Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL20199062M
Compliance #: HL20199063C

Date Concluded: January 23, 2020

Name, Address, and County of Licensee Investigated:
Hillcrest Terrace of Chisholm
PO Box 786
Hibbing, MN 55746
Saint Louis County

Name, Address, and County of Housing with Services location:
Hillcrest Terrace, Nashwauk
507 E Platt Ave.
Nashwauk, MN 55769
Saint Louis County

Facility Type: Home Care Provider

Investigator's Name:
Kathie Siemsen, RN
Special Investigator

Finding: Substantiated, individual responsibility

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

Allegation(s):
It is alleged: The alleged perpetrator (AP) neglected the client when s/he gave a double dose of insulin which caused a drop in the client's blood sugar. This resulted in hospitalization for the client.

Investigative Findings and Conclusion:
Neglect was substantiated. The alleged perpetrator was responsible for the maltreatment. The alleged perpetrator neglected to document and report when the client refused a blood sugar check, morning insulin and breakfast. At supper time the client received scheduled insulin which cause his blood sugar to drop significantly and resulted in the client being hospitalized.

The investigation included interviews with facility staff, including nursing staff, and unlicensed staff. In addition, the investigator contacted law enforcement. The investigator observed the

clients, the facility's medication administration system. The investigator reviewed client medical records, facility policies, past incidents and employee files.

The client's diagnoses included diabetes and dementia. The client was orientated to person and sometimes orientated to place and time. The client's service plan included assistance with medication administration and blood sugar checks one time a day. The client's physician orders included blood sugar testing and Lantus (a long acting insulin) 28 units at 8:00 a.m. and Novolg (short acting) insulin 12 units at 5:00 p.m.

The medication administration record indicated at 5:00 p.m. the client received scheduled medications: an oral anti-diabetic medication and 12 units of Novolog insulin. At 5:30 p.m., the client was disorientated, irritable and lethargic. The unlicensed personnel (ULP) notified the registered nurse (RN) on-call and the RN advised the ULP to call the emergency medical service (EMS). Upon arrival of EMS, the client's blood sugar was a life threatening level of 27 (normal reference range is 70 - 99). EMS gave the client Glucagon (a medication used to increase and control blood glucose levels) and transported the client to the hospital for evaluation.

The facility records lacked documentation the AP checked the client's blood sugar at the scheduled 8:00 a.m. blood sugar check the day of the client's hospitalization.

The client's hospital record indicated the client admitted with hypoglycemia (low blood sugar) due to medication. The client's blood sugar remained unstable and he required an intravenous blood sugar solution and monitoring. The next day the client discharge back to the facility with instructions to notify the nurse of high or low blood sugar prior to giving medications and check blood sugar levels four times a day.

During an interview, the client was unable to recall and answer questions appropriately. The client was not sure when he received his insulin but thought it was at night. The client stated he trusted staff to give him the right medication.

During an interview with ULP-D, she stated the AP was responsible for checking the client's blood sugar and giving insulin on the day shift. ULP-D stated in the evening, she heard the EMS call over a scanner and contacted the AP who told her the client refused his blood sugar check and breakfast. On behalf of the AP, ULP-D went to the facility at 10:00 p.m. to fill out the change in condition report. ULP-D stated when a client refuses cares or medications, staff are supposed to contact the nurse.

The interim director of nursing (IDON) stated there was not documentation on the medication administration record of a blood glucose check or the administration of insulin that morning by the AP. The AP also did not document the client did not eat breakfast that morning. The next scheduled blood sugar check was at 8:00 p.m. The IDON stated the client would not know how much insulin he received due to dementia. The IDON stated staff should circle a refusal on the medication administration record and complete a refusal form.

The facility obtained a consulting company to manage operations and retrained all staff. The AP no longer works at the facility.

In conclusion, neglect was substantiated.

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

Vulnerable Adults interviewed: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: No, the AP failed to respond to a subpoena.

Action taken by facility:
The facility obtained a consulting company to manage operations and retrained all staff. The AP no longer works at the facility.

Action taken by the Minnesota Department of Health:

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

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

cc:
Health Regulation Division – Home Care and Assisted Living Program
The Office of Ombudsman for Long-Term Care
Nashwauk Police Department
Nashwauk City Attorney
Saint Louis County Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H20199	A. BUILDING: _____ B. WING _____	C 11/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST TERRACE OF CHISHOLM	624 SW THIRD STREET BOX 552 CHISHOLM, MN 55719

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0 000	Initial Comments ******ATTENTION****** HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, the Minnesota Department of Health issued a correction order(s) pursuant to a survey. 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: On November 21, 2019 and November 22, 2019, the Minnesota Department of Health initiated an investigation of complaint #HL20199060M, #HL20199061C, #HL20199062M, #HL20199063C, #HL20199064M, #HL20199065C. At the time of the survey, there were 51 clients receiving services under the comprehensive license. The following immediate correction orders are issued for #HL20199060M, #HL20199061C, #HL20199062M,# HL20199063C, #HL20199064M, #HL20199065C, tag identification 0325, 0805, 0860, 0935, 2015.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. 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 surveyors' 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 144A.474 SUBDIVISION 11 (b)(1)(2)	
0 325	144A.44, Subd. 1(14) Free From Maltreatment Subdivision 1. Statement of rights. A person who receives home care services has these rights:	0 325		

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0 325	Continued From page 1 (14) the right to be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act; This MN Requirement is not met as evidenced by: Based on observations, interviews, and document review, the facility failed to ensure seven of seven clients reviewed (C1, C2, C3, C4, C5, C6, C7) were free from maltreatment. C1 was neglected. C2, C3, C4, C5, C6 and C7 were financially exploited. Findings include: On January 23, 2020, the Minnesota Department of Health (MDH) issued a determination that neglect and financial exploitation occurred, and that an individual staff persons were responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	0 325	No plan of correction is required. Please see MDH public maltreatment report for details.	
0 805 SS=E	144A.479, Subd. 6(a) Reporting Maltrx of Vulnerable Adults/Minors Subd. 6. Reporting maltreatment of vulnerable adults and minors. (a) All home care providers must comply with requirements for the reporting of maltreatment of minors in section 626.556 and the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. Each home care	0 805		

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0 805	Continued From page 2 provider must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to report financial exploitation (drug diversion) to the Minnesota Adult Abuse Reporting Center (MAARC) immediately and no longer than 24 hours 6 of 7 clients (C2, C3, C4, C5, C6, C7) reviewed. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety), and was issued at a pattern scope (when more than a limited number of clients are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). C2's medical record was reviewed. C2's diagnoses included closed displaced fracture of the right femur, anemia, sick sinus syndrome, chronic kidney disease and low back pain. C2 would take prescribed medications as ordered and be comfortable and free from pain. C2 also had visual difficulties. The licensee's internal investigation dated November 4, 2019, and November 5, 2019, indicated two of C2's Hydrocodone (an opioid pain medication) in C2's pill case did not appear to be Hydrocodone. C2 received Hydrocodone 5/325 milligrams (mg) three times a day at 7:00 a.m. 3:00 p.m. and 11:00 p.m. It was determined	0 805		

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0 805	Continued From page 3 the medication in C2's pill case was Tylenol 325 mg (the dosage bought over the counter). The investigation also brought up additional concerns with other residents' medications. During the investigation there was concerns expressed with an unlicensed personnel (ULP)-E who had been passing medications. C3's medical record was reviewed. C3's diagnoses included diabetes, neuropathy, lumbago with sciatica and right peripheral field vision cut. C3 received Tylenol #3 (Tylenol with codeine) one tablet by mouth at 2:00 p.m. and 8:00 p.m. C3's narcotic log indicated dated October 23, 2019, indicated ULP-E and ULP-G signed out two Tylenol #3 tablets for C3. When facility staff compared ULP-G's initials to her previous initials, the initials did not match. On October 28, 2019, the narcotic log indicated ULP-E signed out two Tylenol #3 tablets for C3 and lacked a second staff witness initials. C3's medication administration record (MAR) dated October 2019 lacked documentation on October 28, 2019 for the 2:00 p.m. dose of Tylenol #3. The October MAR also indicated C3 had been refusing the 2:00 p.m. dose of Tylenol #3 since October 4, 2019. On October 24, 2019, the MAR indicated ULP-H gave C3 Tylenol #3 at 2:00 p.m. The internal investigation dated November 4, 2019 and November 5, 2019, indicated on November 5, 2019 ULP-H stated she did not give C3 the Tylenol #3 at 2:00 p.m. as C3 had been refusing the 2:00 p.m. dose. C4's medical record was reviewed. C4's diagnoses included diabetes, anxiety, dementia, depression and macular degeneration.	0 805		

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0 805	Continued From page 4 The internal investigation dated November 4, 2019 and November 5, 2019, indicated C4 had an order for Tylenol #3 by mouth every eight hours as needed for pain. C4's narcotic log dated October 29, 2019, at 1:30 p.m. indicated ULP-E and ULP-H signed out two tablets of Tylenol #3 for C4. ULP-H saw that her initials were on the narcotic log and reported to the facility manager that the initials on the log were not signed by ULP-H. In addition, C4's Tylenol #3 order directed to give one tablet and ULP-E signed out two. C5's medical record was reviewed. C5's diagnoses included dementia, anxiety, depression, Parkinson's disease and osteoporosis. The internal investigation dated November 4, 2019 and November 5, 2019, indicated C5 had an order for Narco (an opioid) 5/325 mg two tablets twice a day as needed for pain. The narcotic log indicated ULP-E signed out the Narco on October 5, 2019, at 8:30 p.m., October 7, 2019, at 1:30 p.m. cosigned by ULP-H and October 21, 2019, at 2:00 p.m. On October 29, 2019, at 8:30 a.m. the narcotic log indicated ULP-H signed out the Narco. ULP-H reported to the facility manager that on October 17, 2019, and October 29, 2019, that the initials on those dates were not hers. In addition, C5 reported she had not taken the Narco for weeks. C6's medical record was reviewed. C6's diagnoses included Depression knee pain, chest wall pain, anxiety and arthritis. The internal investigation dated November 4, 2019 and November 5, 2019, indicated C6 had an order for Tramadol (an opioid) 50 mg one	0 805		

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0 805	Continued From page 5 tablet twice daily as needed for pain. The narcotic log indicated ULP-E signed out the Tramadol on October 16, 2019, and cosigned by ULP-H and on October 18, 2019, and cosigned by ULP-I. ULP-H and ULP-I reported the initials were not theirs. On November 5, 2019, at 3:30 p.m. the internal investigation was reported to the police department and to the MAARC. The Findings for C7: C7's medical record was reviewed. C7's diagnoses included osteoarthritis, lumbar degenerative disk disease, Alzheimer's disease, dementia, anxiety and depression. C7 had an order for Percocet (an opioid) 5/325 mg one tablet mouth every 12 hours for pain as needed. C7's MAR dated March 2019 indicated C7 received Percocet on March 2, 2019, March 3, 2019, March 12, 2019 and March 18, 2019. The internal Investigation worksheet indicated the internal report was made to the executive director on March 25, 2019 at 4:15 p.m. The nature and the description of the incident indicated the client's medications were set up on March 1, 2019, by RN-M. A concern was reported that the pills in C7's pill case for Percocet was Tylenol 325 mg. The section indicating the date, time and person making a report to the common entry point was blank. In addition, the signature and date of the investigator and the director of operations were also blank. The Summary of Investigative Findings confirmed that the three remaining pills in the controlled substance pill case were Tylenol 325 mg and not the Percocet that was set up by the RN-M on March 1,2019.	0 805		

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0 805	Continued From page 6 Staff confirmed their initials were not recorded by them and noted to be in ULP-L's handwriting. During an interview on November 21, 2019 at 5:37 p.m., the interim director of nursing (IDON) stated the facility where C2, C3, C4, C5 and C6 reside, the medications previously came from the pharmacy in bottles and the nurses set up the medications in pill boxes. Now the medications come on cards in bubble packs. The drug diversion occurred before the new system was put into place. The drug diversion was discovered on Friday November 1, 2019. The previous DON did the investigation and did not report until to the state agency until November 5, 2019. The IDON thought the former DON had reported it but investigated first and then reported the drug diversion. During an interview on November 22, 2019, at 1:06 p.m., the IDON stated at the facility where C7 resided have the same narcotic system as where C2, C3, C4, C5 and C6 reside. Changes have been put into place regarding counts, two staff sign out the narcotics, shift to shift narcotic counting, the medications come in bubble packs and if there were any problems staff let the on call nurse know. The facilities will be getting lock boxes, using keys instead of codes. The IDON further verified the incident occurred in March 2019, when the new system was not in place and not reported to the state agency until August 2019. Then it was the former DON who had been let go. The facility's Vulnerable Adult Reporting and Investigation policy dated August 9, 2019, indicated upon hearing the description of the incident of which appears to be suspected abuse, neglect or financial exploitation the facility would	0 805		

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0 805	Continued From page 7 make a report to the common entry point (CEP) immediately. Immediately means as soon as possible but no longer than 24 hours of knowledge of the incident. TIME PERIOD OF CORRECTION: Seven (7) days.	0 805		
0 860 SS=E	144A.4791, Subd. 8 Comprehensive Assessment and Monitoring Subd. 8. Comprehensive assessment, monitoring, and reassessment. (a) When the services being provided are comprehensive home care services, an individualized initial assessment must be conducted in person by a registered nurse. When the services are provided by other licensed health professionals, the assessment must be conducted by the appropriate health professional. This initial assessment must be completed within five days after initiation of home care services. (b) Client monitoring and reassessment must be conducted in the client's home no more than 14 days after initiation of services. (c) Ongoing client monitoring and reassessment must be conducted as needed based on changes in the needs of the client and cannot exceed 90 days from the last date of the assessment. The monitoring and reassessment may be conducted at the client's residence or through the utilization of telecommunication methods based on practice	0 860		

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0 860	Continued From page 8 standards that meet the individual client's needs. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the licensee failed to complete a pain assessment for 5 of 7 clients (C2, C3, C4, C6, C7) after the licensee discovered the clients' pain medications were diverted. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety), and was issued at a pattern scope (when more than a limited number of clients are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). C2's medical record indicated C2's diagnoses included pain related to closed displaced fracture of the right femur low back pain. C2's service plan dated July 18, 2019, indicated C2 would take prescribed medications as ordered to be comfortable and free from pain. C2 also had visual difficulties. The licensee's internal investigation drug diversion findings related to C2 dated November 4, 2019, and November 5, 2019, indicated two of C2's Hydrocodone (an opioid pain medication) in C2's pill case did not appear to be Hydrocodone. C2 received Hydrocodone 5/325 milligrams (mg) three times a day at 7:00 a.m. 3:00 p.m. and 11:00 p.m. It was determined the medication in C2's pill case was Tylenol 325 mg (the dosage bought over the counter). The investigation also brought up additional concerns with other clients' medications.	0 860		

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0 860	Continued From page 9 C2's medical record lacked a pain assessment after November 1, 2019. C3's medical record indicated C3's diagnoses included pain related to diabetes with diabetic neuropathy and lumbago with sciatica. C3's service plan dated July 18, 2019, indicated C3 would take prescribed medications as ordered. The internal investigation dated November 4 and 5, 2019, indicated C3 received Tylenol #3 (Tylenol with codeine) one tablet by mouth at 2:00 p.m. and 8:00 p.m. C3's narcotic log dated October 23, 2019 indicated unlicensed personnel (ULP)-E and ULP-G signed out two Tylenol #3 tablets for C3. When facility staff compared ULP-G's initials to her previous initials, the initials did not match. On October 28, 2019, the narcotic log indicated ULP-E signed out two Tylenol #3 tablets for C3. The narcotic log lacked a second staff witness initials. The medication administration record (MAR) dated October 2019, lacked documentation on October 28, 2019, for the 2:00 p.m. dose. The October MAR also indicated C3 had been refusing the 2:00 p.m. dose of Tylenol #3 since October 4, 2019. On October 24, 2019, the MAR indicated ULP-H gave C3 Tylenol #3 at 2:00 p.m. On November 5, 2019, ULP-H stated she did not give C3 the Tylenol #3 at 2:00 p.m. as C3 had been refusing the 2:00 p.m. dose. C3's medical record lacked a pain assessment after November 1, 2019. During an interview on November 21, 2019 at 4:00 p.m., C3 stated she only took the one Tylenol #3 at night for left leg pain. C3 stated she had refused the 2:00 p.m. scheduled dose for about three weeks. C3 had the morning Tylenol	0 860		

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0 860	Continued From page 10 #3 discontinued also. C3 trusts that the staff would give her the correct medication. C4's medical record indicated C4's diagnoses included pain related to anemia, anxiety, diabetes, osteoarthritis, dementia and depression. C4's service plan dated July 18, 2019, indicated C4 would take prescribed medications as ordered. The internal investigation dated November 4 and 5, 2019, indicated C4 had an order for Tylenol #3 by mouth every eight hours as needed for pain. On October 29, 2019, at 1:30 p.m. the narcotic log indicated ULP-E and ULP-H signed out two tablets of Tylenol #3 for C4. ULP-H saw her initials were on the narcotic log and reported to the facility manager that the initials on the log were not signed by herself. In addition, C4's Tylenol #3 order directed to give one tablet and ULP-E signed out two. C4's medical record lacked a pain assessment after November 1, 2019. During an interview on November 21, 2019, at 4:45 p.m. C4 stated he did not know what medications he was taking but did know he was getting pain medications. C4 stated he has not had any additional or any out of the ordinary pain. C4 trusts the staff would provide him with the correct medications at the right dose. C6's medical record indicated C6's diagnoses included pain related to knee pain, chest wall pain, arthritis, lower leg pain and low back pain. C6's service plan dated July 18, 2019, indicated C6 would take prescribed medications as ordered.	0 860		

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0 860	Continued From page 11 The internal investigation dated November 4 and 5, 2019, indicated C6 had an order for Tramadol (an opioid) 50 mg one tablet twice daily as needed for pain. The narcotic log indicated ULP-E signed out the Tramadol on October 16, 2019 cosigned by ULP-H and on October 18, 2019 cosigned by ULP-I. ULP-H and ULP-I reported the initials were not theirs. C6's medical record lacked a pain assessment after November 1, 2019 . C7's medical record indicated C7's diagnoses included pain related to dementia, Alzheimer's disease, anxiety, osteoarthritis and degenerative disk disease. C7's service plan dated July 30, 2019, indicated C7 would take prescribed medications as ordered. C7 had an order for Percocet (an opioid) 5/325 mg one tablet mouth every 12 hours for pain as needed. C7's MAR dated March 2019, indicated C7 received Percocet on March 2, 3, 12, 18, 2019. The internal investigation worksheet indicated the internal report was made to the executive director on March 25, 2019 at 4:15 p.m. The nature and the description of the incident indicated the client's medications were set up on March 1, 2019, by RN-M. Staff reported a concern the pills in C7's pill case for Percocet was Tylenol 325 mg. The drug diversion 'Summary of Investigative Findings' indicated after reviewing client records and meeting with each staff individually it was confirmed by the staff which initials were fraudulently recorded by ULP-L. It was confirmed that the three remaining pills in the controlled substance pill case were Tylenol 325 mg and not the Percocet that was set up by the RN-M on	0 860		

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0 860	Continued From page 12 March 1, 2019. C7's medical record lacked a pain assessment after March 2, 2019. During an interview on November 22, 2019, at 1:00 p.m., C7 stated she had back pain and takes pain medication only when it "hurt bad." C7 did not know the name of the pain medication or what it looked like. C7 trusted the staff to give her the right medication as ordered. During an interview on November 21, 2019 at 5:37 p.m., the interim director of nursing(IDON) did not know if pain assessments were done after the discovery of the drug diversion to ensure C2, C3, C4, C6, C7 were not having unnecessary pain. During that timeframe it was the former DON responsibility, who had been let go. The IDON further stated staff would be reviewing all clients' pain medications and for pain in both facilities. The licensee's Change in Condition policy dated July 6, 2019, indicated the registered nurse (RN) would complete an assessment for a change in condition and communicate with the physician TIME PERIOD OF CORRECTION: Seven (7) days.	0 860		
0 935 SS=G	144A.4792, Subd. 8 Documentation of Administration of Medication Subd. 8. Documentation of administration of medications. Each medication administered by comprehensive home care provider staff must be documented in the client's record. The documentation	0 935		

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0 935	Continued From page 13 must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the client's needs when medication was not administered as prescribed and in compliance with the client's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure the refusal of medications was documented in the medical record for 1 of 7 clients (C1). This resulted in C1 being hospitalized. This practice resulted in a level three violation (a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of clients are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). C1's medical record indicated C1's diagnoses included diabetes and dementia. C1 was orientated to person and sometimes orientated to	0 935		

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0 935	Continued From page 14 place and time. C1's service plan dated July 18, 2019 indicated C1 received assistance with medication set up and administration, blood glucose reading one time a day, and monitored safety for C1. The facility investigation indicated on November 3, 2019, C1's orders included at 8:00 a.m. blood glucose testing and 28 units (u) of Lantus (long acting) insulin and at 5:00 p.m. 12 u of Novolog (fast acting) insulin. The medication administration record (MAR) indicated there was no administration entry for the 8:00 a.m. Lantus insulin or the blood glucose testing. Per the Resident Concern Form (non-emergency) dated November 3, 2019, unlicensed personnel (ULP)-D did not notify the facility C1 refused to eat breakfast and therefore did not receive 8:00 a.m. Lantus insulin until 10:10 p.m. The investigation concluded this may tie into the recent effect with C1's blood sugar when C1 refused breakfast, insulin and blood sugar check on that morning and then at 5:00 p.m. C1 received 12 u of Novolog insulin from the evening ULP. At 5:30 p.m. the ULP observed C1 sitting in the second floor living room. C1 was disorientated, irritable and lethargic. The ULP immediately called the registered nurse (RN) on call and reported C1's status. The RN advised the ULP to call the emergency medical service (EMS). Upon arrival, EMS checked C1's blood glucose and it was 27 (normal reference range is 70 - 99). EMS transported C1 to the emergency room for evaluation. C1's hospital record dated November 3, 2019, indicated C1's diagnosis was hypoglycemia (low blood glucose) due to medication. C1 received an oral diabetes medication at 5:00 p.m. followed by short acting insulin. C1 was admitted to the	0 935		

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0 935	Continued From page 15 hospital for observation and blood glucose control. C1 received an intravenous sugar solution. C1 discharged back to the facility the next day. During an interview on November 21, 2019 at 5:00 p.m., the facility manager (ULP-B) stated C1 refused his insulin two times that morning and ULP-E and ULP-D did not report it to the nurse. C1 was then given insulin and his blood sugar dropped. ULP-D came into the facility at 10:00 p.m. to fill out the report after hearing the EMS call to the facility on the scanner. ULP-B further stated directions on when to call the nurse was on the MAR. During an interview on November 21, 2019 at 5:27 p.m., the interim director of nursing (IDON) stated the progress notes were vague. There was not documentation on the MAR of a blood glucose check or the administration of insulin that morning by ULP-E. C1 did not eat breakfast either that morning. The next scheduled blood glucose check was at 8:00 p.m. C1 did receive a scheduled dose of insulin at supper time. C1 did not go to the dining room for supper and when staff went to look for C1, C1 was found on the couch in the living room. C1 was confused and lethargic. The staff notified the on call nurse and was directed to call EMS. When EMS arrived they checked C1's blood glucose and it was 27. While in the emergency room C1 commented he received a double dose of insulin. The IDON stated C1 would not know how much insulin he received due to dementia. Since being in the hospital, C1's blood glucose was checked after eating. The incident report indicated C1 refused the blood glucose check and the insulin but nothing was documented on the MAR. The IDON stated refusals should be circled on the MAR and	0 935		

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0 935	Continued From page 16 a refusal form should have been filled out. The refusal form was in place at the time C1 refused the blood glucose check and the insulin. The IDON further stated the incident report was filled out later that evening after C1 went to the hospital. Parameters were in place at that time which should have been something that was called in. During an interview on January 21, 2020 at 9:36 a.m. ULP-D stated ULP-E was responsible for obtaining C1's blood glucose and administering C1's insulin. ULP-D was not aware C1 had refused the blood glucose testing and the insulin until later in the day and C1 had a habit of refusing. When C1 refused staff would get another staff and they would try to get C1 to comply. Sometimes C1 was cooperative and sometimes C1 continued to refused. When a client refused medications staff were to notify the building supervisor. AP-D was not notified that day by AP-E. AP-D became aware from another coworker that C1 was in the hospital. Then it became known C1 did not get his insulin. ULP-D verified after finding out from her coworker that was when she went into the facility at 10:00 p.m. and filled out the change of condition report. The facility's Change in Resident Condition policy dated July 6, 2019, indicated the registered nurse would be notified of condition changes that included decreased appetite and refusal of cares. The Documentation of Medication Reminders, Medication Assistance and Medication Administration policy dated 2/2010, indicated medication administration would be documented on the MAR by ULP's initials under the date the medication was administered. The ULP would chart on each MAR any problems associated with the medication administration. This included	0 935		

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0 935	Continued From page 17 refusals and to notify the nurse immediately. TIME PERIOD OF CORRECTION: Seven (7) days	0 935		
02015 SS=E	626.557, Subd. 3 Timing of Report Subd. 3. Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has	02015		

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02015	Continued From page 18 been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to report financial exploitation (drug diversion) to the Minnesota Adult Abuse Reporting Center (MAARC) immediately and no longer than 24 hours 6 of 7 clients (C2, C3, C4, C5, C6, C7) reviewed. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety), and was issued at a	02015		

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02015	Continued From page 19 pattern scope (when more than a limited number of clients are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). C2's medical record was reviewed. C2's diagnoses included closed displaced fracture of the right femur, anemia, sick sinus syndrome, chronic kidney disease and low back pain. C2 would take prescribed medications as ordered and be comfortable and free from pain. C2 also had visual difficulties. The licensee's internal investigation dated November 4, 2019, and November 5, 2019, indicated two of C2's Hydrocodone (an opioid pain medication) in C2's pill case did not appear to be Hydrocodone. C2 received Hydrocodone 5/325 milligrams (mg) three times a day at 7:00 a.m. 3:00 p.m. and 11:00 p.m. It was determined the medication in C2's pill case was Tylenol 325 mg (the dosage bought over the counter). The investigation also brought up additional concerns with other residents' medications. During the investigation there was concerns expressed with an unlicensed personnel (ULP)-E who had been passing medications. C3's medical record was reviewed. C3's diagnoses included diabetes, neuropathy, lumbago with sciatica and right peripheral field vision cut. C3 received Tylenol #3 (Tylenol with codeine) one tablet by mouth at 2:00 p.m. and 8:00 p.m. C3's narcotic log indicated dated October 23, 2019, indicated ULP-E and ULP-G signed out two Tylenol #3 tablets for C3. When facility staff compared ULP-G's initials to her previous initials,	02015		

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02015	Continued From page 20 the initials did not match. On October 28, 2019, the narcotic log indicated ULP-E signed out two Tylenol #3 tablets for C3 and lacked a second staff witness initials. C3's medication administration record (MAR) dated October 2019 lacked documentation on October 28, 2019 for the 2:00 p.m. dose of Tylenol #3. The October MAR also indicated C3 had been refusing the 2:00 p.m. dose of Tylenol #3 since October 4, 2019. On October 24, 2019, the MAR indicated ULP-H gave C3 Tylenol #3 at 2:00 p.m. The internal investigation dated November 4, 2019 and November 5, 2019, indicated on November 5, 2019 ULP-H stated she did not give C3 the Tylenol #3 at 2:00 p.m. as C3 had been refusing the 2:00 p.m. dose. C4's medical record was reviewed. C4's diagnoses included diabetes, anxiety, dementia, depression and macular degeneration. The internal investigation dated November 4, 2019 and November 5, 2019, indicated C4 had an order for Tylenol #3 by mouth every eight hours as needed for pain. C4's narcotic log dated October 29, 2019, at 1:30 p.m. indicated ULP-E and ULP-H signed out two tablets of Tylenol #3 for C4. ULP-H saw that her initials were on the narcotic log and reported to the facility manager that the initials on the log were not signed by ULP-H. In addition, C4's Tylenol #3 order directed to give one tablet and ULP-E signed out two. C5's medical record was reviewed. C5's diagnoses included dementia, anxiety, depression, Parkinson's disease and osteoporosis. The internal investigation dated November 4,	02015		

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02015	Continued From page 21 2019 and November 5, 2019, indicated C5 had an order for Narco (an opioid) 5/325 mg two tablets twice a day as needed for pain. The narcotic log indicated ULP-E signed out the Narco on October 5, 2019, at 8:30 p.m., October 7, 2019, at 1:30 p.m. cosigned by ULP-H and October 21, 2019, at 2:00 p.m. On October 29, 2019, at 8:30 a.m. the narcotic log indicated ULP-H signed out the Narco. ULP-H reported to the facility manager that on October 17, 2019, and October 29, 2019, that the initials on those dates were not hers. In addition, C5 reported she had not taken the Narco for weeks. C6's medical record was reviewed. C6's diagnoses included Depression knee pain, chest wall pain, anxiety and arthritis. The internal investigation dated November 4, 2019 and November 5, 2019, indicated C6 had an order for Tramadol (an opioid) 50 mg one tablet twice daily as needed for pain. The narcotic log indicated ULP-E signed out the Tramadol on October 16, 2019, and cosigned by ULP-H and on October 18, 2019, and cosigned by ULP-I. ULP-H and ULP-I reported the initials were not theirs. On November 5, 2019, at 3:30 p.m. the internal investigation was reported to the police department and to the MAARC. The Findings for C7: C7's medical record was reviewed. C7's diagnoses included osteoarthritis, lumbar degenerative disk disease, Alzheimer's disease, dementia, anxiety and depression. C7 had an order for Percocet (an opioid) 5/325	02015		

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HILLCREST TERRACE OF CHISHOLM	624 SW THIRD STREET BOX 552 CHISHOLM, MN 55719

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02015	Continued From page 22 mg one tablet mouth every 12 hours for pain as needed. C7's MAR dated March 2019 indicated C7 received Percocet on March 2, 2019, March 3, 2019, March 12, 2019 and March 18, 2019. The internal Investigation worksheet indicated the internal report was made to the executive director on March 25, 2019 at 4:15 p.m. The nature and the description of the incident indicated the client's medications were set up on March 1, 2019, by RN-M. A concern was reported that the pills in C7's pill case for Percocet was Tylenol 325 mg. The section indicating the date, time and person making a report to the common entry point was blank. In addition, the signature and date of the investigator and the director of operations were also blank. The Summary of Investigative Findings confirmed that the three remaining pills in the controlled substance pill case were Tylenol 325 mg and not the Percocet that was set up by the RN-M on March 1,2019. Staff confirmed their initials were not recorded by them and noted to be in ULP-L's handwriting. During an interview on November 21, 2019 at 5:37 p.m., the interim director of nursing (IDON) stated the facility where C2, C3, C4, C5 and C6 reside, the medications previously came from the pharmacy in bottles and the nurses set up the medications in pill boxes. Now the medications come on cards in bubble packs. The drug diversion occurred before the new system was put into place. The drug diversion was discovered on Friday November 1, 2019. The previous DON did the investigation and did not report until to the state agency until November 5, 2019. The IDON thought the former DON had reported it but investigated first and then reported the drug diversion.	02015		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H20199	A. BUILDING: _____ B. WING _____	C 11/22/2019

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02015	Continued From page 23 During an interview on November 22, 2019, at 1:06 p.m., the IDON stated at the facility where C7 resided have the same narcotic system as where C2, C3, C4, C5 and C6 reside. Changes have been put into place regarding counts, two staff sign out the narcotics, shift to shift narcotic counting, the medications come in bubble packs and if there were any problems staff let the on call nurse know. The facilities will be getting lock boxes, using keys instead of codes. The IDON further verified the incident occurred in March 2019, when the new system was not in place and not reported to the state agency until August 2019. Then it was the former DON who had been let go. The facility's Vulnerable Adult Reporting and Investigation policy dated August 9, 2019, indicated upon hearing the description of the incident of which appears to be suspected abuse, neglect or financial exploitation the facility would make a report to the common entry point (CEP) immediately. Immediately means as soon as possible but no longer than 24 hours of knowledge of the incident. TIME PERIOD OF CORRECTION: Seven (7) days.	02015		