DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL208553003M
Compliance #: HL208553040C

Date Concluded: June 6, 2024

Name, Address, and County of Licensee Investigated:
Central Minnesota Senior Care, Inc.
619 Benson Ave. SW
Willmar, MN 56201
Kandiyohi County

Facility Type: Home Care Provider

Evaluator's Name: Erin Johnson-Crosby, 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 facility neglected the client when unlicensed personnel (ULP) administered the client incorrect medications, resulting in hospitalization.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility was aware medication administration protocols were not followed by facility staff prior to the incident. A medication error occurred, and the client was hospitalized and received treatment for hypotension. Following the error, the facility failed to identify causative factors contributing to the breakdown of the facility's medication management process and failed to implement interventions to prevent further occurrence.

The investigator conducted interviews with home care agency staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record(s), hospital records, internal investigation, incident reports, personnel files, staff

schedules, and related policies and procedures. Also, the investigator observed the medication administration process.

The client received comprehensive home care services in their home. The client's diagnoses included depression, hypertension, and seizure disorder. The client's service plan included assistance with medication administration three times per day and behavior monitoring. The client's assessment indicated the client was alert and oriented and the home care agency was responsible for all aspects of medication management.

The facility's internal investigation indicated unlicensed personnel (ULP) pre-set up three different client medications and put the client's initials on each medication cup. The ULP did not look at the medication cup prior to administration and administered the incorrect medications to the client. When the ULP became aware of the medication error, the ULP attempted to contact the on-call nurse at 8:24 a.m., the house nurse at 8:25 a.m., and the manager on-call at 8:26 a.m. The investigation indicated the program director called the ULP back at 9:27 a.m. The ULP stated that at the time she was the only staff member working and had numerous other medications to pass. The investigation indicated the RN did not call the ULP back until 9:55 a.m. The investigation included that the ULP and/or the program director did not think to call poison control, 911, or the hospital while waiting for the RN to call back. The RN directed the program director to contact the emergency room (ER) and ER staff instructed them to send the client to the hospital for further evaluation.

The client arrived at the ER approximately two and half hours after receiving the medications. Emergency department records indicated that the client had received five antihypertensives (medications to lower blood pressure). The client felt lightheaded and could not stand without feeling like she was going to faint. ER documentation indicated that the client's blood pressures were "in the 80's and 90's" and the client's normal blood pressure was the 170 range. The client was treated for hypotension (low blood pressure), administered intravenous (IV) fluids, hospitalized overnight, and returned home the next afternoon.

During an interview, the ULP stated she set up three different client medication cups and brought them all into the client's room. The ULP stated that she didn't look at the name on the cup before she gave them to the client. The ULP stated that pre-setting up medications was a normal practice at the facility, as there was only one staff member scheduled in the morning. When the ULP went to give the other client their medications, she noticed the initials were incorrect on the medication cup. The ULP immediately called the licensed practical nurse (LPN), the program director, and the on-call nurse but nobody answered. The ULP stated the program director contacted her around 9:30 a.m. but did not provide any direction. The ULP stated the nurse did not call back until around 10:00 a.m. The ULP stated that no one came to the site to help her; she was the only staff working and had other clients that required services and medication administration. The ULP stated when the registered nurse (RN) returned her call, the RN told the ULP to check the client's blood pressure and it was around 80/50 (normal is 120/80) and the client complained of being dizzy and lightheaded. The ULP did not inform the

client she received incorrect medications at that time. The RN then directed staff to contact the ER to see if the client should be sent to the hospital. ER staff directed the ULP to call 911 and have the client sent to the hospital due to the client's current symptoms and low blood pressure reading.

During an interview, the licensed practical nurse (LPN) stated she was aware ULP pre-set up medications since there was so much to do in the morning and only one staff was scheduled. The LPN stated that ULP could pre-set up medications if the medications were put in an envelope with the client's name, but this would not ensure that medications were administered correctly. The LPN stated on the day the incident occurred, the ULP text her about the medication error at 8:09 a.m., however, the LPN was not working that day and did not see the text message until later that evening. The LPN stated she did not believe that a RN came in to the facility to train or competency test the ULP to ensure proper medication administration after the error occurred.

During an interview, the RN did not remember missing a call that morning and did not remember what time she called the ULP back. The RN said she directed staff to have the client was sent to the ER. The RN was not aware that it was a common practice to pre-set up medications at this site and stated that this practice was "not a good idea, too much room for error." The RN stated she had not re-trained or re-educated staff and had not followed up with the client since the incident occurred.

During an interview, the client recalled that morning that the ULP came in to give her pills around 7:30 or 8:00 a.m. A little while later, the client began feeling dizzy and wobbly. The client recalled that the ULP came back later and checked her blood pressure, but did not explain the reason for it. Around 10:00 a.m., an ER nurse called and told her she had been given the incorrect medications. The client initially told the ER nurse she had the correct medications, since the ULP had not informed her about the medication error. The client said the ER nurse encouraged her to go to the ER since she was dizzy, and her blood pressure was low. The client stated that the ambulance arrived around 10:15 a.m.; she spent one night in the hospital and received IV fluids. The client stated that she now checks her medications to make sure she is receiving the correct medications.

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 626.5572, subdivision 17
"Neglect" means neglect by a caregiver or self-neglect.

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

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: No, VA declined for family to be interviewed
Alleged Perpetrator interviewed: Not applicable

Action taken by facility:
The program director verbally told staff to not pre-set up medications.

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
Kandiyohi County Attorney
Willmar City Attorney
Willmar Police Department
Minnesota Board of Nursing

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H20855	A. BUILDING: ______ B. WING ______	C 04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL MN SENIOR CARE INC	619 BENSON AVE SW WILLMAR, MN 56201

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0 000	Initial Comments ******ATTENTION****** HOME CARE PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482 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: #HL208553040C/#HL208553003M On April 11, 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 26 clients receiving services under the provider's Comprehensive Home Care license. The following correction order is issued/orders are issued for ##HL208553040C/#HL208553003M, tag identification 0325, 0790, 0805, 0935, and 1215.	0 000	Home Care Provider 144A. Minnesota Department of Health is documenting the State 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 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	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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0 000	Continued From page 1	0 000	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(a)(14) Free From Maltreatment 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: The facility failed to ensure one of one client reviewed (C1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the agency was responsible for the maltreatment, in connection with incidents which occurred. Please refer to the public maltreatment report for details.	0 325	No plan of correction is required for this tag.	
0 790 SS=F	144A.479, Subd. 3 Quality Management The home care provider shall engage in quality management appropriate to the size of the home care provider and relevant to the type of services the home care provider provides. The quality management activity means evaluating the quality of care by periodically reviewing client services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to clients. Documentation about quality	0 790		

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0 790	Continued From page 2 management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in quality management activities appropriate to the size of the home care provider and relevant to the type of services provided. This had the potential to affect all clients and staff. 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, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the clients). The findings include: On April 11, 2024, at 4:30 p.m., the investigator requested the licensee's quality management minutes. On April 16, 2024, the investigator emailed licensed assisted living director (LALD)-D requesting the licensee's quality management minutes. On April 18, 2024, at 1:30 p.m., LALD-D stated the licensee had the program director go through and review a checklist at each site. The investigator again requested the quality management minutes for the last year.	0 790	Home Care Provider 144A. Minnesota Department of Health is documenting the State 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 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	

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0 790	Continued From page 3 The licensee's quality management minutes were not provided by the licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 790	REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144A.474 SUBDIVISION 11 (b)(1)(2).	
0 805 SS=D	144A.479, Subd. 6(a) / 626.557, Subd. 3 Reporting Maltrx of Vulnerable Adults/Minors (a) All home care providers must comply with requirements for the reporting of maltreatment of minors in chapter 260E and the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. Each home care provider must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or	0 805		

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0 805	Continued From page 4 (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment of neglect for one of one client (C1) with records reviewed.	0 805		

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0 805	Continued From page 5 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, 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 clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: C1 admitted to home care services on May 16, 2016, with diagnoses including depression, hypertension, and seizure disorder. C1's service plan dated November 4, 2021, indicated C1 required assistance with medication administrator three times daily, and behavior monitoring. C1's assessment dated March 29, 2024, indicated C1 was sent to the emergency room after a medication discrepancy where C1 was administered someone else's medications. C1 was hospitalized overnight. The assessment indicated facility staff would provide all aspects of medication administration. The assessment indicated staff would administer medications per prescriber orders. Nurses will periodically review documentation activities and verify effectiveness of systems to ensure safe handling and administration. The assessment indicated staff would notify a nurse promptly if there was a problem with medication management. Staff should contact the house nurse during normal business hours Monday through Friday and the on-call registered nurse (RN) on evenings, overnight, weekends, and holidays.	0 805		

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0 805	Continued From page 6 C1's progress notes dated March 27, 2024, indicated C1 received another client's medications. C1's blood pressure was 83/53 and C1 felt dizzy and was taken to the emergency room around 10:30 a.m. The licensee's incident/accident report form dated March 27, 2024, at 8:09 a.m., completed by unlicensed personnel (ULP)-A, identified she gave C1 the wrong medications and C1 was dizzy when she was sitting down. ULP-A noted she called the manager on call, house nurse and on call nurse. The licensee's incident/emergency report document dated March 28, 2024, completed by a quality assurance staff member, indicated on March 27, 2024, at 8:05 a.m., ULP-A administered another residents medications to C1. C1 was brought to the emergency room and kept in the hospital overnight. The form indicated retraining on the vulnerable adult and medication management policy would be reviewed. The document indicated licensed practical nurse (LPN)-B was contacted by ULP-A on March 27, 2024, at 8:30 a.m. Emergency department records dated Marcy 27, 2024, at 10:48 a.m., indicated C1 was given another clients medications including five antihypertensives (blood pressure medications). C1 began feeling light headed and could not stand without feeling like she was going to faint. C1's blood pressures were in the 80's and 90's with a normal blood pressure in the 170's. C1 was given intravenous fluids but continued to feel lightheaded. C1 was hospitalized over night. The licensee reported the incident to the state	0 805		

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0 805	Continued From page 7 agency on March 28, 2024, at 11:10 a.m., and March 29, 2024, at 1:50 p.m., both of which were after the required timeline of within 24 hours. On April 18, 2024, at 1:30 a.m., licensed assisted living director (LALD)-D stated she was aware a MAARC report was not made within 24 hours and the staff member responsible for reporting alleged maltreatment was re-trained after the incident. The licensee's undated Reporting of Maltreatment of Vulnerable Adults indicated a mandated reporter who had reason to believe that a vulnerable adult was being or had been maltreated, or who had knowledge that a vulnerable adult had sustained a physical injury which was not reasonably explained "shall immediately report the information to the CEP [common entry point], but no longer than 24 hours from the time of the initial knowledge of the incident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 805		
0 935 SS=G	144A.4792, Subd. 8 Documentation of Administration of Medication Each medication administered by comprehensive home care provider staff must be documented in the client'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	0 935		

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0 935		0 935		

Continued From page 8

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 accurate administration of prescribed medication orders for one of one client (C1) reviewed for medication errors. An unlicensed staff administered the wrong medications to C1. C1 was hospitalized for hypotension (low blood pressure). Licensed staff were aware unlicensed staff were pre-setting up medications prior to the incident and continued this practice after the incident occurred.

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 an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include

C1 admitted to home care services on May 16, 2016, with diagnoses including depression, hypertension, and seizure disorder.

C1's service plan dated November 4, 2021, indicated C1 required assistance with medication administrator three times daily, and behavior monitoring.

0 935 | 0 935

Continued From page 9

C1's assessment dated March 29, 2024, indicated C1 was sent to the emergency room after a medication discrepancy where C1 was administered someone else's medications. C1 was hospitalized overnight. The assessment indicated facility staff would provide all aspects of medication administration. The assessment indicated staff would administer medications per prescriber orders. Nurses will periodically review documentation activities and verify effectiveness of systems to ensure safe handling and administration. The assessment indicated staff would notify a nurse promptly if there was a problem with medication management. Staff should contact the house nurse during normal business hours Monday through Friday and the on call registered nurse (RN) on evenings, overnight, weekends, and holidays.

C1's progress notes dated March 27, 2024, indicated C1 received another client's medications. C1's blood pressure was 83/53 and C1 felt dizzy and was taken to the emergency room around 10:30 a.m.

The licensee's incident/accident report form dated March 27, 2024, at 8:09 a.m., completed by unlicensed personnel (ULP)-A, identified she gave C1 the wrong medications and C1 was dizzy when she was sitting down. ULP-A noted she called the manager on-call, the house nurse, and on-call nurse who did not initially answer the calls.

The licensee's incident/emergency report document dated March 28, 2024, completed by a quality assurance staff member, indicated on March 27, 2024, at 8:05 a.m., ULP-A administered another residents medications to C1. C1 was brought to the emergency room and

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 935	Continued From page 10 kept for observation over night. The form indicated re-training on the vulnerable adult and medication management policy would be reviewed. The document indicated licensed practical nurse (LPN)-B was contacted by ULP-A on March 27, 2024, at 8:30 a.m. Emergency department records dated Marcy 27, 2024, at 10:48 a.m., indicated C1 was given another clients medications including five antihypertensives (blood pressure medication). C1 began feeling light headed and could not stand without C1 feeling like she was going to faint. C1's blood pressures were in the 80's and 90's with a normal blood pressure in the 170's. C1 was given intravenous fluids but continued to feel lightheaded. C1 was hospitalized over night. The licensee's internal investigation dated April 27, 2024, indicated the ULP pre-set up three client medications and put the client's initials on each medication cup. The ULP did not look at the medication cups before administration and administered the incorrect medications to C1. When the ULP became aware of the medication error, the ULP attempted to contact the on-call nurse at 8:24 a.m., the house nurse at 8:25 a.m., the manager on call at 8:26 a.m. The investigation indicated the program director called the ULP back at 9:27 a.m. The ULP stated at the time she was the only staff working and had numerous other medications to pass. The investigation indicated the RN did not call the ULP back until 9:55 a.m. The investigation indicated the ULP, or program director, did not think to call poison control, 911, or the hospital, while waiting for the RN to call back. The RN later directed the program director to contact the emergency room (ER) and ER staff instructed staff to send the client to the hospital.	0 935		

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	H20855	A. BUILDING: ______ B. WING ______	C 04/11/2024

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0 935	Continued From page 11 On April 11, 2024, at 2:00 p.m., ULP-A stated on the morning of March 27, 2024, she set up three different client medications. ULP-A then went to C1's room to give her pills and did not look at the name on the cup. ULP-A then went to administer the other client's medications and noticed C1's name on the medication cup and realized she gave C1 the wrong medications. ULP-A stated she called or text the LPN, the program director, and the on-call nurse but nobody answered. ULP-A stated she did not receive a call back until around 10:00 a.m., almost two hours after the medications were given. ULP-A stated the program director contacted the nurse and the nurse told ULP-A to check C1's blood pressure and then call the ambulance. C1's blood pressure was 80/50 (normal range 120/80) and C1 complained of being dizzy. ULP-A stated she continued to administer medications that shift and the next morning without any re-training or education completed. ULP-A stated the LPN re-trained her around noon the next day but the RN never observed her administer medications. On April 11, 2024, at 4:30 p.m., LPN-B stated ULP-A text her on March 27, 2024, at 8:09 a.m., but LPN-B was not working that day and did not see the text message until later that evening. LPN-B stated ULP-A was usually a good medication passer but was having bad luck lately. LPN-B stated some staff pre-set up medications in an envelope with the client's name and then administered the medications. LPN-B stated if multiple clients medications were set up for administration there would be no way to ensure medications were not given to the incorrect client. LPN-B stated pre-setting up medications occurred because there was so much to do in the morning and only one staff was scheduled.	0 935		

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0 935	Continued From page 12	0 935		

LPN-B stated that maybe there should be two staff in the morning and thought that might help. LPN-B stated she came in around noon the next day and observed ULP-A administer one medication to a client following the incident as her re-training of ULP-A.

On April 11, 2024, at 1:00 p.m., registered nurse (RN)-E stated she was not the site RN even though her name and number was listed as the RN in charge. RN-E stated over the last four months she had been on site about two to three times. RN-E stated she was called on March 27, 2024, but was not sure what time she was called. RN-E stated the program director called her and requested she come and assess C1 since the client was given the wrong medications. RN-E told the program director C1 needed to go to the hospital. RN-E stated there had not been a facility RN since January 2024. RN-E stated staff should not pre-set up medications for multiple clients as there would be "too much room for error."

On April 11, 2024, at 4:10 p.m., C1 stated on March 27, 2024, the ULP came in to give her pills around 7:30 or 8:00 a.m. A little while later, she began feeling dizzy and wobbly but did not know why. The client stated a while later the ULP came back and checked her blood pressure, but the ULP did not tell her why. Around 10:00 a.m., an ER nurse called and told her she had been given the incorrect medications. The client told the ER nurse she had recieved the correct medications because she had not yet been informed of the medication error. The client said the nurse encouraged her to go into the ER since she was dizzy, and her blood pressure was low. The client stated the ambulance arrived shortly after that around 10:15 a.m. The client stated she spent one night in the hospital and received IV fluids.

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0 935	Continued From page 13 The client stated she now checks her medications to make sure she is receiving the correct medications. The licensee's undated Medication Management policy indicated all medication errors will be reviewed to investigate how they may have occurred and may include any medical or nursing care that was provided, client outcomes, and any ongoing client monitoring. Educations and training will be provided to staff who were involved in the error. If the medications error was completed by a nurse, the investigation and training will be completed by another nurse. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 935		
01215 SS=G	144A.4797, Subd. 1(c) Readily Available Contact Person (c) The appropriate contact person must be readily available either in person, by telephone, or by other means to the staff at times when the staff is providing services. This MN Requirement is not met as evidenced by: Based on interview and document review the licensee lacked a contact person readily available in person, by telephone, or by other means to the staff at times when staff are providing services, when unlicensed personnel (ULP) administered t incorrect medications to a client (C1). The ULP's inital attempts to contact facility nursing and management staff were unsuccessful and the registered nurse (RN) was not available for over	01215		

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01215	Continued From page 14	01215		

an hour and a half. This had the potential to affect all 26 clients receiving services.

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 an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

On April 11, 2024, at 12:30 p.m., the investigator observed a sign on a bulletin board that listed multiple staff with phone numbers.

The licensee's incident/accident report form dated March 27, 2024, at 8:09 a.m., completed by unlicensed personnel (ULP)-A, identified she gave C1 the wrong medications and C1 was dizzy when she was sitting down. ULP-A noted she called the manager on call, the house nurse, and on-call nurse. ULP-A's calls were not answered.

The licensee's incident/emergency report document dated March 28, 2024, completed by a quality assurance staff member, indicated on March 27, 2024, at 8:05 a.m., ULP-A administered another client's medications to C1. C1 was brought to the emergency room and kept for observation over night. The form indicated the vulnerable adult and medication management policy would be reviewed. The document indicated licensed practical nurse (LPN)-B was contacted by ULP-A on March 27, 2024, at 8:30 a.m.

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01215	Continued From page 15 Emergency department records dated Marcy 27, 2024, at 10:48 a.m., indicated C1 was given another client's medications including five antihypertensives (blood pressure medications). C1 began feeling light headed and could not stand without feeling like she was going to faint. C1's blood pressures were in the 80's and 90's with a normal blood pressure in the 170's. C1 was given intravenous fluids but continued to feel lightheaded. C1 was hospitalized over night. The licensee's internal investigation dated April 17, 2024, indicated on March 27, 2024, ULP-A contacted the on call nurse at 8:24 a.m.,, the house nurse at 8:25 a.m., the manager on call at 8:26 a.m., and sent the medication error form to the program director (unlicensed staff) via email around 8:30 a.m. The investigation indicated the program director called ULP-A back at 9:27 a.m. Between 9:27 a.m., and 10:12 a.m., ULP-A and the program director exchanged four phone calls. ULP-A stated at that time she was the only staff working and had numerous other medications to pass. The investigation indicated the registered nurse (RN) called back at 9:55 a.m. On April 18, 2024, at 12:45 p.m., ULP-G (quality investigator) stated she did not know why the RN did not answer the phone on the morning of March 27, 2024. ULP-G stated she was not aware until April 17, 2024, that the RN did not answer the phone at the time of the incident. On April 18, 2024, at 1:30 p.m., licensed assisted living director (LALD)-D stated she was not aware until the investigator was onsite that the RN or on call staff did not answer the phone after the medication error occurred. LALD-D stated after the onsite visit, the licensee had assigned one RN to the facility. LALD-D was not aware of why	01215		

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01215	Continued From page 16 the on call staff did not answer their phone on March 27, 2024, and identified facility wide training had not been completed since the incident. LALD-D stated after the onsite investigation the licensee now has a designated RN for the site. The licensee lacked a policy which addressed availability of identified contact person. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01215		