached to R1 one time per shift. Documentation included multiple notes from staff indicating R1 did not have an alarm, or the alarm was not working. There was no indication any action was taken to ensure R1 safety. R1's service delivery of care record for toileting from admission to death included instructions for staff to provide toileting and incontinence care to the resident every 2-3 hours. However, the report indicated R1's toileting service was scheduled only 3 times daily, not every 2-3 hours as assessed and indicated in the resident's care plan. The resident's toileting documentation failed to show toileting and incontinence care was provided every 2-3 hours. R1's service delivery of care record for safety checks from admission to death indicated safety checks were not implemented as indicated in R1's assessment and care plan until December 23, 2023, 52 days after R1 was admitted to the facility for falls, and after R1 had sustained 9 falls in the facility. On November 9, 2023, at 4:35 p.m. a fall incident report indicated R1's first fall occurred the day after admission. The incident report indicated R1 had an unwitnessed fall, and indicated immediate action taken to prevent recurrence was to watch R1 more closely. At 4:47 p.m. licensed practical nurse (LPN)-B documented no injury was noted, however, there was no indication any action was taken to prevent recurrence. On November 10, 2023, at 12:30 a.m. a fall incident report indicated R1 had an unwitnessed fall in the hallway from his wheelchair. The report identified R1 was incontinent of bladder and was toileted last at 7:30 p.m. (7 hours prior to the fall).	01650		

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01650	Continued From page 15 The incident report indicated R1 had a head strike with a small laceration to the back of his head that was bleeding. The incident report indicated R1 had not received toileting services, or safety checks as indicated in his assessment and care plan. There was no indication any action was taken to prevent recurrence. On November 10, 2023, at 5:43 a.m. a fall incident report indicated R1 had an unwitnessed fall and was found in his room by his dresser resulting in a head strike and R1's previous head laceration was bigger and bleeding. The incident report indicated the immediate intervention was to check on R1 more frequently. However, there was no indication safety checks were implemented, and no action was taken to prevent recurrence. On November 10, 2023, at 12:37 p.m. a progress note indicated the facility received new orders from hospice for a bed alarm. The record failed to indicate a bed alarm was ever implemented. On November 11, 2023, at 6:30 a.m. a fall incident report indicated R1 had an unwitnessed fall. The report indicated R1's alarm was in use but did not sound. The incident report indicated the immediate intervention was to check on R1 more frequently. However, there was no indication safety checks were implemented, and no action was taken to prevent recurrence. On November 23, 2023, at 6:37 p.m. a fall incident report indicated R1 had an unwitnessed fall, his alarm sounded, and he was found face down between his bed and rocking chair with a head strike causing a small goose egg. R1 was incontinent of bladder at the time the fall occurred. The immediate intervention to prevent	01650		

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01650	Continued From page 16 recurrence was to provide every 2-hour safety checks. However, no action was taken to prevent recurrence, and there was no indication every 2-hour safety checks were implemented. On December 6, 2023, at 8:44 p.m. a fall incident note indicated R1 called for assistance and staff found R1 on the floor. The note indicated R1's alarm was under the bed not attached to R1, and indicated the adhesive part was no longer sticking. No incident report was completed, and there was no indication any action was taken to ensure R1 safety and prevent recurrence. On December 11, 2023, at 5:46 p.m. a fall incident note indicated R1 was found on the floor, with his alarm unattached laying on his pillow. No incident report was completed. On December 18, 2023, at 7:00 a.m. a fall incident report indicated R1 had an unwitnessed fall. The report indicated no alarm was in use at the time the incident occurred. The immediate action to prevent recurrence was to implement a bed alarm. The incident report indicated it was reviewed by the facility registered nurse (RN) who indicated R1's care plan was followed at the time the incident occurred despite the R1's alarm not being utilized, and no safety checks had been implemented as indicated in R1's assessment and plan of care. There was no indication any action was taken to prevent recurrence. On December 28, 2023, at 8:55 a.m. a fall incident report indicated R1 had an unwitnessed fall, resulting in a head strike with a laceration that was bleeding. The report indicated R1's alarm was not in use at the time the incident occurred. The incident report reviewed by the facility RN who indicated R1's care plan was	01650		

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01650	Continued From page 17 followed at the time of the incident despite R1's alarm not being utilized at the time, and no safety checks had been implemented as indicated in R1's assessment and plan of care. There was no indication any action was taken to prevent recurrence. R1 service delivery of care record for safety checks indicated safety checks were not implemented until December 29, 2023, at 11:00 a.m. (52 days after admission) when R1's first safety check was documented as completed. On January 6, 2024, at 2:51 a.m. a fall progress note indicated R1 was found on the floor. The note failed to indicate R1 had any injuries. No incident report was completed. On January 6, 2024, at 7:39 a.m. another progress note indicated R1 was found in bed with blood on the floor, his hands, bedding, and staff noted R1 had a laceration on the back left side of his head. The note indicated R1 required 9 staples at the hospital to repair the injury and returned to the facility later that day. R1's progress notes, incident reports, and post incident follow up failed to show the incidents were reviewed to determine potential cause or contributing factors, if R1's care plan was followed, if fall interventions were implemented at the time the incident occurred, or if new interventions were needed, and no post fall risk assessment was completed after the falls occurred. As a result, the licensee failed to identify assessed interventions including frequent safety checks, and scheduled toileting had not been implemented. Although staff repeatedly documented the chair/bed alarm tabs was not working, or was not in use, there was no	01650		

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01650	Continued From page 18 indication any action was taken to ensure the concern was corrected. One staff documented 15-minute checks would be done due to the alarm not functioning, however there was no indication 15-30-minute safety checks were provided to ensure R1's safety. On July 15, 2024, at 1:04 p.m. ULP-D stated R1 had falls but did not recall a fall mat or audio monitoring ever being implemented. ULP-D indicated safety checks would have been provided if they were in R1's scheduled services. On July 15, 2024, at 1:20 p.m. ULP-C stated R1 was admitted with a high risk for falls. The ULP indicated the morning of the incident when R1 was found in his bed with a head laceration, there was blood all over on the floor, bedding, and resident's hands and head. ULP-C stated no one reported R1 had fallen or was injured when she came on shift. ULP-C stated R1 had an alarm on his bed/chair, an audio alarm staff carried, scheduled safety checks, toileting every 2-3 hours, and a fall mat to reduce his risk for falls and injury. However, R1's record failed to indicate the facility implemented an audio alarm or fall mat, and there was no indication every 2-3-hour toileting was provided. On July 15, 2024, at 11:52 a.m. the licensed assisted living director (LALD)-A and LPN-B stated things were missed and not implemented with R1 to ensure his safety and prevent recurring falls and injury. The LALD indicated the staff who failed to complete an incident report when R1 fell and required staples was terminated for noncompliance with facility procedure. However, a review of personnel files provided by the facility indicated the ULP staff who was terminated 3 months after the incident with R1, was not the	01650		

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01650	Continued From page 19 same staff who documented the fall incident requiring staples. In addition, R1's record indicated multiple staff failed to complete incident reports for fall incident that occurred. The facility policy titled "Fall Prevention & Management" dated June 15, 2024, indicated the Registered Nurse (RN) would assess each resident for his/her risk for falls, design a service plan, and implement procedures to minimize falls and/or injury. The policy defined a fall as an unintended landing on a floor or lower position not caused by a sudden major health event such as a stroke. A fall can be inferred if the fall is witnessed, if the resident is found on the floor, or if the resident states that a fall has occurred. Section A. indicated a fall risk assessment was completed on each resident on admission, annually, upon change of condition, and reviewed following a fall. Section 3. indicated a resident identified as high risk for falls at any time during his or her stay remains on the Fall Prevention interventions unless their risk assessment score declines. Section 4. Risk factors for falls included unstable gait, decreased balance, or mobility deficit (e.g., poor sitting balance), confusion and inability to communicate needs, cognitive impairment, general weakness, physical disability resulting from a medical condition (Parkinson's, cardiovascular accident (CVA), Alzheimer's disease, dementia), medications that are associated with a higher risk for falling. The policy indicated possible prevention general safety precautions and interventions should be used for all residents and including providing call system that is within easy reach and secured, use of alert wristband or necklace, use of non-slip footwear, awareness of medication side effects, providing adequate light in all rooms and common areas, using nightlight's, keeping the resident's	01650		

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01650	Continued From page 20 environment free of obstacles. High risk to fall prevention strategies included evaluate resident for placement to a higher level of care, verifying that frequently used resident items are within reach, offering toileting to the resident every two hours while awake and every four hours during the night (less than four hours of rest at night increases the risk of acute confusion due to sleep deprivation), conducting resident safety checks more frequently, every 2 hours and PRN (pro re or as needed), utilizing chair and bed alarms for residents with impulsive, and napping and toileting schedules. The policy indicated if a resident falls, the following steps should be taken assess the resident post fall including vital signs (pulse, temperature, respirations, and blood pressure), inspection for bruises, swelling, and lacerations, notify RN or on-call in accordance with site guidelines, complete Head Strike Protocol as directed in RTasks if head hit during fall. The policy indicated nursing was to review and update the resident's service plan as applicable for an injured resident, complete incident report in RTasks. Section B. Risk Management Review indicated the Registered Nurse evaluates fall data to measure and analyze falls and reviews potential contributing factors and follow-up actions, based on compiled incident report data, a periodic trend summary should be provided and discussed as a team to enhance quality management/risk management. A facility policy and procedure titled "Service Plan" dated August 1, 2021, indicated all residents receiving assisted living services will have a service plan in place. Service plans are based on the outcomes of initial and subsequent assessments, reassessments, monitoring, and individual reviews of the resident's needs and preferences. Services plans shall be revised, if	01650		

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01650	Continued From page 21 needed, based on resident reassessments and monitoring. Section 9. indicated a service plan would include a description of the services that are to be provided based on the most recent assessment and resident preferences, and the frequency of each service to be provided based on the most recent assessment and the resident preferences and actions taken if the service can not be provided. A facility policy and procedure titled "Service Plan Modification" dated August 1, 2021, indicated service plan needs to be modified due to a change in a prescriber's order or a change in the resident's needs, the Service Plan Modification form will be completed; this form includes: Describe changes in service and whether the service is added (new), changed, or discontinued, Frequency of the Service, Identification of the staff who will perform the service, and Schedule and methods of monitoring staff. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01650		
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	01760		

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01760	Continued From page 22 completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure medications were administered as prescribed for one of one residents, (R2), reviewed for missed medications. R2 was harmed when the facility failed to ensure scheduled morphine was available to administer as ordered. R2 missed 8 doses of medication over 2 days, and suffered increased pain, withdrawal symptoms, and had a decline in condition following the incident. The licensee failed to ensure actions were taken to meet R2's needs when the medication was not administered as prescribed. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings include: R2 was admitted on December 17, 2021, with diagnoses including late onset Alzheimer's disease, and chronic obstructive pulmonary disease (COPD). R2's 90-day assessment on April 1, 2024,	01760		

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	20172	A. BUILDING: _____ B. WING _____	C 06/10/2024

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01760	Continued From page 23 indicated R2 was visibly short of breath (SOB) with ambulation, had chronic pain, and received medication management services. The assessment indicated a licensed nurse would monitor R2's medication supplies and reorder them as needed on a timely basis. R2's care plan - medication management section updated on July 19, 2024, indicated a licensed nurse would monitor medications usage and order refills when needed. The plan indicated if a medication was not given for any reason the staff must document in the record and notify a licensed nurse. On June 20, 2024, R2's hospice admission documentation indicated she was admitted to hospice for end of life care related to exacerbation of COPD. The hospice admission included orders for the resident to receive morphine solutab 5 mg hourly as needed (PRN) for SOB and pain. The resident's medication administration record (MAR) for June 2024, included no scheduled orders for morphine, and indicated the resident utilized the PRN morphine only 1 time that month for SOB with relief noted. On July 8, 2024, the resident's morphine order was changed and scheduled every 6 hours for pain and SOB, and hourly PRN. On July 14, 2024, a facility registered nurse (RN)-H progress note indicated staff updated the RN-H the resident would run out of morphine. The note indicated the RN-H instructed staff (unknown) to contact hospice and re-order the medication. The note indicated the RN-H would continue to monitor the situation, however there was no indication the RN-H followed up with staff	01760		

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01760	Continued From page 24 or hospice to ensure the resident had the medication available. Later that day on July 14, 2024, at 4:57 p.m. a narcotic tracking log indicated the facility received 6 tablets of morphine logged into R2's narcotic tracking log by 2 unlicensed staff, and indicated the resident had 11 tablets available for administration. The record failed to indicate staff notified facility nursing or hospice R2 had received 6 tablets and would run out of the medication. A review of facility provided pharmacy faxes included one fax dated July 16, 2024, which indicated the resident had no refills available, and the provider was contacted. There was no indication staff followed up with R2's pharmacy, provider, or hospice to ensure R2 received her scheduled morphine as ordered. No other faxed communication was provided after R2 ran out of prescribed morphine. On July 17, 2024, at 5:50 a.m. two staff documented R2's morphine count was 0 available to administer. There was no indication staff notified facility nursing or hospice R2 had no morphine available. R2's medication administration record (MAR) indicated at 10:22 a.m., 5:00 p.m., and 11:00 p.m. multiple staff documented they were unable to administer R2's morphine because none was available. There was no indication any of the staff notified hospice or nursing R2 had no morphine available to administer. On July 17, 2024, a triage note indicated staff reported R2 had fallen. A hospice post fall visit note indicated a hospice nurse was onsite around 7:00 p.m. to assess R2's injuries post fall, R2	01760		

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01760	Continued From page 25 denied any pain at that time. There was no indication staff notified the hospice nurse R2 had no morphine available to administer. On July 18, 2024, at 5:00 a.m., 11:00 a.m. 5:00 p.m., and 11:00 p.m. multiple staff documented in R2's medication administration record (MAR) they were unable to administer R2's morphine because none was available. There was no indication staff notified hospice or nursing R2 had no morphine to administer. On July 19, 2024, at 11:00 a.m. staff documented they were unable to administer R2's morphine because none was available. There was no indication staff notified hospice or nursing R2 had no morphine to administer. At 11:24 a.m. the RN-H documented in a nurses note R2 was suffering morphine withdrawal symptoms, was diaphoretic (sweating), vomiting, and had high blood pressure from not receiving the scheduled morphine. The note indicated RN-H contacted hospice who delivered morphine to R2 STAT. A review of hospice triage notes indicated facility staff failed to inform hospice that R2 would run out of morphine, and failed to notify hospice when R2 had no morphine available to administer. R2's MAR and administration notes indicated R2 utilized 4 doses of as needed (PRN) morphine for pain on July 19, 2024, in addition to the scheduled doses administered after the morphine was delivered to the facility. Prior to that day R2 had only utilized 1 PRN dose of morphine indicating R2 had a significant increase in her pain. R2's record indicated there were numerous opportunities for staff to communicate R2 would	01760		

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01760	Continued From page 26 run out of morphine including during routine change of shift narcotic counts, and with each scheduled administration when the medication was unavailable to be administered as scheduled/prescribed, but there was no indication any staff took action to report the concern to hospice or nursing. On July 23, 2024, at 11:06 a.m. hospice RN-I stated she had sent a refill request for R2's morphine on July 14, 2024, but only entered a quantity of 6 tablets instead of 60 by mistake. RN-I stated she was unaware R2 had only received 6 tablets and would run out. RN-I verified no one from the facility alerted her that R2 would run out of the medication, and no one reported R2 had no medication available to administer until 2 days later after R2 suffered withdrawal symptoms. RN-I stated she was onsite daily, but staff failed to report any concern with R2 not having morphine. RN-I stated when she arrived on site to assess R2 on July 19, 2024, she was in severe pain, had elevated pulse, elevated blood pressure, tremors, was shaking, had increased anxiety/restlessness, was vomiting, and sweating. RN-I stated R2 begged and pleaded for help to feel better. RN-I stated R2 required multiple PRN doses of morphine to get her pain under control. RN-I stated the incident could have been prevented if staff had communicated R2 would run out, and when R2 had no morphine available. RN-I stated when she was informed R2 had run out of morphine and was suffering withdrawals 2 days later the medication was provided STAT. RN-I stated R2 had not fully recovered from the incident and had declined drastically since the incident occurred. On July 18, 2024, at 11:09 a.m. during email communication RN-H indicated she was the	01760		

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01760	Continued From page 27 regional RN responsible to oversee the care of residents at the facility. RN-H stated they had a RN oncall 24/7 to answer questions, triage concerns, and could be called in to refill a medication if necessary. On July 19, 2024, R2 change of condition assessment indicated R2 was aspirating when eating and drinking, and had an increased need for staff assistance with mobility, transfers, toileting, and incontinence care. On July 22, 2024, at 12:35 p.m. during a phone interview and email correspondence RN-H verified no staff at the facility notified her R2 received only 6 tablets of morphine instead of 60 on July 14, 2024, staff had not informed her R2 had run out of morphine until 2 days later when R2 aspirated while suffering withdrawal symptoms, and verified no concerns were identified or reported prior to that. RN-H denied the omission of a prescribed scheduled morphine for 2 days resulting in the resident suffering withdrawal symptoms was any fault of the licensee. RN-H stated staff were to call any time a narcotic was delivered to the facility so it could be checked in by a nurse but indicated that did not occur, as a result she was not aware R2 would run out of morphine. On July 23, 2024, at 7:12 a.m. RN-H indicated in email correspondence R2's morphine omission was not a medication error or medication discrepancy. RN-H indicated hospice failed to order R2's morphine and ordered the incorrect number of morphine tablets on July 14, 2024. On July 23, 2024, at 2:16 p.m. during a phone interview R2's family member stated R2 had progressively declined since the incident and was	01760		

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01760	Continued From page 28 actively dying. A facility policy and procedure titled "Medication Management Individualized Plan" effective August 1, 2021, indicated the licensee would maintain a current individualized medication management record for each resident based on the resident assessment that must contain the following: Section d. indicated they would identify the person responsible to monitor supplies and ensure medication refills were ordered on a timely basis. Section f. Procedures for staff to notify the RN or appropriate licensed health professional when a problem arises with medication management services. Section g. Resident specific requirements relating to documenting medications are administered as prescribed and monitoring of medication use to prevent possible complications or adverse reactions. A undated facility policy and procedure titled "Medication Discrepancy (error)" indicated If a medication discrepancy occurred, staff would notify on call, log into Rtasks and file an incident report, notify the nurse or director who would notify the resident's family and provider. A undated facility policy and procedure titled " Medication Ordering" indicated when medication was with in 7 days of running out (narcotics 2 weeks). After faxing staff would put a note on the fax that indicated it was faxed with the date and initial, and the fax was placed in the pharmacy sheet pending section. The policy indicated if staff came across a medication that was OUT they should call the pharmacy to inform them (or have a nurse, or manager call). If staff are unsure or had any questions, they should send a snap message in RTasks to the nurse or call the on call.	01760		

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01760	Continued From page 29 An undated facility policy and procedure titled "Receiving Logging from Pharmacy" Section 5. When receiving narcotic medication staff were to call the on-call nurse and inform them "I received (___number of tablets) of narcotic from pharmacy" and enter the medication into the narcotic log in RTasks and put then put the medication in the med cart. The policy indicated all narcotics must be signed into the RTasks upon delivery. If there was no director or nurse on site when a narcotic was delivered staff should call the on-call nurse. A facility policy and procedure titled "Resident Record Documentation" dated August 1, 2021, indicated staff would document medications, and services important and pertinent information relating to each resident. Section 1 indicated staff would document daily, medications, services, treatments, or therapies provided to residents. Section 3. indicated medications administered would be documented in a resident's chart which must include the date and time of the administration. Section 4. indicated when medications, services, treatments, or therapies were not performed per the service agreement and schedule, personnel must document the reason why it was not performed or administered. Section 5 indicated tasks not performed or administered must be reported and followed up on to meet the resident's needs. Section 6. indicated other pertinent information that should be documented in a resident's chart include but are not limited to, information about change in condition, and incidents (i.e., falls or injuries). No further information was provided. TIME PERIOD FOR CORRECTION: Two (2)	01760		

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01760	Continued From page 30 days.	01760		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop, implement, and maintain current medication management policies and procedures consistent with current practice standards and guidelines to prevent potential diversion of controlled narcotic medications to include required documentation of accurate disposition documentation for one of one resident (R2) with records reviewed. This practice resulted in a level two violation (a	01910		

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01910	Continued From page 31 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: R2 was admitted on December 17, 2021, with diagnoses including late onset Alzheimer's disease, and chronic obstructive pulmonary disease (COPD). R2's 90-day assessment on April 1, 2024, indicated R2 was visibly short of breath (SOB) with ambulation, had chronic pain, and received medication management services. On June 20, 2024, R2's hospice admission documentation indicated she was admitted to hospice for end-of-life care related to exacerbation of COPD. The hospice admission included orders for the resident to receive morphine solutab 5 mg hourly as needed (PRN) for shortness of breath. R2's medication administration record (MAR) for June 2024, indicated the resident utilized the PRN morphine 1 time that month for shortness of breath with relief noted. On July 8, 2024, the resident's morphine order was changed and scheduled every 6 hours for pain and shortness of breath, and hourly PRN. R2's MAR for July indicated she received 52 scheduled doses of morphine, and 5 PRN doses.	01910		

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01910	Continued From page 32 R2's pill count history report from June 1, 2024, to July 22, 2024, included columns for the medication to be counted with each delivery received, each dose administered in the dispensed/given, and included a column for the number of pills remaining. The pill count form failed to show staff consistently recorded tracking for the pill count with each administration of the narcotic dose given to prevent diversion. As a result, the tracking for the log lacked documentation in the dispensed/given column and did not align with the amount remaining column to be able to quickly identify if potential diversion occurred. Although it appeared staff completed change of shift counts, the tracking did not show documentation for each administered dose and remaining count after each dose was given. For example: On July 19, 2024, at 5:12 p.m. unlicensed personnel (ULP) documented the morphine count was 43. On July 19, 2024, at 5:54 p.m. the count was changed to 41 (indicating 2 morphine were given), however the given column was blank. On July 19, 2024, at 10:01 p.m. the count changed from 41 to 39 (indicating 2 more morphine were given) however the given column remained blank. On July 19, 2024, at 9:33 a.m. licensed practical nurse (LPN)-B stated all medication narcotic tracking to prevent diversion was done online. LPN-B stated the counts were off because it was a Rtasks issue and staff struggled to count the scheduled and PRN administrations accurately because they were on one card. When asked how do staff know if something is missing if the count is not accurate, LPN-B stated she did not know, and indicated staff would know if the count was off at the end of their shift. LPN-B stated staff	01910		

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01910	Continued From page 33 did not document and change the count with each controlled drug given, and stated narcotic tracking was not being done ongoing. On July 22, 2024, 12:35 p.m. during a phone interview Registered Nurse (RN)-H, R2's pill count report was reviewed. RN-H stated the documentation narcotic tracking log did not look good and it appeared staff were not documenting the narcotic count when the medication was given. RN-H stated the electronic system was a good system and staff should be entering each given/dispensed dose then changing the count remaining with each administered dose. RN-H stated the count should be verified with each change of shift count, and when more medication was received to ensure an accurate ongoing narcotic tracking log to prevent and identify potential diversion. On July 22, 2024, at 1:38 p.m. during a follow up voice message (RN)-H confirmed staff were not entering information into the narcotic log tracking system correctly. RN-H stated the pill count history report indicated staff were just doing the change of shift count and not documenting when the narcotic was giving and changing the remaining count. RN-H indicated she understood the lack documentation concerns. An undated facility policy and procedure titled " Medication Counting Narcotics" indicated it was the responsibility of both team members (those just starting the shift and those leaving the shift) to physically count each medication in the narcotic drawer and/or fridge prior to the team member leaving for the day. This is to take place with both people, together at the same time. The policy failed to indicate staff should track the amount of pills remaining with each dose given.	01910		

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01910	Continued From page 34 A facility policy and procedure titled "Narcotic Log - Electronic" indicated all schedule II-controlled substances must be recorded in the electronic charting system. Section 2. All Schedule II controlled substances will be counted and recorded in the electronic counting system. This count will be conducted at every shift change. Section 4. The accuracy of the count will be documented by the password of the personnel in the electronic charting system. The RN will verify the documentation in the electronic charting system, including counts and records regularly. Section 5. If a dose of medication is dropped, or otherwise wasted, the dose may be disposed of and documented by two personnel in the electronic charting system. The policy failed to indicate staff should track the number of pills remaining with each dose given. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	01910		
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 interview and record review, the licensee failed to provide care and services according to acceptable health care, medical or	02310		

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02310	Continued From page 35 nursing standards for two of two residents (R1, R2) with falls and medication management and administration services reviewed. R1 was harmed when the licensee failed to implement interventions according to the resident's plan of care, R1 had multiple recurring falls with head injury lacerations, one requiring 9 staples. R2 was harmed when the facility failed to ensure scheduled morphine was available to administer as ordered. R2 missed 8 doses of medication over 2 days, and suffered increased pain, withdrawal symptoms, and had a decline in condition following the incident. 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: FALLS R1: R1 was admitted to the licensee on November 8, 2023, with diagnoses including Parkinson's disease, aspiration pneumonia, dysphagia (difficulty swallowing), and dementia. R1's admission assessment dated November 8, 2023, indicated the resident was admitted to the facility due to frequent falls. The admission assessment identified R1 had 10 or more falls in the last 3 months, with 4 falls in the last week prior to admission. The assessment and care plan indicated R1 was cognitively impaired with	02310		

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02310	Continued From page 36 memory loss/confusion related to dementia and Parkinson's Disease. The assessment identified R1 was at a risk for falls related to gait and balance problems, decreased strength/endurance due to physical decline, syncope, inability to communicate his needs, tremors causing decreased muscular coordination, unsteady staggered motion when turning, and impaired judgment. The assessment indicated R1 required assistance every 2 to 3 hours with toileting and incontinence care. The assessment indicated staff should check on R1 frequently and provide 24 hour supervision and monitoring. R1's signed service plan dated November 8, 2023, indicated staff were to provide toileting assistance 3 times daily. The service plan failed to include interventions to reduce R1's risk for falls including toileting and incontinence care every 2-3 hours, or safety checks. On November 8, 2023, at 4:07 p.m. an admission progress note indicated R1 was admitted due to frequent falls at home. The note indicated R1 was non-verbal and required 1 staff assistance with transfers and toileting. On November 9, 2023, R1's hospice admission paper work indicated he was admitted to hospice for end of life care related to Parkinson's disease, the admission documentation indicated R1 had a decline in function, was disoriented, and required fall precautions. R1's care plan updated last November 22, 2023, indicated R1 was dependent on staff assistance with toileting and incontinence care every 2-3 hours. The care plan fall interventions included offer assistance as needed, assure appropriate lighting, provide frequent wellbeing safety checks,	02310		

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02310	Continued From page 37 and indicated R1 utilized a bed and chair alarm to alert staff of attempts to self-transfer. R1's service delivery of care report for the resident's bed/chair alarm from admission to death was reviewed and indicated staff were to check the resident's tabs alert system, and ensure it was working and attached to the resident one time per shift. Documentation included multiple notes from staff indicating the resident did not have an alarm, or the alarm was not working. R1's service delivery of care record for toileting from admission to death included instructions for staff to provide toileting and incontinence care to the resident every 2-3 hours. However, the report indicated R1's toileting service was scheduled only 3 times daily, not every 2-3 hours as assessed and indicated in the resident's care plan. As a result, the resident's toileting documentation failed to show toileting and incontinence care was provided every 2-3 hours. R1's service delivery of care record for safety checks from admission to death indicated safety checks were not implemented as indicated in R1's assessment and care plan until 52 days after R1 was admitted to the facility for falls, and after R1 had sustained 7 falls in the facility. On November 9, 2023, at 4:35 p.m. a fall incident report indicated R1's first fall occurred the day after admission. The incident report indicated R1 had an unwitnessed fall, and indicated immediate action taken to prevent recurrence was to watch R1 more closely. At 4:47 p.m. licensed practical nurse (LPN)-B documented no injury was noted, however, there was no indication any action was taken to prevent recurrence.	02310		

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02310	Continued From page 38 On November 10, 2023, at 12:30 a.m. a fall incident report indicated R1 had an unwitnessed fall in the hallway from his wheelchair. The report identified R1 was incontinent of bladder and was toileted last at 7:30 p.m. (7 hours prior to the fall). The incident report indicated R1 had a head strike with a small laceration to the back of his head that was bleeding. The incident report indicated R1 had not received toileting services, or safety checks as indicated in his assessment and care plan. There was no indication any action was taken to prevent recurrence. On November 10, 2023, at 5:43 a.m. a fall incident report indicated R1 had an unwitnessed fall and was found in his room by his dresser resulting in a head strike and R1's previous head laceration was bigger and bleeding. The incident report indicated the immediate intervention was to check on R1 more frequently. However, there was no indication safety checks were implemented, and no action was taken to prevent recurrence. On November 10, 2023, at 12:37 p.m. a progress note indicated the facility received new orders from hospice for a bed alarm. The record failed to indicate a bed alarm was ever implemented. On November 11, 2023, at 6:30 a.m. a fall incident report indicated R1 had an unwitnessed fall. The report indicated R1's alarm was in use but did not sound. The incident report indicated the immediate intervention was to check on R1 more frequently. However, there was no indication safety checks were implemented, and no action was taken to prevent recurrence. On November 17, 2023, at 3:00 p.m. a service	02310		

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02310	Continued From page 39 delivery note for the tabs alarm indicated R1 did not have a tabs alarm, and his bed alarm was not working. On November 23, 2023, at 6:37 p.m. a fall incident report indicated R1 had an unwitnessed fall, his alarm sounded, and he was found face down between his bed and rocking chair with a head strike causing a small goose egg. R1 was incontinent of bladder at the time the fall occurred. The immediate intervention to prevent recurrence was to provide every 2-hour safety checks. However, no action was taken to prevent recurrence, and there was no indication every 2-hour safety checks were implemented. On November 26, 2023, at 5:42 p.m. a service delivery note for the tabs alarm indicated R1 bed alarm did not work, staff would complete safety checks every 15 - 30 min checks, and indicated new alarm was needed ASAP. There was no indication 30 minute checks were completed, the record failed to show action was taken to ensure R1 had an alarm system that worked and was utilized. On December 6, 2023, at 8:44 p.m. a fall incident note indicated R1 called for assistance and staff found R1 on the floor. The note indicated R1's alarm was under the bed not attached to R1, and indicated the adhesive part was no longer sticking. No incident report was completed, and there was no indication any action was taken to ensure R1 safety and prevent recurrence. On December 11, 2023, at 5:46 p.m. a fall incident note indicated R1 was found on the floor, with his alarm unattached laying on his pillow. No incident report was completed.	02310		

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02310	Continued From page 40 On December 12, 2023, at 6:48 p.m. a service delivery note for the tabs alarm indicated R1's alarm was not working. On December 12, 2023, at 12:13 a.m. ULP care note indicated R1 had bruising on his right elbow, and left hip. On December 18, 2023, at 7:00 a.m. a fall incident report indicated R1 had an unwitnessed fall. The report indicated no alarm was in use at the time the incident occurred. The immediate action to prevent recurrence was to implement a bed alarm. The incident report indicated it was reviewed by the facility registered nurse (RN) who indicated R1's care plan was followed at the time the incident occurred despite the R1's alarm not being utilized, and no safety checks had been implemented as indicated in R1's assessment and plan of care. There was no indication any action was taken to prevent recurrence. On December 22, 2023, at 8:31 p.m. a service delivery note for the tabs alarm, staff documented N/A indicating there was no alarm utilized. On December 26, 2023, at 8:34 p.m. a service delivery note for the tabs alarm, staff documented N/A indicating there was no alarm utilized. On December 28, 2023, at 8:55 a.m. a fall incident report 10 days later indicated R1 had an unwitnessed fall, resulting in a head strike with a laceration that was bleeding. The report indicated R1's alarm was not in use at the time the incident occurred. The incident report reviewed by the facility RN who indicated R1's care plan was followed at the time of the incident despite R1's alarm not being utilized at the time, and no safety checks had been implemented as indicated in	02310		

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02310	Continued From page 41 R1's assessment and plan of care. There was no indication any action was taken to prevent recurrence. R1 service delivery of care record for safety checks indicated safety checks were not implemented until December 29, 2023, at 11:00 a.m. (52 days after admission) when R1's first safety check was documented as completed. On January 6, 2024, at 2:51 a.m. a fall progress note indicated R1 was found on the floor. The note failed to indicate R1 had any injuries. No incident report was completed. On January 6, 2024, at 7:39 a.m. another progress note indicated R1 was found in bed with blood on the floor, his hands, bedding, and staff noted R1 had a laceration on the back left side of his head. The note indicated R1 required 9 staples at the hospital to repair the injury and returned to the facility later that day. On January 20, 2024, R1's record of death indicated he died of natural causes from aspiration pneumonia, related to Parkinson's disease, and dementia. On July 15, 2024, at 1:04 p.m. ULP-D stated R1 had falls but did not recall a fall mat or audio monitoring ever being implemented. ULP-D indicated safety checks would have been provided if they were in R1's scheduled services. On July 15, 2024, at 1:20 p.m. ULP-C stated R1 was admitted with a high risk for falls. The ULP indicated the morning of the incident when R1 was found in his bed with a head laceration, there was blood all over on the floor, bedding, and resident's hands and head. ULP-C stated no one	02310		

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02310	Continued From page 42 reported R1 had fallen or was injured when she came on shift. ULP-C stated R1 had an alarm on his bed/chair, an audio alarm staff carried, scheduled safety checks, toileting every 2-3 hours, and a fall mat to reduce his risk for falls and injury. However, R1's record failed to indicate the facility implemented an audio alarm or fall mat, and there was no indication every 2-3-hour toileting was provided. On July 15, 2024, at 11:52 a.m. the licensed assisted living director (LALD)-A and LPN-B stated things were missed and not implemented with R1 to ensure his safety and prevent recurring falls and injury. The LALD indicated the staff who failed to complete an incident report when R1 fell and required staples was terminated for noncompliance with facility procedure. However, a review of personnel files provided by the facility indicated the ULP staff who was terminated 3 months after the incident with R1, was not the same staff who documented the fall incident. R1's progress notes, incident reports, and post incident follow up failed to show the incidents were reviewed to determine potential cause or contributing factors, if the R1's care plan was followed, if fall interventions were implemented at the time the incident occurred, or if new interventions were needed, and no post fall risk assessment was completed after the falls occurred. As a result, the licensee failed to identify assessed interventions including frequent safety checks, and scheduled toileting had not implemented to ensure R1's safety. Although staff repeatedly documented the chair/bed alarm tabs was not working, or was not in use, there was no indication any action was taken to ensure the concern was corrected. One staff documented 15-minute checks would be done due to the	02310		

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02310	Continued From page 43 alarm not functioning, however there was no indication 15-30 minute safety checks were provided to ensure R1's safety. R2: R2 was admitted on December 17, 2021, with diagnoses including late onset Alzheimer's disease, and chronic obstructive pulmonary disease (COPD). R2's 90-day assessment on April 1, 2024, indicated R2 was visibly short of breath (SOB) with ambulation, had chronic pain, and received medication management services. The assessment indicated a licensed nurse would monitor R2's medication supplies and reorder them as needed on a timely basis. R2's care plan - medication management section updated on July 19, 2024, indicated a licensed nurse would monitor medications usage and order refills when needed. The plan indicated if a medication was not given for any reason the staff must document in the record and notify a licensed nurse. On June 20, 2024, R2's hospice admission documentation indicated she was admitted to hospice for end of life care related to exacerbation of COPD. The hospice admission included orders for the resident to receive morphine solutab 5 mg hourly as needed (PRN) for SOB and pain. The resident's medication administration record (MAR) for June 2024, included no scheduled orders for morphine, and indicated the resident utilized the PRN morphine only 1 time that month for SOB with relief noted. On July 8, 2024, the	02310		

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02310	Continued From page 44 resident's morphine order was changed and scheduled every 6 hours for pain and SOB, and hourly PRN. On July 14, 2024, a facility registered nurse (RN)-H progress note indicated staff updated RN-H the resident would run out of morphine. The note indicated RN-H instructed staff (unknown) to contact hospice and re-order the medication. The note indicated RN-H would continue to monitor the situation, however there was no indication the RN-H followed up with staff or hospice to ensure the resident had the medication available. Later that day on July 14, 2024, at 4:57 p.m. a narcotic tracking log indicated the facility received 6 tablets of morphine logged into R2's narcotic tracking log by 2 unlicensed staff, and indicated the resident had 11 tablets available for administration. The record failed to indicate staff notified facility nursing or hospice R2 had received 6 tablets and would run out of the medication. A review of facility provided pharmacy faxes included one fax dated July 16, 2024, which indicated the resident had no refills available, and the provider was contacted. There was no indication staff followed up with R2's pharmacy, provider, or hospice to ensure R2 received her scheduled morphine as ordered. No other faxed communication was provided after R2 ran out of prescribed morphine. On July 17, 2024, at 5:50 a.m. two staff documented R2's morphine count was 0 available to administer. There was no indication staff notified facility nursing or hospice R2 had no morphine available. R2's medication	02310		

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02310	Continued From page 45 administration record (MAR) indicated at 10:22 a.m., 5:00 p.m., and 11:00 p.m. multiple staff documented they were unable to administer R2's morphine because none was available. There was no indication any of the staff notified hospice or nursing R2 had no morphine available to administer. On July 17, 2024, a triage note indicated staff reported R2 had fallen. A hospice post fall visit note indicated a hospice nurse was onsite around 7:00 p.m. to assess R2's injuries post fall, R2 denied any pain at that time. There was no indication staff notified the hospice nurse R2 had no morphine available to administer. On July 18, 2024, at 5:00 a.m., 11:00 a.m. 5:00 p.m., and 11:00 p.m. multiple staff documented in R2's medication administration record (MAR) they were unable to administer R2's morphine because none was available. There was no indication staff notified hospice or nursing R2 had no morphine to administer. On July 19, 2024, at 11:00 a.m. staff documented they were unable to administer R2's morphine because none was available. There was no indication staff notified hospice or nursing R2 had no morphine to administer. At 11:24 a.m. RN-H documented in a nurses note R2 was suffering morphine withdrawal symptoms, was diaphoretic (sweating), vomiting, and had high blood pressure from not receiving the scheduled morphine. The note indicated RN-H contacted hospice who delivered morphine to R2 immediately (STAT). A review of hospice triage notes indicated facility staff failed to inform hospice that R2 would run out of morphine, and failed to notify hospice when	02310		

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02310	Continued From page 46 R2 had no morphine available to administer. R2's MAR and administration notes indicated R2 utilized 4 doses of as needed (PRN) morphine for pain on July 19, 2024, in addition to the scheduled doses administered after the morphine was delivered to the facility. Prior to that day R2 had only utilized 1 PRN dose of morphine. On July 23, 2024, at 11:06 a.m. hospice RN-I stated she had sent a refill request for R2's morphine on July 14, 2024, but only entered a quantity of 6 tablets instead of 60 by mistake. RN-I stated she was unaware R2 had only received 6 tablets and would run out. RN-I verified no one from the facility alerted her that R2 would run out of the medication, and no one reported R2 had no medication available to administer until 2 days later after R2 suffered withdrawal symptoms. RN-I stated she was onsite daily, but staff failed to report any concern with R2 not having morphine. RN-I stated when she arrived on site to assess R2 on July 19, 2024, she was in severe pain, had elevated pulse, elevated blood pressure, tremors, was shaking, had increased anxiety/restlessness, was vomiting, and sweating. RN-I stated R2 begged and pleaded for help to feel better. RN-I stated R2 required multiple PRN doses of morphine to get her pain under control. RN-I stated the incident could have been prevented if staff had communicated R2 would run out, and when R2 had no morphine available. RN-I stated when she was informed R2 had run out of morphine and was suffering withdrawals 2 days later the medication was provided STAT. RN-I stated R2 had not fully recovered from the incident and had declined drastically since the incident occurred. On July 18, 2024, at 11:09 a.m. during email	02310		

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02310	Continued From page 47 communication RN-H indicated she was the regional RN responsible to oversee the care of residents at the facility. RN-H stated they had a RN oncall 24/7 to answer questions, triage concerns, and could be called in to refill a medication if necessary. On July 19, 2024, R2 change of condition assessment indicated R2 was aspirating when eating and drinking, and had an increased need for staff assistance with mobility, transfers, toileting, and incontinence care. On July 22, 2024, at 12:35 p.m. during a phone interview and email correspondence RN-H verified no staff at the facility notified her R2 received only 6 tablets of morphine instead of 60 on July 14, 2024, staff had not informed her R2 had run out of morphine until 2 days later when R2 aspirated while suffering withdrawal symptoms, and verified no concerns were identified or reported prior to that. RN-H denied the omission of a prescribed scheduled morphine for 2 days resulting in the resident suffering withdrawal symptoms was any fault of the licensee. RN-H stated staff were to call any time a narcotic was delivered to the facility so it could be checked in by a nurse but indicated that did not occur, as a result she was not aware R2 would run out of morphine. On July 23, 2024, at 2:16 p.m. during a phone interview R2's family member stated R2 had progressively declined since the incident and was actively dying. A licensee policy titled "Fall Prevention & Management" dated June 15, 2024, indicated the Registered Nurse (RN) would assess each resident for his/her risk for falls, design a service	02310		

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02310	Continued From page 48 plan, and implement procedures to minimize falls and/or injury. The policy defined a fall as an unintended landing on a floor or lower position not caused by a sudden major health event such as a stroke. A fall can be inferred if the fall is witnessed, if the resident is found on the floor, or if the resident states that a fall has occurred. Section A. indicated a fall risk assessment was completed on each resident on admission, annually, upon change of condition, and reviewed following a fall. Section 3. indicated a resident identified as high risk for falls at any time during his or her stay remains on the Fall Prevention interventions unless their risk assessment score declines. Section 4. Risk factors for falls included unstable gait, decreased balance, or mobility deficit (e.g., poor sitting balance), confusion and inability to communicate needs, cognitive impairment, general weakness, physical disability resulting from a medical condition (Parkinson's, cardiovascular accident (CVA), Alzheimer's disease, dementia), medications that are associated with a higher risk for falling. The policy indicated possible prevention general safety precautions and interventions should be used for all residents and including providing call system that is within easy reach and secured, use of alert wristband or necklace, use of non-slip footwear, awareness of medication side effects, providing adequate light in all rooms and common areas, using nightlight's, keeping the resident's environment free of obstacles. High risk to fall prevention strategies included evaluate resident for placement to a higher level of care, verifying that frequently used resident items are within reach, offering toileting to the resident every two hours while awake and every four hours during the night (less than four hours of rest at night increases the risk of acute confusion due to sleep deprivation), conducting resident safety checks	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20172	A. BUILDING: _____ B. WING _____	C 06/10/2024

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02310	Continued From page 49 more frequently, every 2 hours and PRN (pro re or as needed), utilizing chair and bed alarms for residents with impulsive, and napping and toileting schedules. The policy indicated if a resident falls, the following steps should be taken assess the resident post fall including vital signs (pulse, temperature, respirations, and blood pressure), inspection for bruises, swelling, and lacerations, notify RN or on-call in accordance with site guidelines, complete Head Strike Protocol as directed in RTasks if head hit during fall. The policy indicated nursing was to review and update the resident's service plan as applicable for an injured resident, complete incident report in RTasks. Section B. Risk Management Review indicated the Registered Nurse evaluates fall data to measure and analyze falls and reviews potential contributing factors and follow-up actions, based on compiled incident report data, a periodic trend summary should be provided and discussed as a team to enhance quality management/risk management. A facility policy and procedure titled "Medication Management Individualized Plan" effective August 1, 2021, indicated the licensee would maintain a current individualized medication management record for each resident based on the resident assessment that must contain the following: Section d. indicated they would identify the person responsible to monitor supplies and ensure medication refills were ordered on a timely bases. Section f. Procedures for staff to notify the RN or appropriate licensed health professional when a problem arises with medication management services. Section g. Resident specific requirements relating to documenting medications are administer as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions.	02310		

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02310	Continued From page 50 A undated facility policy and procedure titled "Medication Discrepancy (error)" indicated If a medication discrepancy occurred, staff would notify oncall, log into Rtasks and file an incident report, notify the nurse or director who would notify the resident's family and provider. A undated facility policy and procedure titled " Medication Ordering" indicated when medication was with in 7 days of running out (narcotics 2 weeks). After faxing staff put a note on it that it was faxed with the date and initial, the fax is placed in the pharmacy sheet, pending section. The policy indicated if staff come across a medication that is OUT they should call the pharmacy to inform them (or have a nurse, or manager call). If staff are unsure or have any questions, they should send a snap message in RTasks to the nurse or call the on call if it cannot wait until the nurse was in the building. A undated facility policy and procedure titled "Receiving Logging from Pharmacy" Section 5. When receiving narcotic medication call the on call nurse to inform them "I received 30 tabs of narcotic from pharmacy" and enter the medication into the narcotic log in RTasks and put the medication in the med cart. The policy indicated all narcotics must be signed into the RTasks upon delivery. If there was no director or nurse on site when a narcotic was delivered staff should call the on-call nurse. A facility policy and procedure titled "Resident Record Documentation" dated August 1, 2021, indicated staff would document medications, and services important and pertinent information relating to each resident. Section 1 indicated staff would document daily, medications, services,	02310		

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02310	Continued From page 51 treatments, or therapies provided to residents. Section 3. indicated medications administered would be documented in a resident's chart which must include the date and time of the administration. Section 4. indicated when medications, services, treatments, or therapies were not performed per the service agreement and schedule, personnel must document the reason why it was not performed or administered. Section 5 indicated tasks not performed or administered must be reported and followed up on to meet the resident's needs. Section 6. indicated other pertinent information that should be documented in a resident's chart include but are not limited to, information about change in condition, and incidents (i.e., falls or injuries). A licensee policy titled "Fall Prevention & Management" dated June 15, 2024, indicated the Registered Nurse (RN) would assess each resident for his/her risk for falls, design a service plan, and implement procedures to minimize falls and/or injury. The policy defined a fall as an unintended landing on a floor or lower position not caused by a sudden major health event such as a stroke. A fall can be inferred if the fall is witnessed, if the resident is found on the floor, or if the resident states that a fall has occurred. Section A. indicated a fall risk assessment was completed on each resident on admission, annually, upon change of condition, and reviewed following a fall. The policy indicated possible prevention general safety precautions and interventions should be used for all residents and including providing call system that is within easy reach and secured, use of alert wristband or necklace, use of non-slip footwear, awareness of medication side effects, providing adequate light in all rooms and common areas, using nightlight's, keeping the resident's environment	02310		

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02310	Continued From page 52 free of obstacles. High risk to fall prevention strategies included evaluate resident for placement to a higher level of care, verifying that frequently used resident items are within reach, offering toileting to the resident every two hours while awake and every four hours during the night (less than four hours of rest at night increases the risk of acute confusion due to sleep deprivation), conducting resident safety checks more frequently, every 2 hours and PRN (pro re or as needed), utilizing chair and bed alarms for residents with impulsive, and napping and toileting schedules. The policy indicated if a resident falls, the following steps should be taken assess the resident post fall including vital signs (pulse, temperature, respirations, and blood pressure), inspection for bruises, swelling, and lacerations, notify RN or on-call in accordance with site guidelines, complete Head Strike Protocol as directed in RTasks if head hit during fall. The policy indicated nursing was to review and update the resident's service plan as applicable for an injured resident, complete incident report in RTasks. Section B. Risk Management Review indicated the Registered Nurse evaluates fall data to measure and analyze falls and reviews potential contributing factors and follow-up actions, based on compiled incident report data, a periodic trend summary should be provided and discussed as a team to enhance quality management/risk management. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days.	02310		
02360	144G.91 Subd. 8 Freedom from maltreatment	02360		

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02360	Continued From page 53 Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: Based on interviews and document review, the licensee failed to ensure two of two residents (R1, R2) reviewed were free from maltreatment. R1 and R2 were neglected. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		