Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL244277025M
Compliance #: HL244273232C

Date Concluded: July 20, 2023

Name, Address, and County of Licensee Investigated:
Diamond Willow of Baxter
14396 Grand Oaks Drive
Baxter, MN 56425
Crow Wing County

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

Evaluator's Name: Barbara Axness, 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 resident when the facility failed to ensure a system was in place to ensure availability of medication refills and failed to administer medication in accordance with physician orders.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility had no system in place to ensure medication was available and administered as prescribed. When a medication error was identified, the resident's physician was not notified of the error and the resident was not monitored for potential adverse effects of missing the medication. The facility failed to evaluate and identify a root cause of the error, failed to identify causative factors contributing to the breakdown of the facility's medication management system, and failed to implement interventions to prevent further occurrence.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted the physician. The investigation included review of medical records, assessments, care plans, medication administration records, and progress notes. At the time of the onsite visit, the investigator observed staff providing resident cares and the facility's medication administration process.

The resident resided in an assisted living memory care unit. The resident's diagnoses included hypertension (high blood pressure) and Multiple Sclerosis. The resident's service plan included assistance with dressing, grooming, bathing, repositioning, toileting, transfer assistance with two staff and a mechanical lift, and medication administration. The resident's assessment indicated the resident required anticoagulant (blood thinning medication) therapy and received Brilinta (an antiplatelet medication that can help prevent blood clots) per prescriber orders and had a history of heart valve replacement.

The resident's physician orders contained an order for Brilinta, 90 milligrams (mg) twice per day.

Review of the resident's medication administration record (MAR) indicated nine doses of Brilinta were missed over a five-day period. The medication was documented as out of stock and not available. During this time, one dose of the medication was marked as administered, however was not administered, as no medication was available.

The resident's record contained documentation of two separate messages sent via fax. The first fax, sent the day after the Brilinta ran out, was marked "Urgent" with a request for the physician at the cardiology clinic to send a refill to the resident's pharmacy. The fax did not indicate the medication was out and did not include notification of the resident's missed doses. No response was noted from the prescriber and the record included no evidence of additional attempts made to contact the provider.

A second fax was sent four days later, notifying the physician of the missed Brilinta doses. The fax did not include a request for response or action from the prescriber and contained no report of any adverse effects observed due to the missed medication. The resident's record contained no documentation of additional efforts made to contact the physician's office.

A medication error report was not completed on the resident's nine missed doses of Brilinta.

Five days after the medication ran out, a new order for Brilinta was obtained and signed by a provider associated with a different health system.

A formal complaint was filed with the facility regarding the resident's missed Brilinta medication. On the form, the complaint indicated "the resident ran out of medication, Brilinta…. this was a 90-day supply, and he should have had a refill request sent in sooner. His prescription is for a 90-day supply, and it has been four and a half months since last fill." The medication

error complaint was reviewed by the licensed assisted living director (LALD) and the registered nurse (RN); however, no investigation was completed to identify the reason of the error, the breakdown in the facility's medication management and refill system, or how to prevent further medication errors from occurring.

During an interview, the LALD confirmed the resident's Brilinta medication wasn't ordered in time, the medication ran out, and a doctor needed to sign for the medication to be refilled. The LALD indicated the prescription should have been reordered prior to the medication running out. The LALD further indicated a medication error form should have been completed related to the missed medication. The LALD verified there was no documentation of follow-up completed after the error was identified but indicated the facility did complete an analysis of how the error occurred and how it could be prevented moving forward. The LALD was questioned about why the facility's identified refill date was different from the refill date of the 90-day supply but was not able to provide an answer.

During an interview, the registered nurse (RN) confirmed a medication error form was not completed despite the resident missing several days of medications and the medication documented as administered, when no supply of the medication was available. The RN was not familiar with Brilinta or potential adverse effects of the medication. The RN stated they later discovered the original prescriber of the Brilinta was no longer working at the clinic where the refill request and notification faxes were sent. The RN confirmed she did not receive a reply to the messages and was not sure if the fax about the missed doses was received or reviewed by anyone at the clinic. The RN indicated a different provider from a different health system refilled the medication, but the facility did not update the new provider of the missed Brilinta doses because the provider had already been updated by the resident's family. The RN thought the provider would know that the facility was out of medication as they sent a request for a refill. The RN was asked about the facility's process to ensure medication availability, as several additional residents were noted to be out of various medications. The RN stated, "I have voiced my concerns, I can't do my nurse duties when I'm on the floor, but I can't not be on the floor helping." The RN was told by management "it's going to get better when we get staff" and felt the facility had an appropriate medication reordering process. The RN expressed that she felt the current facility medication review process was also working well. The RN was asked why several resident MARs identified various medications were not administered due to being unavailable, and replied, "I couldn't tell you why meds are still running out."

During an interview with administrative staff at the cardiologist's office, staff stated they were made aware of the need for a Brilinta refill by the pharmacy and had a different provider sign for the refill the next day. An administrative staff member indicated their office received no notification from the facility about the need for a refill or any missed Brilinta doses stating, "at no point do I see any notes the facility reached out to us."

During an interview, the resident's family member stated while visiting one day, they noticed the resident was administered seven pills instead of his usual eight. When she came to visit the

resident a few days later, she again observed seven instead of eight pills administered. When she asked staff about the resident's eighth pill, she was told he was out of his Brilinta. The staff was not sure how long the medication had been out but told the family the empty bottle was on the RN's desk. The family member asked the RN why the medication wasn't ordered earlier and was told that she [the RN] had been too busy. The family member indicated the medication should have run out well before it did and asked if the resident had been getting the wrong dosage. The RN told the family the medication was checked off as given in the medication record, so he [the resident] must have been given it. The family was also told since the licensed practical nurse (LPN) responsible for reordering medications was no longer employed there, there was nothing they [the facility] could do about it.

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: No due to cognitive impairement
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
No action taken.

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

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

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

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

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

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Crow Wing County Attorney
Baxter City Attorney
Baxter Police Department
Minnesota Board of Executives for Long Term Services and Supports
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24427	A. BUILDING: _____ B. WING _____	R-C 06/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMOND WILLOW OF BAXTER	14396 GRAND OAKS DRIVE BAXTER, MN 56425

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{0 000}	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL244277025M #HL244273232C #HL244273984M/#HL244276603C On June 29, 2023, through June 30, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 15 residents receiving services under the provider's Assisted Living with Dementia Care license. On June 29, 2023, through June 30, 2023, the Minnesota Department of Health conducted a licensing order follow-up related to correction orders for complaints: #HL244273984M, #HL244276603C issued on January 9, 2023, reissued on March 29, 2023, and May 18, 2023. The following correction orders are re issued for #HL244273984M/#HL244276603C tag identification 0470, 0510, 1760.	{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 License 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 144G.31 subd. 1, 2, and 3.	

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{0 000}	Continued From page 1 The following correction order is issued for #HL244273984M/#HL244276603C tag identification 2320. The following correction orders are issued for #HL244277025M #HL244273232C tag identification 0620, 1760, 2360, 3000.	{0 000}		
{0 470} SS=I	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions;	{0 470}		

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{0 470}	Continued From page 2 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide sufficient/competent staffing to adequately meet resident needs for six of six residents (R2, R10, R11, R13, R14, R15) with records reviewed. 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 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 residents). The findings include: On June 29, 2023, from 5:20 p.m. through 11:05 p.m., the investigator observed the unlicensed personnel (ULP) working on the Scandia household unit. At the time of the observations, there were eight residents on the unit. There was one ULP working primarily on the Scandia household unit, one ULP working primarily on the Fjord household unit, and a float ULP who provided assistance on both the Scandia and Fjord household units. R2 R2's diagnoses included multiple systems atrophy (a nervous system disease that causes trouble moving, paralysis of the vocal cords, and breathing problems), hypotension (low blood pressure), and chronic pain. R2's unsigned, undated, service plan indicated the resident received assistance with toileting,	{0 470}		

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{0 470}	Continued From page 3 repositioning, eating, bed mobility, and medication administration. The resident required two people with a mechanical lift for transfers. R2's most recent assessment, dated May 18, 2023, indicated the resident required assist of two staff with cares for check/change of incontinence product upon rising, after meals, at bedtime, and during rounding at night, as needed. R2 was noted to be dependent on staff to check and change her incontinence product every two to three hours. The assessment further indicated staff were to monitor for incontinence every two to three hours and as needed. The resident had a pressure ulcer on her coccyx. The resident's preferred bedtime was 10 p.m. to 11 p.m. On June 29, 2023, at 5:20 p.m., R2 was observed sitting in a broda chair in front of the TV in the common area. On June 29, 2023, at 6:20 p.m., R2 was observed sitting in a broda chair in front of the TV in the common area. On June 29, 2023, at 7:15 p.m., R2 was observed sitting in a broda chair in front of the TV in the common area. On June 29, 2023, at 8:30 p.m., R2 was observed sitting in a broda chair in front of the TV in the common area. During observations during these times, R2 was not offered repositioning and not offered to have her incontinence product checked and/or changed. On June 29, 2023, at 8:50 p.m., ULP-R and ULP-V brought R2 to her room. A mechanical lift	{0 470}		

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{0 470}	Continued From page 4 was used to transfer the resident from her chair to the bed. When the resident was lifted from the chair, the investigator could smell a strong urine smell. The disposable soaker pad on the chair was observed to be saturated with urine. ULP-V stated they would have to get a new transfer sling as the sling that was under the resident was saturated with urine. ULP-R stated, "I have to wash my hands again because I definitely touched something." Another transfer sling was brought to the room, however ULP-R stated since so many were in the wash, they had to use a commode sling as that was the only one that was clean. R2 was moved to the bed to change her brief. The brief was saturated with urine and the resident had also had a bowel movement. Peri cares were completed with wipes. A wound dressing was observed on the resident's coccyx but was not changed. The resident was not offered any evening cares, her teeth were not brushed, and clean clothes were not put on. A new disposable soaker pad was placed on the resident's broda chair and the resident was put back in the chair and brought back out to the TV in the common area. R2 was observed to sit in the same spot from 9:00 p.m. until 11:05 p.m., when the investigator exited the facility. R2's Service Recap Summary for the evening shift on June 29, 2023, did not have any documentation entered for the toileting task, oral cares, grooming assistance, or dressing assistance. The documentation indicated repositioning and wound care was completed. R10 R10's diagnoses included schizoaffective disorder, bilateral leg weakness, and peripheral	{0 470}		

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{0 470}	Continued From page 5 polyneuropathy (a condition impacting the central nervous system that can cause weakness, numbness, and pain) R10's undated, unsigned, service plan indicated the resident received assistance with dressing, grooming, bathing, medication administration, and required two people with a mechanical lift for transfers. R10's most recent assessment, dated May 8, 2023, indicated the resident would be toileted every two to three hours and as needed. Staff were to assist with managing the resident's incontinence care and were to monitor every two to three hours. The resident's preferred bedtime was 9:00 p.m. On June 29, 2023, at 6:20 p.m., ULP-R administered medications to R10. R10 was observed sitting in her broda chair in her room watching TV. ULP-R stated they would be back to help her get ready for bed. On June 29, 2023, at 7:00 p.m., R10 was observed sitting in her broda chair in her room watching TV. On June 29, 2023, at 9:20 p.m., R10 stated she wanted to go to bed. On June 29, 2023, at 9:40 p.m. R10 pushed her call light and requested to go to bed. ULP-V told the resident they were "running a bit short that night," but offered to help get the resident started until the float ULP was able to come help. On June 29, 2023, at 9:45 p.m., ULP-R entered the room to assist ULP-V with R10's evening cares. R10's dentures were brushed but staff	{0 470}		

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{0 470}	Continued From page 6 were not able to locate pajamas so the resident was offered a clean shirt to wear to bed. A sign on the resident's bathroom door was observed to read, "Friendly reminder for PM cares: teeth/dentures cleaned, hands/face washed, hand/foot or shoulder massage." R10 was offered a washcloth for her face. A cream was applied by ULP-R. A mechanical lift was used to transfer the resident from the broda chair to the bed. When the resident was lifted from the chair, the investigator could smell a strong urine smell. The surface of the broda chair was observed to be wet. The resident's pants had a large urine stain on them. The resident's incontinence product was observed to be saturated with urine. On June 29, 2023, at 10:05 p.m., ULP-V was asked if this was how a typical night went and ULP-V confirmed this was a pretty average night and how it usually goes. ULP-V was asked if it was normal for several residents to be soaked through their pants and ULP-V stated that "yes, sometimes that can happen." During observations during these times, R10 was not offered repositioning or offered to have her incontinence product checked and changed. R10's Service Recap Summary for the evening shift on June 29, 2023, did not have any documentation entered for the toileting task. The documentation indicated repositioning was completed, as well as offloading to prevent skin breakdown. R11 R11's diagnoses included late onset Alzheimer's disease with behavioral disturbance, vascular dementia without behavioral disturbance, and failure to thrive.	{0 470}		

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{0 470}	Continued From page 7 R11's undated, unsigned, service plan indicated the resident received assistance with dressing, grooming, bathing, mobility, toileting, transfers, and medication administration. R11's most recent assessment, dated June 24, 2023, indicated staff were to assist the resident with brushing teeth, hair and other grooming/hygiene needs and monitor for completion and appropriateness of tasks. Staff were to toilet the resident per the service plan. The assessment indicated the resident was "independent on going to bed." The resident was noted to need assistance of one staff member with a gait belt for transfers. On June 29, 2023, at 5:30 p.m., R11 was observed sitting at the dining room table with a family member. On June 29, 2023, at 6:25 p.m., R11 was observed with a family member who assisted the resident back to her room. On June 29, 2023, at 7:25 p.m., R11 was observed to be sleeping in bed. On June 29, 2023, at 8:30 p.m., R11 was observed to be sleeping in bed. ULP-V brought R11 her evening medications. On June 29, 2023, at 10:35 p.m., R11 was observed to be sleeping in bed. During observations during these times, R11 was not offered cares or asked if she needed to use the bathroom. R11's Service Recap Summary for the evening	{0 470}		

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{0 470}	Continued From page 8 shift on June 29, 2023, did not have any documentation entered for any of the evening tasks, including safety checks, repositioning, toileting, dressing, oral care, or removing compression stockings. R13 R13's diagnoses included mild cognitive impairment, delirium, and failure to thrive. R13's unsigned service plan, last updated June 2, 2023, indicated the resident received assistance with dressing, grooming, bathing, transfers, toileting, and medication administration. The service plan indicated the resident received assistance with toileting three times per day. R13's most recent assessment, dated June 28, 2023, indicated the resident required assistance of two with a gait belt and staff were to assist with toileting and assistance of brief change(s) upon rising, before lunch, after lunch, before dinner, after dinner, before bedtime, and 3 times during the NOC [night] shift. The assessment indicated the resident "likes to toilet himself in the night. Staff to leave bathroom light on so resident knows where bathroom is located in room." The assessment did not identify a preferred bed time, just that the resident naps throughout the day. R13's care plan indicated the resident required "significant transfer assist" and two staff would assist with a gait belt. The resident was noted to have "limited assistance with toileting (resident does more than staff) Note: Assist of 2..." On June 29, 2023, at 7:05 p.m., R13 was observed sitting in a chair in his room. The lights were off and the resident's TV was on. The resident's shirt appeared to have various stains	{0 470}		

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DIAMOND WILLOW OF BAXTER	14396 GRAND OAKS DRIVE BAXTER, MN 56425

(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
{0 470}	Continued From page 9 from the evening meal on it. The resident appeared tired and stated, "I want to go to bed." On June 29, 2023, at 7:25 p.m., R13 was observed sleeping in a chair in his room. The lights were off and the resident's TV was on. On June 29, 2023, at 7:45 p.m., R13 was observed sleeping in a chair in his room. The lights were off and the resident's TV was on. On June 29, 2023, at 8:05 p.m., R13 yelled out to the investigator as she was walking down the hall. R13 stated, "Please help, I'm dying here." The resident stated he wanted to go to bed. The resident was still sitting in a chair in his room with the lights off and the TV on. On June 29, 2023, at 8:25 p.m., ULP-V brought medications to R13. R13 stated, "Can we get some men in here to move me?" ULP-V asked the resident if he wanted to go to bed and the resident said yes, he wanted to go to bed. ULP-V told the resident she would come back to get him to bed. On June 29, 2023, at 9:25 p.m., R13's bedroom door was observed to be closed. The investigator knocked and entered the room. R13 was observed sitting in his chair. R13 stated, "Can you get me out of here, they keep shutting the door, I'm captured here. I'd like to go to bed." The investigator provided reassurance and left the door open per his request. R13 was still wearing his soiled clothing. On June 29, 2023, at 10:05 p.m., R13 was observed sleeping in a chair in his room. The lights were off and the resident's TV was on. The resident was still wearing his soiled clothing.	{0 470}		

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{0 470}	Continued From page 10 On June 29, 2023, at 10:10 p.m., ULP-V was observed washing dishes in the kitchen. On June 29, 2023, at 10:35 p.m., R13 was observed sleeping in a chair in his room. The lights were off and the resident's TV was on. The resident was still wearing his soiled clothing. On June 29, 2023, at 10:40 p.m., ULP-V completed rounds with the incoming night shift staff. During observations during these times, R13 was not offered cares or the opportunity to use the bathroom. R13's Service Recap Summary for the PM shift on June 29, 2023, was not completed. Hourly safety checks from 3:00 p.m. through 10:00 p.m. were not documented. Oral care was documented as declined on the PM shift by the night shift ULP. Activities of daily living assistance for grooming, mobility/walking, bed mobility, dressing assistance, transfer assistance, and motion and tab alarms for the PM shift was documented by the night shift ULP and included the following notes from the overnight ULP: Resident said don't turn that damn thing on [motion alarm], so staff didn't turn it on so as to not agitate the resident. Previous staff said he was wandering a lot on pm shift and kept taking his tab alarm off himself and when he got into bed he sleeps with no shirt on so there is nothing to clip the alarm onto. Resident likes to sleep in just his brief so there is no way to clip the alarm onto him. Resident was put into bed by NOC staff, he didn't have any clean washcloths so staff used cleaning wipes to get his peri area but was unable to thoroughly clean the rest of his body due to	{0 470}		

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{0 470}	Continued From page 11 lack of clean supplies, but resident was comfortably in bed and lights out at 11 pm. Resident gets kind of agitated with the motion alarm and likes to hide it from staff so it wasn't on. Noc staff assisted as best they could with peri cares and didn't have enough clean supplies to be able to thoroughly clean his upper half (not any clean wash cloths in his bathroom) On June 29, 2023, at 10:45 p.m., the investigator asked ULP-W if it was normal for R13 to still be out of bed this late. ULP-W stated the resident often won't go to bed until 2:00 a.m. and typically resists cares. The other night shift aide, ULP-X entered the resident's room and confirmed R13 will often refuse cares and stated he is very stubborn at times. ULP-X stated the resident can usually take himself to the bathroom if needed. The investigator told both staff members the resident had not been offered any cares on the evening shift, had not refused any cares and noted the resident had not been toileted since at least 7:00 p.m. The staff members then asked R13 if he needed to use the bathroom and R13 stated, "no, I have already gone four times." The investigator suggested for staff to utilize a different approach and again mentioned the resident had not been offered any cares or toileting for several hours. ULP-W and ULP-X assisted the resident to stand up. A large wet spot was observed on the resident's pants and on his chair. On June 29, 2023, at 10:55 p.m., the resident was brought to the toilet and an incontinence product, saturated with dark yellow urine, was removed from the resident's pants and thrown in the garbage. The investigator asked ULP-X what cares should be offered to a resident before bed. ULP-X stated full cares would include peri cares	{0 470}		

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{0 470}	Continued From page 12 with a washcloth, brush hair, brush teeth, wash face, wash arm pits, and put on pajamas. The investigator told both staff members none of this had been completed or offered to the resident. A clean brief was placed on the resident. No cares were offered or completed. The resident was walked to his bed. When the resident entered his bed at 10:55 p.m., he stated he was "comfortable and grateful." R14 R14's diagnoses included stage 4 pancreatic cancer, weight loss, and a gait disturbance. R14's service plan, dated June 6, 2023, indicated the resident received assistance with dressing, grooming, bathing, oral cares, repositioning, toileting, transfers, and medication administration. R14's most recent assessment, dated June 26, 2023, indicated the resident was independent with mobility, transfers, bed mobility, dressing, and toileting. On June 29, 2023, at 5:50 p.m., R14 was observed sitting in her bed eating supper. On June 29, 2023, at 8:00 p.m., R14 was observed sitting in her bed. The resident's head of bed was elevated and the resident's feet were observed to be pressed against the footboard. On June 29, 2023, at 8:20 p.m., ULP-V brought medication to R14. On June 29, 2023, at 9:35 p.m., ULP-V went back to see if R14's medication had been effective. On June 29, 2023, at 10:40 p.m., during rounds	{0 470}		

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{0 470}	Continued From page 13 with the incoming night shift, R14 was observed to be sitting in her bed wearing the same shirt she was wearing earlier that evening. During observations during these times, R14 was not offered any cares or assistance with getting out of bed. R14's Service Recap Summary for the evening shift on June 29, 2023, did not have any documentation entered for any of the evening tasks, including safety checks, repositioning, toileting, dressing, or oral cares. R15 R15's diagnoses included irritable bladder, unspecified retention of urine, anxiety disorder, dementia, and adult failure to thrive. R15's unsigned, undated, service plan indicated the resident received assistance with dressing, grooming, bathing, oral cares, repositioning, toileting, transferring, catheter cares, and medication administration. R15's most recent assessment, dated May 8, 2023, indicated staff were to assist with grooming and hygiene every morning and bedtime. Staff were to ensure the resident received a partial bed bath with cares including face, hands, armpits, chest, abdominal folds, legs, feet, and peri area. The resident was noted to be an assist of two staff and a gait belt. Staff were to also assist the resident with catheter cares. The resident was noted to be incontinent of bowels and staff were to check and change every two to three hours and as needed. The resident's preferred bed time was 7:00 p.m. to 8:00 p.m.	{0 470}		

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{0 470}	Continued From page 14 On June 29, 2023, at 5:20 p.m., R15 was observed sitting in her bed. On June 29, 2023, at 7:45 p.m., ULP-V brought medications to R15. On June 29, 2023, at 7:55 p.m., ULP-V changed the resident's brief in bed. ULP-V did not ask if the resident wanted to be repositioned or get out of bed. ULP-V had a catheter but was wearing an incontinent product for bowel movements. The resident had a bowel movement in her incontinence product. ULP-V changed the resident's incontinent product but did not offer any evening cares or change the resident's clothing. On June 29, 2023, at 10:35 p.m., R15 was observed sitting in her bed. On June 29, 2023, at 10:40 p.m., during rounds with the incoming night shift, R15 was observed to be sitting in her bed wearing the same shirt she was wearing earlier that evening. R15's catheter bag was noted to have not been emptied during the evening shift. ULP-V emptied the catheter collection bag after being prompted to do so by the night shift staff and confirmed about 650 milliliters of dark yellow urine was in the bag. During observations during these times, R15 was not offered cares, turning and repositioning, or have her incontinence product checked. R15's Service Recap Summary for the evening shift on June 29, 2023, did not have any documentation entered for any of the evening tasks, including safety checks, repositioning, toileting, dressing, or oral cares. There was a task to monitor urine output but no task directing staff to empty the resident's catheter bag or enter	{0 470}		

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{0 470}	Continued From page 15 the output. The task was not documented and was left blank. On June 30, 2023, at 11:15 a.m., clinical nurse supervisor (CNS)-K stated all residents should have morning and evening cares done and those cares would include washing faces, brushing teeth, changing in to pajamas, and peri cares. CNS-K was told the investigator did not observe any instances of full evening cares being offered or completed, to six of the eight residents observed on June 29, 2023. CNS-K stated that would be abnormal and the times she has worked the floor on the evenings, all cares were completed. CNS-K stated some residents are independent and don't need any assistance but staff should be double checking to make sure they got ready for bed. CNS-K stated it was the expectation that staff would toilet or check and change residents every two to three hours. CNS-K stated they had some complaints regarding the overnight staff not toileting residents or changing their incontinence product so they're soaked but she didn't have any concerns regarding the evening shift. CNS-K stated they have been trying to staff more and add an evening household coordinator but "on average, about three staff per week are quitting, it's been great fun." CNS-K stated once they're fully staffed, things should get better. On June 30, 2023, 11:51 a.m., ULP-Y stated this was her first time working at this location and was from another facility. ULP-Y stated the residents receive "pretty basic cares," and ULP-Y did not receive orientation to residents before her shift that morning. On June 30, 2023, at 12:25 p.m., licensed assisted living director (LALD)-U stated they had	{0 470}		

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{0 470}	Continued From page 16 heard some concerns about residents not getting full cares or being found saturated in urine, but it hasn't been on a consistent basis. LALD-U stated she or another nurse would review the charts when complaints were received and they'd "go back and see if the resident declined cares that night and there was documentation to follow up on that to be true, due to the resident making that decision." LALD-U was asked if staff were trained on how to approach residents with dementia and was given the example of R13 telling the night shift staff he had used the bathroom four times already when he had not been offered toileting assistance, required two people to transfer, and was soaked through his pants and if that would be considered a refusal of care from R13. LALD-U stated the topic of approaching a resident would be reviewed at their next staff meeting. LALD-U confirmed residents should be toileted or checked and changed every two hours. LALD-U stated all staff should have orientation to the facility and residents prior to providing direct care to residents. LALD-U was not aware ULP-Y had not received orientation before working today. On July 6, 2023, at 2:00 p.m., CNS-K stated it would be an expectation for staff to complete charting at the end of their shift and staff had been educated they need to do it. CNS-K stated many of the issues mentioned by the investigator were refusals from the resident and "I don't need to do much of a follow up if they decline night cares, they have the right to refuse it, we can't make them let us." CNS-K was asked about the specific charting issues, including lack of documentation, from observations by the investigator compared to documentation on June 29, 2023. CNS-K stated, "Yep, if they don't do cares they're not going to document they	{0 470}		

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{0 470}	Continued From page 17 completed it. That would be false documentation." CNS-K was asked about follow up for instances where entire shifts were not documented and stated it was likely due to a resident declining cares. CNS-K stated, "staff have been educated to document why something was declined, some are doing it some are not, we'll just continue educating them." CNS-K confirmed not all staff are documenting catheter urine output and there is not a place to enter it unless staff make a note. CNS-K confirmed staff should have removed R2's dressing to her coccyx if her incontinence product was so saturated. An acuity review completed by CNS-K on June 22, 2023, indicated of the 15 current residents, five used a mechanical lift, six needed turning and repositioning assistance, six required assistance of two with activities of daily living, and three needed assistance with eating. CNS-K determined three ULP per shift (days, afternoons, and nights) would "meet resident needs based off of my assessment." Quality Management minutes from the June 13, 2023, meeting included a care audit which read, "getting complaints of wet briefs from overnight, sent Rtask message to them and was told improvement was made and was not happening." CNS-K and LALD-U were the only two present for the meeting. Quality Management minutes from the June 26, 2023, meeting included a concern related to resident complaints of not getting cares completed. The minutes noted, "As a team at the next staff meeting we'll go over how to say things to the residents in different ways to get different results. Also addressing that only asking once and if they refuse is not ok. Need to ask multiple	{0 470}		

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{0 470}	Continued From page 18 times and document these requests." CNS-K and LALD-U were the only two present for the meeting. No further information provided.	{0 470}		
{0 510} SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control when direct care staff failed to appropriately glove and perform adequate hand hygiene (HH). The deficient practice had the potential to affect all residents, employees, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	{0 510}		

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{0 510}	Continued From page 19 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 residents). The findings include: On June 29, 2023, at 7:45 p.m., unlicensed personnel (ULP)-V was observed donning clean gloves to clean R15's suprapubic catheter site. ULP-V washed and dried the site but did not change gloves or perform hand hygiene and proceeded to apply ointment directly to the resident's catheter insertion site. ULP-V rubbed the ointment around the area and then removed her gloves and performed hand hygiene. On June 30, 2023, at 11:00 a.m., clinical nurse supervisor (CNS)-K confirmed staff would be expected to change gloves and wash hands after cleaning the suprapubic catheter site and before applying ointment to the area. On June 30, 2023, at 11:45 a.m., ULP-Y stated she was hired to provide direct care, but in the last five months her main job was activities. Shortly after, ULP-C was observed cutting up lettuce with gloved hands. ULP-C then touched the cupboard and fridge and with the same gloved hands, touched the lettuce that was going to be served to residents. The Center for Disease Control and Prevention (CDC) guidance titled, Hand Hygiene in Healthcare Settings dated January 8, 2021, indicated healthcare personnel (HCP) should perform HH before and after all patient (resident) contact, contact with potentially infectious material, and immediately before donning and after doffing gloves. The CDC indicated gloves	{0 510}		

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{0 510}	Continued From page 20 should be changed and HH performed before moving from work on a soiled body site to a clean body site on the same patient. The CDC recommended alcohol-based hand sanitizer (ABHS) with 60% to 95% alcohol, or washing hands with soap and water for at least 15 seconds. The CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings webpage document dated, November 29, 2022, identified, "Adherence to infection prevention and control practices is essential to providing safe and high quality patient care across all settings where healthcare is delivered. This document concisely describes a core set of infection prevention and control practices that are required in all healthcare settings, regardless of the type of healthcare provided." The document identified practices were selected from among existing CDC recommendations and represented fundamental standards of care that were not expected to change based on emerging evidence or to be regularly altered by changes in technology or practices, and were applicable across the continuum of healthcare settings, indicating, "The practices outlined in this document are intended to serve as a standard reference and reduce the need to repeatedly evaluate practices that are considered basic and accepted as standards of medical care." The scope section of the document further identified development of core practices for an infection control program also applied to "assisted living communities." In addition, the document referenced core practices that should be implemented in all settings included, but not limited to: 1. Leadership support - including the governing body of the healthcare facility or organization was	{0 510}		

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{0 510}	Continued From page 21 accountable for the success of infection prevention activities and to assign one or more qualified individuals with training in infection prevention and control to manage the facility's infection prevention (control) program. 2. Education and Training of Healthcare Personnel on Infection Prevention - including providing job-specific, infection prevention education and training to all healthcare personnel for all tasks; before individuals were allowed to perform their duties and at least annually as a refresher; the document directed to provide additional training for recognized lapses in adherence and to address newly recognized infection transmission threats; provide written infection prevention policies and procedures that were available, current, and based on evidence-based guidelines 3. Patient, Family and Caregiver Education - including provide appropriate infection prevention education to patients, family members, and visitors. 4. Performance and Monitoring Feedback - including identifying and monitoring adherence to infection prevention practices and infection control requirements; monitor the incidence of infections that may be related to care provided at the facility and act on the data and use information collected through surveillance to detect transmission of infectious agents in the facility. 5. Standard Precautions - including use of Standard Precautions to care for all residents. Standard Precautions included: hand hygiene, environmental cleaning and disinfection, injection and medication safety, risk assessment with use of appropriate personal protective equipment (e.g., gloves, gowns, face masks) based on activities being performed, and minimizing potential exposures. Cleaning of medical	{0 510}		

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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
{0 510}	Continued From page 22 equipment, such as blood glucose meters or CPAP, according to the manufacturer's guidelines. No further information was provided.	{0 510}		
0 620 SS=D	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment and complete a thorough investigation for one of one resident (R12) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R12's diagnoses included hypertension (high blood pressure) and Multiple Sclerosis.	0 620		

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0 620	Continued From page 23 R12's undated, unsigned, service plan indicated the resident received assistance with dressing, grooming, bathing, repositioning, toileting, transfers with two people and a mechanical lift, and medication administration. R12's most recent assessment dated May 8, 2023, indicated the resident requires anticoagulant (blood thinning medication) therapy, currently takes Brilinta (antiplatelet blood thinning medication) per MD orders, and has a history of heart valve replacement. R12's prescriber orders dated May 31, 2022, contained an order for Brilinta (an antiplatelet medication that can help prevent blood clots), 90 milligrams (mg) twice a day. Three, 90 day refills were authorized. R12's record also contained an emergency refill prescription order dated June 22, 2023, for Brilinta 90 mg twice a day. R12's June 2023 Medication Administration Record (MAR) contained the following: June 18, 2023, the 8:00 p.m. dose was marked as out June 19, 2023, the 8:00 a.m. dose was marked as out. The nurse commented "ordered from pharmacy" June 19, 2023, the 8:00 p.m. dose was marked as med not available June 20, 2023, the 8:00 a.m. dose was marked as administered June 20, 2023, the 8:00 p.m. dose was marked as out June 21, 2023, the 8:00 a.m. dose was marked as out June 21, 2023, the 8:00 p.m. dose was marked as none of this med in the med cart, [household coordinator] confirmed	0 620		

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0 620	Continued From page 24 June 22, 2023, the 8:00 a.m. dose was marked as out. The nurse commented "still waiting on a provider to send prescription to pharmacy." On June 22, 2023, the resident's Brilinta was discontinued. The order was re entered in the computer to resume on June 23, 2023. R13's record did not contain a medication error form. R12's record contained two faxes to the ordering provider. One fax, dated June 19, 2023, was marked "urgent" and had the following entered under comments: "Please send prescription refill to [pharmacy] for the following medication and resident...Brilinta (ticagrelor) 90 mg twice daily..." The second fax to the ordering provider was dated June 23, 2023, and was marked "urgent." The comment on the cover sheet was "following resident missed dosages of his Brilinta 90 mg twice daily from June 18 8 pm dosage until June 22 8am dosage." The fax did not request any response or action from the prescriber or report if the resident was experiencing any adverse effects from missing the doses. The licensee's recent complaint forms were requested and in the complaint forms was a complaint submitted by R12's wife on June 21, 2023. The nature of the complaint was listed as "[R12] ran out of medication, Brilinta, Sunday 6/18/23 per [R12's wife] this was a 90 day supply and he should have had a refill request sent in sooner. His prescription is for a 90 day supply and it had been four and a half months since last fill." The complaint was reviewed by licensed assisted living director (LALD)-U and clinical nurse supervisor (CNS)-K. The follow up action taken included "6/19 perscription (sic) refill request was sent to pharmacy. [CNS-K] was told	0 620		

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0 620	Continued From page 25 that it could take up to 72 hours for a Dr. signature. 6/22 new perscription (sic) arrived and put into MAR." On June 29, 2023, at 4:15 p.m., R12's wife stated while family was visiting on June 18, 2023, it was noted the resident was administered seven pills instead of his usual eight. When she came to visit the resident again on June 20, 2023, she observed seven instead of eight pills again, and asked the staff administering medications where the eighth pill was, and was told he was out of his Brilinta. The staff was not sure how long the medication had been out for but told R12's wife the empty bottle was on CNS-K's desk. R12's wife stated on June 21, 2023, she went to the pharmacy herself to see if the medication was refilled and was told the physician hadn't signed off on it yet. She then went to ask staff at the facility why the medication hadn't been ordered earlier and why it wasn't followed up on the day prior. R12's wife stated CNS-K told her she had been too busy. R12's wife stated she asked CNS-K if a MAARC report was going to be filed and was told no, one would not be completed. R12's wife stated the medication should have run out well before June 18, 2023, and asked if he had been getting the wrong dosage and was told since it was checked off as given in the medication record, he must have been given it. R12's wife stated she was told since the licensed practical nurse (LPN) responsible for reordering medications was no longer employed there, there was nothing they could do about it. R12's wife stated she was upset to have found out his medications were not reordered this way and she should have been notified. On June 30, 2023, at 11:45 a.m., CNS-K confirmed a medication error form had not been	0 620		

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0 620	Continued From page 26 completed on R12 missing several days of medications and it being marked as administered during this time. CNS-K was asked if a MAARC report had been filed for possible neglect and stated she didn't think one had been filed, but they had talked about it. CNS-K stated they didn't file it because they were able to get the medication refilled. CNS-K was asked if she knew what type of medication Brilinta was. CNS-K stated she was not sure what kind of medication it was. CNS-K was told it was an antiplatelet medication that can help prevent blood clots. CNS-K was asked if she knew what adverse effects could happen if several doses were missed. CNS-K stated since it worked like a blood thinner his blood could thicken. CNS-K was asked about the process to ensure medications don't run out as several other residents were noted to have run out of various medications. CNS-K stated, "I have voiced my concerns, I can't do my nurse duties when I'm on the floor but I can't not be on the floor helping." CNS-K stated they have a good medication reordering process and "I'm told it's going to get better when we get staff." On June 30, 2023, at 12:45 p.m., LALD-U stated R12's medication wasn't ordered in time, it ran out, and a doctor needed to sign for it to get it refilled, but the issue was resolved. LALD-U stated the incident was "concerning in the aspect of nobody ever wants to have a med missed because of reordering," and she discussed with CNS-K to make sure "we are keeping a closer eye on that." LALD-U stated, "granted, you can't [get it refilled] if a doctor needs to sign an order...the hang up is making sure we do our due diligence." LALD-U confirmed there should have been a medication error form completed but she did not verify one was done and did not have	0 620		

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0 620	Continued From page 27 documentation of any follow up completed after the error was identified. LALD-U stated, "As to why it ran out, unfortunately, in your world it was not written, so if it's not written it's not done, but yes we did go back and do an analysis of why it happened and how we can prevent it moving forward." LALD-U stated it was determined the prescription should have been reordered two weeks prior. LALD-U was asked if they had looked at the date it was last filled, February 2, 2023, with a 90 day supply and that if it was given as ordered, they should have run out prior to June 18, 2023. 90 days from February 2, 2023 would be on May 3, 2023. LALD-U stated it was because there was an oversupply of his medication. LALD-U was asked if there was an oversupply, why did they run out of the medication, and LALD-U was not sure. LALD-U was asked if a MAARC report was filed for potential neglect and stated, "There was talk about doing a MAARC report, that failed to go through but we had spoke about that and were working with the doctor getting it redone so he could have it soon. It was failed to be reported because we were working on it." On July 6, 2023, at 2:20 p.m., CNS-K stated she faxed the provider about the missed medications but never got a response back or acknowledgement he reviewed it. CNS-K stated they later found out the provider being updated via fax was no longer a practice and a different provider signed the order for the refill. CNS-K was asked if the new ordering provider was aware R12 had missed several doses of Brilinta and CNS-K stated the resident's wife had updated the provider. CNS-K confirmed they [the facility] hadn't updated the provider since she figured the provider was already aware. CNS-K felt the facility's "Medication Monday" process, where she	0 620		

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0 620	Continued From page 28 reviews the medication carts for things that need to be reordered, was working well and since she began doing medication reordering, they hadn't been running out of medications. CNS-K was asked why several residents reviewed showed various medications not given due to being out and stated, "I couldn't tell you why meds are still running out." CNS-K was asked if there had been any system or process issues identified as the root causes of ongoing medication issues related to omissions or other factors to errors. CNS-K confirmed no root cause was identified and did not think any system issues were contributing to recurring med errors. CNS-K stated, "The root cause of the errors is they [unlicensed staff] were not following the MAR, they weren't doing a double check or a single check, so that is on each individual person; that isn't a system failure that's them not doing it. The systems are fine, it's the people." CNS-K stated verbal retraining was provided to staff. CNS-K felt the training was effective and used the same teaching method for all staff. CNS-K was asked if more individualized training provided or if how staff learn or respond to training was reviewed, if they weren't absorbing the verbal training and CNS-K replied, "No, we've not experimented with different ways of how they learn." The licensee's Vulnerable Adults and Maltreatment - Communication, Prevention, and Reporting policy, dated January 16, 2017, reflected reporting under a home care license, not an assisted living with dementia care license. The policy indicated "Consistent with the Minnesota Vulnerable Adults Act and Home Care Regulations, Twin Diamond Operator dba Diamond Willow and Keystone Bluffs prohibits the maltreatment of home care clients. Maltreatment is defined as neglect, abuse, and	0 620		

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0 620	Continued From page 29 exploitation/theft. To support this prohibition, Twin Diamond Operator dba Diamond Willow and Keystone Bluffs educates clients, family members, and staff (mandated reporters) about how to report suspected maltreatment internally and to the Minnesota Adult Abuse Reporting Center (MAARC)." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
{01760} SS=I	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure medication was administered as prescribed for three of three residents (R12, R13, R14) and failed to follow-up on medication administration practices when several medication errors were identified with	{01760}		

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{01760}	Continued From page 30 medications 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 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 residents). The findings include: R12 R12's diagnoses included hypertension (high blood pressure) and Multiple Sclerosis. R12's undated, unsigned, service plan indicated the resident received assistance with dressing, grooming, bathing, repositioning, toileting, transfered with assistance of two people and a mechanical lift, and medication administration. R12's most recent assessment dated May 8, 2023, indicated the resident required anticoagulant (blood thinning medication) therapy, currently takes Brilinta (antiplatelet blood thinning medication) per MD orders, and has a history of heart valve replacement. R12's prescriber orders dated May 31, 2022, contained an order for Brilinta (an antiplatelet medication that can help prevent blood clots), 90 milligrams (mg) twice a day. Three, 90 day refills were authorized. R12's record also contained an emergency refill prescription order dated June 22, 2023, for Brilinta 90 mg twice a day. R12's June 2023 Medication Administration	{01760}		

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{01760}	Continued From page 31 Record (MAR) contained the following: June 18, 2023, the 8:00 p.m. dose was marked as out June 19, 2023, the 8:00 a.m. dose was marked as out. The nurse commented "ordered from pharmacy" June 19, 2023, the 8:00 p.m. dose was marked as med not available June 20, 2023, the 8:00 a.m. dose was marked as administered June 20, 2023, the 8:00 p.m. dose was marked as out June 21, 2023, the 8:00 a.m. dose was marked as out June 21, 2023, the 8:00 p.m. dose was marked as none of this med in the med cart, [household coordinator] confirmed June 22, 2023, the 8:00 a.m. dose was marked as out. The nurse commented "still waiting on a provider to send prescription to pharmacy." On June 22, 2023, the resident's Brilinta was discontinued. The order was re entered in the computer to resume on June 23, 2023. R13's record did not contain a medication error form. R12's record contained two faxes sent to the ordering provider at a cardiology clinic. One fax, dated June 19, 2023, was marked "urgent" and had the following entered under comments: "Please send prescription refill to [pharmacy] for the following medication and resident...Brilinta (ticagrelor) 90 mg twice daily..." The second fax to the ordering provider was dated June 23, 2023, and was marked "urgent." The comment on the cover sheet was "following resident missed dosages of his Brilinta 90 mg twice daily from June 18 8 pm dosage until June 22 8am dosage." The fax did not request any response or action	{01760}		

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{01760}	Continued From page 32 from the prescriber or report if the resident was experiencing any adverse effects from missing the doses. The resident's record contained a signed order, dated June 22, 2023, for a Brilinta refill signed by a provider from a health system not affiliated with the cardiologist's office. The licensee's recent complaint forms were requested and contained a complaint submitted by R12's wife on June 21, 2023. The nature of the complaint was listed as "[R12] ran out of medication, Brilinta, Sunday 6/18/23 per [R12's wife] this was a 90 day supply and he should have had a refill request sent in sooner. His prescription is for a 90 day supply and it had been four and a half months since last fill." The complaint was reviewed by licensed assisted living director (LALD)-U and clinical nurse supervisor (CNS)-K. The follow up action taken included "6/19 perscription (sic) refill request was sent to pharmacy. [CNS-K] was told that it could take up to 72 hours for a Dr. signature. 6/22 new perscription (sic) arrived and put into MAR." On June 29, 2023, at 4:15 p.m., R12's wife stated while family was visiting on June 18, 2023, it was noted the resident was administered seven pills instead of his usual eight. When she came to visit the resident again on June 20, 2023, she observed seven instead of eight pills again. R12's wife asked the staff administering medications where the eighth pill was, and was told he was out of his Brilinta. The staff was not sure how long the medication had been out, but told R12's wife the empty bottle was on CNS-K's desk. R12's wife stated on June 21, 2023, she went to the pharmacy herself to see if the medication was refilled and was told the physician	{01760}		

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{01760}	Continued From page 33 hadn't signed off on it yet. She then went to ask staff at the facility why the medication hadn't been ordered earlier and why it wasn't followed up on the day prior. R12's wife stated CNS-K told her she had been too busy. R12's wife stated she asked CNS-K if a MAARC report was going to be filed and was told no, one would not be completed. R12's wife indicated the medication should have run out well before June 18, 2023, and inquired with staff if he had been getting the wrong dosage. R12's wife was told since it was checked off as given in the medication record, he must have been given it. R12's wife was told since the licensed practical nurse (LPN) responsible for reordering medications was no longer employed there, there was nothing they could do about it. R12's wife was upset to find out R12's medications were not reordered in this way and felt she should have been notified. On June 30, 2023, at 11:45 a.m., CNS-K confirmed a medication error form was not been completed on R12 missing several days of medications although it was marked as administered during this time. CNS-K was asked if a MAARC report had been filed for possible neglect. CNS-K stated she didn't think one had been filed but it was talked about it. CNS-K stated they didn't file it because they were able to get the medication refilled. CNS-K was asked if she knew what type of medication Brilinta was. CNS-K was not sure what kind of medication it was. CNS-K was told it was an antiplatelet medication that can help prevent blood clots. CNS-K was asked if she knew what adverse effects could happen if several doses were missed. CNS-K stated since it worked like a blood thinner his blood could thicken. CNS-K was asked about the process to ensure medications don't run out, as several other residents were noted to have run out of	{01760}		

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{01760}	Continued From page 34 various medications. CNS-K stated, "I have voiced my concerns, I can't do my nurse duties when I'm on the floor but I can't not be on the floor helping." CNS-K felt the facility had a good medication reordering process and "I'm told it's going to get better when we get staff." On June 30, 2023, at 12:45 p.m., LALD-U stated R12's medication wasn't ordered in time, it ran out and a doctor needed to sign for it to get it refilled, but the issue was resolved. LALD-U felt the incident was "concerning in the aspect of nobody ever wants to have a med missed because of reordering," and she had spoken with CNS-K to make sure "we are keeping a closer eye on that." LALD-U stated, "granted, you can't [get it refilled] if a doctor needs to sign an order...the hang up is making sure we do our due diligence." LALD-U confirmed there should have been a medication error form completed, but she did not verify one was done and did not have documentation of any follow up completed after the error was identified. LALD-U stated, "As to why it ran out, unfortunately, in your world, it was not written ,so if it's not written it's not done, but yes we did go back and do an analysis of why it happened and how we can prevent it moving forward." LALD-U stated it was determined the prescription should have been reordered two weeks prior. LALD-U was asked if they had looked at the date it was last filled, February 2, 2023, with a 90 day supply and that if it was given as ordered, they should have run out prior to June 18, 2023. 90 days from February 2, 2023 would be on May 3, 2023. LALD-U stated it was because there was an oversupply of his medication. LALD-U was asked if there was an oversupply, why did the facility run out of the medication, and LALD-U was not sure. LALD-U was asked if a MAARC report was filed for	{01760}		

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{01760}	Continued From page 35 potential neglect and stated, "There was talk about doing a MAARC report, that failed to go through, but we had spoke about that and were working with the doctor getting it redone so he could have it soon. It was failed to be reported because we were working on it." On July 6, 2023, at 2:20 p.m., CNS-K faxed the cardiology provider about the missed medications but never received a response back or acknowledgement he reviewed it. CNS-K later found out the provider being updated via fax was no longer in practice anymore and a different provider, at an unaffiliated health system, signed the order for the refill. CNS-K was asked if the new ordering provider was aware that R12 had missed several doses of Brilinta and CNS-K stated the resident's wife had updated the provider so she figured they were already aware. CNS-K felt their [the facility] "Medication Monday" process where she reviews the medication carts for things that need to be reordered, was working well since she began doing medication reordering, and they hadn't been running out of medications. CNS-K was asked why several residents reviewed showed various medications not given due to being out and stated, "I couldn't tell you why meds are still running out." On July 10, 2023, at 2:15 p.m., administrative staff at the cardiologist's office stated they were made aware of the need for a refill by the pharmacy on June 21, 2023, and a different provider signed off on a refill the next day on June 22, 2023. The administrative staff stated they did not get any notification from the facility about the need for a refill or that the resident had missed any doses. The administrative staff member noted, "at no point do I see any notes the facility reached out to us."	{01760}		

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{01760}	Continued From page 36 On July 10, 2023, at 2:50 p.m., an internal medicine physician at an unaffiliated clinic stated he did not see any attempts from the facility to notify them the resident had missed any doses of Brilinta. R13 R13 admitted to the facility from an acute care hospital on June 1, 2023. R13's unsigned service plan, last updated June 2, 2023, indicated the resident received assistance with dressing, grooming, bathing, transfers, toileting, and medication administration. R13's most recent assessment, dated June 28, 2023, indicated the resident needed full medication management and set up and staff were to administer medications as prescribed by the provider. R13's hospital discharge orders provided to the investigator by the licensee, dated June 1, 2023, included an order for aspirin 81 mg once daily. R13's June 2023 MAR indicated the aspirin was marked as not administered on June 1, 2, 3, 4, 6, 7, 8, 9, 10, 11 and no documention was entered on June 5, 12, and 13. The medication was discontinued on June 14, 2023. On July 6, 2023, at 2:20 p.m., CNS-K stated they never received an order for aspirin but she had entered the aspirin before she had the discharge orders. CNS-K indicated there was no order for aspirin indicated on the physician orders, so it should have been discontinued when the resident admitted, but it never was. CNS-K said the aspirin was never delivered by the pharmacy, so she	{01760}		

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{01760}	Continued From page 37 eventually put it on hold and then discontinued it. CNS-K was asked if there was an order to put the aspirin on hold and CNS-K replied "no, there wasn't" and did not feel an order to hold a medication would need to be obtained. CNS-K stated it would be within the scope of practice for a nurse to put a medication on hold without an order. CNS-K confirmed if there was an order for aspirin and it wasn't given, then it would be a medication error. R13's record contained an order dated June 22, 2023, for augmentin (antibiotic) 500 mg-125 mg tablet, take one tablet by mouth three times a day for seven days for cellulitis. The medication was to start June 23, 2023, and end on June 30, 2023. The order was entered in the resident's MAR on June 23, 2023, at 2:55 p.m., but only one dose was given that day. The 2:00 p.m. dose was grayed out and the 8:00 p.m. dose had an administration note of "given one at 3:15 as per [CNS-K]. R13's July 2023 MAR indicated the medication was to be given through the 8:00 a.m. dose on July 3, 2023. The 8:00 a.m., 2:00 p.m., and 8:00 p.m. doses on July 1 and July 2 were marked as "out" or "done". The July 3, 2023, 8:00 a.m. dose was marked as "done." R14 R14's diagnoses included stage 4 pancreatic cancer, weight loss, and a gait disturbance. R14's service plan dated June 6, 2023, indicated R14 required assistance with medications administration, and safety checks three times daily R14's admission orders dated June 6, 2023,	{01760}		

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{01760}	Continued From page 38 indicated ondansteron (zofran) 4 milligrams (mg) every six hours as needed. R14's physician order dated June 26, 2023 indicated an order for zofran (antiemedic) mg three times daily and one as needed dose daily for nausea. R14's MAR dated June 30, 2023, at 11:12 p.m., indicated ondansetron was unavailable and June 30, 2023 at 8:00 a.m., indicated ondansetron was out. On June 30, 2023, at 12:20p.m., R14 stated she was not aware she had not received zofran for the last two doses. R14 stated she was more nauseous today. R14 indicated the facility did not have zofran available when she was admitted for about a week. On June 30, 2023, at 11:52 a.m., CNS-K stated the last couple of weeks she was not able to keep up with assessments, follow-ups, or medication ordering, as she was too busy providing direct care. CNS-K was not aware if R14 had an increase in nausea related to not receiving the ordered ondasetron. On June 30, 2023, at 12:58 p.m., the licensed assisted living director (LALD)- U stated a medication not administered would be considered a medication error. LALD-U stated she was unaware if an increase of nausea would be neglect as nausea is different for each person. MEDICATION ERROR FOLLOW UP The licensee provided the investigator with five medication error reports for the month of June. Three of the medication errors listed "omission"	{01760}		

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{01760}	Continued From page 39 as the type of error and two medication errors were attributed to giving the wrong dose. Four ULP were responsible for the five medication errors, including one ULP who administered the wrong dose on two occasions. One medication error was due to staff not giving a medication because they couldn't find it. Two medication errors were due to staff documenting a patch was put on, however it was noted the patch was not put on the resident. Three residents were listed on the medication error forms with one resident not having her patch placed twice, one resident receiving the wrong dose and a medication not given due to not being able to find it. Another resident was administered the wrong dose due to staff misreading the order. Quality Management meeting minutes were provided to the investigator. A meeting on June 13, 2023, identified medication errors of a medication not given "due to not finding it." The nurse gave a verbal correction. A meeting on June 26, 2023, identified medication errors of giving the wrong dose and charting a medication as given but it wasn't. The staff member who gave the wrong dose received verbal education to "slow down and read medication labels and check times carefully before administering." The staff member made another medication error on June 27, 2023, for giving the wrong medication and wrong dose at the wrong time. The meeting reviewed a medication management complaint with the resolution listed as, "Looked over the complaint of having too much and the complaint of missing medication. Reviewed as a team and looked over how it can be done differently to not miss and to not order too much. Will review at next meeting." The meeting notes lacked	{01760}		

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{01760}	Continued From page 40 identification of a root cause or if system changes were made in response to the errors, which had continued to have common trends over the last several months. A total of eight medication administration audits were completed. Two were completed on June 14, 2023, with one audit noting staff failed to "double and tripple (sic) check" the label to the MAR. The yes or no box for understanding the indication, side effects, adverse reactions of the medications and proper dispending of medications were not checked. Yes or no boxes for identifying the resident, understanding the indication, side effects, adverse reactions of the medications, identifying the resident by nameband or third party identification were not checked on the second audit. One audit was completed on June 15, 2023, where it was noted staff failed to compare the label to the MAR and staff did not check for allergies or understand the indication, side effects, or adverse reactions of the medications. Staff also failed to wash their hands. One audit was completed on June 16, 2023, with no concerns noted however the yes or no boxes for understanding the indication, side effects, adverse reactions of the medications, checking resident allergies, identify resident by nameband or third party identification were not checked. One audit was completed on June 19, 2023, but the yes or no boxes for checking expiration date, resident allergies, and comparing label to MAR were not checked. One audit was completed on June 20, 2023, but the yes or no boxes for checking resident allergies was not checked. One audit was completed on June 21, 2023, but the yes or no boxes for checking resident allergies, checking expiration date, and identifying resident by nameband or third party identification were not checked. One audit was	{01760}		

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{01760}	Continued From page 41 completed on June 22, 2023, but the yes or no boxes for identifying resident, understanding the indication, side effects, adverse reactions of the medications, resident allergies, comparing medication label to MAR, administering medication, and ensuring medication was taken were not checked. Additional supporting documentation for the medication errors, including documentation of staff retraining, was requested, but not provided. The licensee's Plan of Correction for tag 1760 indicated CNS-K would be responsible to ensure audits were completed monthly with the number of medications missed and medication error and report to the quality assurance committee. The plan to correct the May 2023 violation included a daily review of declined medication to order if the med is noted to be unavailable, the pharmacy and/or provider would be contacted daily with requests for refills until completed, a medication error review was to be completed with follow up documented on the medication form. A summary of medication errors would be brought forward and reviewed at the Quality Assurance meeting to identify any trends adn (sic) system improvements required. The target date for completion was June 9, 2023. On July 6, 2023, at 2:20 p.m., CNS-K was asked if there had been any system or process issues identified as the root causes of ongoing medication issues related to omissions or other factors to errors. CNS-K confirmed no root causes were identified and did not think there were any systems issues contributing to recurring med errors and stated, "The root cause of the errors is they were not following the MAR they weren't doing a double check or a single check so	{01760}		

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{01760}	Continued From page 42 that was on each individual person that isn't a system failure that's them not doing it. The systems are fine, it's the people." CNS-K stated they provided verbal retraining to staff and she felt it was effective and they used the same teaching method for all staff. CNS-K was asked if more individualized training specific to how staff learn or respond to training if they weren't absorbing the verbal training and CNS-K replied, "No, we've not experimented with different ways of how they learn." The licensee's policy for order processing, last updated September 4, 2022, indicated the RN will then need to sign off and double check all the steps of the order to assure accuracy of order process. The licensee's Medication & Treatment Orders - Receiving policy, last updated December 24, 2019, indicated a RN, LPN, therapist or person qualified to receive orders will obtain all medications and treatment orders either in writing, verbally, or electronically by an authorized prescriber per the Comprehensive home care regulations. The licensee's Medication & Treatment Orders policy, last updated October 25, 2021, indicated the RN is responsible for assuring that current, authorized prescriber orders for medications or treatments administered by the staff are kept on file in the clients' records, communicated to the client providing education, and that changes in orders are addressed in the client's service plan and are communicated to the other staff. No further information provided.	{01760}		

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02320	Continued From page 43	02320		
02320 SS=G	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to implement a fall management system that ensured staff provided adequate supervision and implemented appropriate interventions to prevent further falls for one of one resident (R13) reviewed. R13 had multiple falls that resulted in the reopening of a skin tear to the right arm which developed cellulitis. Interventions implemented after falls failed to address the root cause of the fall and were not effective. The resident refused to allow staff to place motion or tab alarms and preferred to sleep without a shirt, resulting in the tab and motion alarms unable to be attached, implemented, or utilized, despite being identified as interventions to prevent further falls. Staff had knowledge of the resident's refusal and inability of staff to implement the alarms but failed to evaluate, assess, identify, and implement any additional or alternative interventions. 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	02320		

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02320	Continued From page 44 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: R13 began receiving assisted living services on June 1, 2023. R13's diagnoses included mild cognitive impairment, delirium, and failure to thrive. R13's unsigned service plan, last updated June 2, 2023, indicated the resident received assistance with dressing, grooming, bathing, transfers, toileting, and medication administration. The service plan indicated the resident received assistance with toileting three times per day. The service plan lacked wound care services. R13's most recent assessment, dated June 28, 2023, indicated the resident had a skin tear to his left forearm and left wrist. The wound treatment plan in place for both wounds was "monitoring weekly and PRN. Leaving open to air unless bleeding, cover with gauze and kerlex." The resident was noted to be at risk for falls and staff would be available to aide in safe transferring to prevent potential falls per service chart task details. A skin diagram on the final page of the assessment indicated there were also two skin tears on the resident's right arm, in addition to the two noted skin tears on the left arm. R13's medical record, including progress notes, incident reports, and documentation of services contained the following: June 1, 2023, at 4:55 p.m., an incident report noted the resident fell after self transferring. Tab	02320		

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02320	Continued From page 45 alarms were implemented as an intervention with confusion and balance instability listed as a causative factor. Clinical nurse supervisor (CNS)-K was in the building at the time of the fall and assessed the resident. The incident report was not signed off by CNS-K until June 2, 2023, at 3:22 p.m. June 2, 2023, at 7:00 p.m., 911 was called when "there was something that appeared to be a tendon coming out of skin" The incident report was created on June 3, 2023 and reviewed by CNS-K on June 8, 2023. June 2, 2023, at 3:20 a.m., an incident report noted the on call licensed practical nurse (LPN) was called after the resident self transferred to go to the bathroom. Since the resident was sleeping without a shirt, staff did not use a gait belt to get him up from the floor. Tab alarm and motion alarm were implemented as interventions and the cause of the fall was listed as "self transfer due to desire to be independent." A skin tear present at admission to the back of his right arm was noted to have broken open when he fell. The incident report was entered by a ULP on June 5, 2023, at 11:32 p.m. and signed off by CNS-K on June 9, 2023, at 10:12 a.m. June 3, 2023, 2:00 a.m. staff had to unlock his door and found him naked with his pendant on the floor. His motion alarm was off and turned away from him. He let staff in with no issues while staff explained the importance of not locking his door and having the alarms. He apologized and agreed. Staff then reset everything while he got back in bed with no issues. R13's June 2023 Service Recap Summary contained a task for "skin coordination wound	02320		

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02320	Continued From page 46 care-uncomplicated" four times per day at 6:30 a.m., midday, PM, and bedtime starting on June 3, 2023, and ending on June 10, 2023. Wound care for the 6:30 a.m. service was not documented on June 9. Wound care for the midday service was not documented on June 5 and June 9. Wound care for the PM service was not documented on June 5 and June 9. Wound care for the bedtime service was not documented on June 5 and June 9. The Service Recap Summary did not detail what the wound care entailed or where the wound was located. R13's MAR did not contain any related wound care tasks. June 6, 2023, day shift staff noted the resident turned off his alarm multiple times and set it on the nightstand. June 9, 2023, at 4:45 a.m., an incident report noted the resident fell, hit his head and sustained a skin tear after self transferring in the dining room. No fall prevention aides were noted to be in use and CNS-K instructed ULP to "assess for any wounds, take vitals, and assist of 2 to get up." An intervention put in place was a light on in the bathroom and the cause of the fall was listed as self transfer due to cognitive deficit. A skin tear was noted to the back right arm. June 24, 2023, at 3:10 a.m., the resident fell after self transferring out of his bed. A skin tear to the back of the resident's right arm was noted to have reopened after the fall. Staff were alerted to the fall by the resident yelling out as they were unable to attach a tab alarm to him due to him sleeping without a shirt and they were not able to find his motion alarm. Interventions put into place for fall prevention included putting the bed against the wall. The cause of the fall was "alarms not	02320		

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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
02320	Continued From page 47 working. Resident confusion." The resident's blood pressure was noted to be 184/67 with a pulse of 103. June 13, 2023, PM staff documented the resident refused to use the motion alarm and "he picked up motion alarm and turned it off." June 13, 2023, PM staff documented the resident refused to have tab alarm on June 19, 2023, PM staff documented the resident refused to allow this alarm to be placed, "resident has hid the floor alarm and did not appreciate staff looking for it." June 19, 2023, overnight staff documented the "resident hid alarm from previous staff and current staff couldn't locate it either. Previous staff said they were unable to attach due to resident not wearing anything to attach alarm to, if resident wakes up and gets dressed and then decides to go back to bed current staff will attach alarm at that time, otherwise current staff will do hourly checks like scheduled." June 19, 2023, PM staff documented "shift unable to attach to resident due to resident not wearing clothing while sleeping in bed." June 20, 2023, 2:00 a.m., unlicensed staff documented the "resident came out kind of confused looking for the bathroom, staff directed him to the bathroom and then made sure he got back into bed, he still didn't want to put a shirt on so staff could put the tab alarm on him and while he was in the bathroom staff tried again to find the motion alarm but was unable to locate it." June 21, 2023, PM staff documented the resident	02320		

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	24427	A. BUILDING: _____ B. WING _____	R-C 06/30/2023

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02320	Continued From page 48 declined to use his alarm as he "keeps taking off." June 22, 2023, overnight staff documented the resident declined to use his alarm, "could not find it searched his room any where I got it on him getting him into bed now not sure if he will keep it on." June 22, 2023, the resident was started on Augmentin 500 milligrams (mg)-125 mg tablet, take by mouth three times a day for seven days for cellulitis. June 22, 2023, the resident was given as needed (PRN) Tylenol 650 mg at 9:08 p.m. for a low grade fever. Upon follow up at 10:35 p.m., it was noted the resident's fever broke and was now 98.8 degrees Fahrenheit. June 24, 2023, overnight staff documented "resident is sleeping without a way to connect the tab alarm to him staff will do hourly to half hourly checks throughout the night. Staff were not able to find the motion alarms, resident has hidden it and staff will continue to look for it when able to, resident doesn't like staff looking through his stuff. The resident had a fall at 3:00 a.m., resident fell in between checks with float staff around 3:10 a.m., float staff checked at 2:30-2:45-ish and he was in bed asleep. He is now back in bed with a clean brief and bandaged up. "Could not find stethoskope (sic) to take manually and machine gave weird numbers multiple times, he seemed ok." June 25, 2023, staff documented "cannot find motion alarm still, resident sleeps with no way to attach the alarm on him at night, staff checked on him hourly and was good all night."	02320		

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02320	Continued From page 49 June 26, 2023, staff documented, "resident likes to hide motion alarm, staff was unable to locate the alarm and will continue to look as often as possible and will continue with hourly checks throughout the night. resident likes to sleep with no shirt on so there is no way to attach the tab alarm to him when he is asleep in bed, staff will do hourly checks which are according to care plan and tasks, if resident wakes up and gives cause staff will adjust to half hourly checks." June 27, 2023, at 2:00 a.m., staff documented the "resident was in his chair already dressed for the day, staff put the tab alarm on him but he is known to take it off on his own but staff will still be doing hourly checks per his care plan, he said he was find and didn't need anything." June 28, 2023, staff documented, "resident sleeps with no shirt so there is no way to clip the alarm to him. resident had it on and when it went off he got upset and asked for it to be off so staff f will do hourly checks like scheduled." R13's progress notes did not contain any documentation of the right arm skin tear, wound care for the right arm skin tear, the cellulitis infection, or implementation of antibiotics. Quality Management meeting minutes were provided to the investigator. A meeting on June 13, 2023, contained a section for fall tracking but it was left blank. A meeting on June 26, 2023, identified R13 had a fall on June 24, 2023, and his bed was moved against the wall. A section for skin altercation (sic)/pressure ulcers/stasis ulcers/open areas did not include R13's skin tear that developed cellulitis. CNS-K and licensed assisted living director (LALD)-U were the only	02320		

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02320	Continued From page 50 two attendees of the meeting. On June 29, 2023, at 7:05 p.m., R13 was observed sitting in a chair in his room. The lights were off and the resident's TV was on. A tab alarm was clipped to the back of the chair but was not clipped to the resident. A motion alarm was on the resident's bedside table but was off and not in use. On June 29, 2023, at 7:25 p.m., R13 was observed sleeping in a chair in his room. The lights were off and the resident's TV was on. A tab alarm was clipped to the back of the chair but was not clipped to the resident. A motion alarm was on the resident's bedside table but was off and not in use. On June 29, 2023, at 7:45 p.m., R13 was observed sleeping in a chair in his room. The lights were off and the resident's TV was on. A tab alarm was clipped to the back of the chair but was not clipped to the resident. A motion alarm was on the resident's bedside table but was off and not in use. On June 29, 2023, at 8:05 p.m., R13 yelled out to the investigator as she was walking down the hall. R13 stated, "Please help, I'm dying here." The resident stated he wanted to go to bed. The resident was still sitting in a chair in his room with the lights off and the TV on. A tab alarm was clipped to the back of the chair but was not clipped to the resident. A motion alarm was on the resident's bedside table but was off and not in use. On June 29, 2023, at 8:25 p.m., ULP-V brought medications to R13. Unlicensed personnel (ULP)-V was asked to show the investigator	02320		

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02320	Continued From page 51 where the resident's infected skin tear was and identified an area on the resident's right arm and noted it to be red and swollen. ULP-V stated the resident has had an infection since June 23, 2023, and is taking an antibiotic for seven days. ULP-V stated the resident fell after he was admitted and tore open a skin tear to his right arm and it eventually got red. A tab alarm was clipped to the back of the chair but was not clipped to the resident. A motion alarm was on the resident's bedside table but was off and not in use. On June 29, 2023, at 9:25 p.m., R13's bedroom door was observed to be closed. The investigator knocked and entered the room. R13 was observed sitting in his chair. R13 stated, "Can you get me out of here, they keep shutting the door, I'm captured here. I'd like to go to bed." The investigator provided reassurance and left the door open per his request. A tab alarm was clipped to the back of the chair but was not clipped to the resident. A motion alarm was on the resident's bedside table but was off and not in use. On June 29, 2023, at 10:05 p.m., R13 was observed sleeping in a chair in his room. The lights were off and the resident's TV was on. A tab alarm was clipped to the back of the chair but was not clipped to the resident. A motion alarm was on the resident's bedside table but was off and not in use. On June 29, 2023, at 10:35 p.m., R13 was observed sleeping in a chair in his room. The lights were off and the resident's TV was on. A tab alarm was clipped to the back of the chair but was not clipped to the resident. A motion alarm was on the resident's bedside table but was off	02320		

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02320	Continued From page 52 and not in use. On June 29, 2023, at 10:40 p.m., ULP-V completed rounds with the incoming night shift staff. A tab alarm was clipped to the back of the chair but was not clipped to the resident. A motion alarm was on the resident's bedside table but was off and not in use. On June 29, 2023, at 10:45 p.m., the investigator asked ULP-W if R13 ever used the tab alarm or motion alarm. ULP-W stated the resident sleeps without a shirt so the tab can't be clipped to him in bed and if they put it on him while he's in a chair, he will usually unclip the alarm and take it off. ULP-W stated the resident will frequently hide or turn off the motion alarm so they generally don't use either alarm. R13's documentation of services for the PM shift on June 29, 2023, was not completed. Hourly safety checks from 3:00 p.m. through 10:00 p.m. were not documented. Activities of daily living assistance for grooming, mobility/walking, bed mobility, dressing assistance, transfer assistance, and motion and tab alarms for the PM shift was documented by the night shift ULP and included the following notes from the overnight ULP: Resident said don't turn that damn thing on [motion alarm], so staff didn't turn it on so as to not agitate the resident. Previous staff said he was wandering a lot on pm shift and kept taking his tab alarm off himself and when he got into bed he sleeps with no shirt on so there is nothing to clip the alarm onto. Resident likes to sleep in just his brief so there is no way to clip the alarm onto him. Resident was put into bed by NOC staff, he didn't have any clean washcloths so staff used cleaning wipes to get his peri area but was unable to thoroughly clean the rest of his body due to	02320		

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02320	Continued From page 53 lack of clean supplies, but resident was comfortably in bed and lights out at 11 pm. Resident gets kind of agitated with the motion alarm and likes to hide it from staff so it wasn't on... On June 30, 2023, at 11:35 a.m., CNS-K stated the resident admitted from a hospital and came to the facility with a skin tear on his right elbow. CNS-K stated the resident was seen in the emergency room on June 2, 2023, and received stitches but she wasn't sure what the diagnosis and said "The hospital never said what it was but it was his elbow and it was hanging down, I wish I had a picture to show you, but the hospital put it back in and stitched it up." No additional documentation on the wound, wound care, any new orders, or when the stitches were removed was entered, "I didn't document anything on that, I've been too busy on the floor." CNS-K stated they noticed the resident's arm began to get red on Wednesday (June 21, 2023) and hospice put in an order for antibiotics. CNS-K confirmed no infection charting for the cellulitis diagnosis or additional monitoring was being done on the skin tear and she was currently checking on it once a week. CNS-K agreed with the investigator that weekly monitoring of a skin tear with a cellulitis diagnosis was not sufficient. CNS-K confirmed documentation was not done because "I just haven't had time to do much, I've been with all these staff quitting, I've been on the floor being an aide." On June 30, 2023, at 12:45 p.m., LALD-U stated she was aware R13 had fallen and got a skin tear and then developed cellulitis; hospice was contacted to start an antibiotic. LALD-U was not sure when the skin tear became infected but just knew [CNS-K] was looking at it once a week and	02320		

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02320	Continued From page 54 that hospice was monitoring it. On July 6, 2023, at 2:00 p.m., CNS-K confirmed R13's assessment did not include details of the resident's right arm skin tear that was being treated for cellulitis at the time the assessment was completed and stated, "that was an oversight." CNS-K confirmed the LPN triaged and handled the call from staff after R13 fell on June 2, 2023. CNS-K stated the "LPN can make the call if he needs to be sent into the hospital." CNS-K stated she wasn't aware LPNs couldn't triage nursing related issues and stated, "what's the point of having a LPN on call then?" CNS-K was asked about the delay in reviewing incident reports and she stated, "I'm not glued to a computer 24/7 where I can review that incident 24/7." CNS-K was asked how an intervention would be implemented timely or how staff would know what to do to prevent further falls and CNS-K stated she'd tell them on the phone when they called what to do and staff would be aware of interventions because they were verbally told. In addition, she would send a RTasks message. CNS-K was asked about the resident's ongoing refusal to allow alarms to be used or that he'll become upset if staff try to look for where he hid the alarms and if she felt the alarms remained an effective intervention. CNS-K felt the alarms were effective when the resident allowed them to be used so it continued to be an effective intervention. CNS-K agreed the alarms could be aggravating but "no one has staff to do one on one to make sure he stays in bed. We could put a bed alarm on him but we'd have to assess it again and see if it would work." CNS-K was asked if she had done any root cause analysis on the entirety of the resident's falls or identified any consistent factors and stated, "No, there is not one specific thing leading to these falls. He has	02320		

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02320	Continued From page 55 dementia. He's confused." CNS-K was asked if they had ever considered a scheduling toileting plan where staff would take the resident to the bathroom at a specific time each night as a proactive measure as the resident seemed to be seeking out the bathroom within a few hour timeframe during several of his falls. CNS-K stated, "he's on a two to three hour toileting plan and three to four hours on nights." CNS-K was asked if there had been any consideration to add other staff members to the quality management committee and she stated, "no, we haven't taken into consideration adding anyone else to the meetings because we just haven't." CNS-K was not sure if other staff, including unlicensed personnel, would be appropriate to add to the quality management committee. CNS-K was asked if a change in condition assessment was done when the resident admitted to hospice. CNS-K stated one was not completed because hospice came and assessed the resident and admitting to hospice wouldn't be a change in condition since he hadn't changed much since he admitted to the facility. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		
02360	144G.91 Subd. 8 Freedom from maltreatment 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:	02360		

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02360	Continued From page 56 Based on interview and record review, the facility failed to ensure one of one of one residents (R1) was free from maltreatment. 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	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	
03000 SS=D	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of	03000		

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03000	Continued From page 57 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 for one of one resident (R12) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or	03000		

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03000	Continued From page 58 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R12's diagnoses included hypertension (high blood pressure) and Multiple Sclerosis. R12's undated, unsigned service plan indicated the resident received assistance with dressing, grooming, bathing, repositioning, toileting, transfers with two people and a mechanical lift, and medication administration. R12's most recent assessment dated May 8, 2023, indicated the resident requires anticoagulant therapy and currently takes Brilinta (antiplatelet type of anticoagulant) per MD orders and has a history of heart valve replacement. R12's prescriber orders dated May 31, 2022, contained an order for Brilinta (an antiplatelet medication that can help prevent blood clots), 90 milligrams (mg) twice a day. Three, 90 day refills were authorized. R12's record also contained an emergency refill prescription order dated June 22, 2023, for Brilinta 90 mg twice a day. R12's June 2023 Medication Administration Record (MAR) contained the following: June 18, 2023, the 8:00 p.m. dose was marked as out June 19, 2023, the 8:00 a.m. dose was marked as out. The nurse commented "ordered from pharmacy" June 19, 2023, the 8:00 p.m. dose was marked as med not available June 20, 2023, the 8:00 a.m. dose was marked as administered June 20, 2023, the 8:00 p.m. dose was marked	03000		

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03000	Continued From page 59 as out June 21, 2023, the 8:00 a.m. dose was marked as out June 21, 2023, the 8:00 p.m. dose was marked as none of this med in the med cart, [household coordinator] confirmed June 22, 2023, the 8:00 a.m. dose was marked as out. The nurse commented "still waiting on a provider to send prescription to pharmacy." On June 22, 2023, the resident's Brilinta was discontinued. The order was re entered in the computer to resume on June 23, 2023. R13's record did not contain a medication error form. R12's record contained two faxes sent to the ordering provider. One fax dated June 19, 2023, was marked "urgent" and had the following entered under comments: "Please send prescription refill to [pharmacy] for the following medication and resident...Brilinta (ticagrelor) 90 mg twice daily..." The second fax to the ordering provider was dated June 23, 2023, and was marked "urgent." The comment on the cover sheet was "following resident missed dosages of his Brilinta 90 mg twice daily from June 18 8 pm dosage until June 22 8 am dosage." The fax did not request any response or action from the prescriber or report if the resident was experiencing any adverse effects from missing the doses. The licensee's recent complaint forms were requested and included a complaint submitted by R12's wife on June 21, 2023. The nature of the complaint was listed as "[R12] ran out of medication, Brilinta, Sunday 6/18/23 per [R12's wife] this was a 90 day supply and he should have had a refill request sent in sooner. His	03000		

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	24427	A. BUILDING: _____ B. WING _____	R-C 06/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMOND WILLOW OF BAXTER	14396 GRAND OAKS DRIVE BAXTER, MN 56425

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03000	Continued From page 60 prescription is for a 90 day supply and it had been four and a half months since last fill." The complaint was reviewed by licensed assisted living director (LALD)-U and clinical nurse supervisor (CNS)-K. The follow up action taken included "6/19 perscription (sic) refill request was sent to pharmacy. [CNS-K] was told that it could take up to 72 hours for a Dr. signature. 6/22 new perscription (sic) arrived and put into MAR." On June 29, 2023, at 4:15 p.m., R12's wife stated while family was visiting on June 18, 2023, it was noted the resident was administered seven pills instead of his usual eight. When she came to visit the resident again on June 20, 2023, she observed seven instead of eight pills again and asked the staff administering medications where the eighth pill was and was told he was out of his Brilinta. The staff was not sure how long the medication had been out but told R12's wife the empty bottle was on CNS-K's desk. R12's wife stated on June 21, 2023, she went to the pharmacy herself to see if the medication was refilled and was told the physician hadn't signed off on it yet. She then went to ask staff at the facility why the medication hadn't been ordered earlier and why it wasn't followed up on the day prior. R12's wife stated CNS-K told her she had been too busy. R12's wife asked CNS-K if a MAARC report was going to be filed and was told no, one would not be completed. R12's wife stated the medication should have run out well before June 18, 2023, and asked if he had been getting the wrong dosage. R12's wife was told since it was checked off as given in the medication record, it must have been given. R12's wife was told since the licensed practical nurse (LPN) responsible for reordering medications was no longer there, there was nothing they could do about it. R12's wife was	03000		

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03000	Continued From page 61 upset to have found out his medications were not reordered in this way and felt she should have been notified. On June 30, 2023, at 11:45 a.m., CNS-K confirmed a medication error form had not been completed on R12 missing several days of medications but having it marked as administered during this time. CNS-K was asked if a MAARC report had been filed for possible neglect and she didn't think one had been filed but they had talked about it. CNS-K stated they didn't file it because they were able to get the medication refilled. CNS-K was asked if she knew what type of medication Brilinta was. CNS-K stated she was not sure what kind of medication it was. CNS-K was told it was an antiplatelet medication that can help prevent blood clots. CNS-K was asked if she knew what adverse effects could occur if several doses were missed. CNS-K stated since it worked like a blood thinner his blood could thicken. CNS-K was asked about the process to ensure medications don't run out, as several other residents were noted to have run out of various medications. CNS-K stated, "I have voiced my concerns, I can't do my nurse duties when I'm on the floor but I can't not be on the floor helping." CNS-K felt the facility had a good medication reordering process and was told "it's going to get better when we get staff." On June 30, 2023, at 12:45 p.m., LALD-U stated R12's medication wasn't ordered in time, it ran out, a doctor needed to sign for it and get it refilled, but the issue was now resolved. LALD-U stated the incident was "concerning in the aspect of nobody ever wants to have a med missed because of reordering," and she spoke with CNS-K to make sure "we are keeping a closer eye on that." LALD-U stated, "granted, you can't	03000		

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03000	Continued From page 62 [get it refilled] if a doctor needs to sign an order...the hang up is making sure we do our due diligence." LALD-U confirmed there should have been a medication error form completed but she did not verify if one was done and did not have documentation of any follow up completed after the error was identified. LALD-U stated, "As to why it ran out, unfortunately, in your world, it was not written so if it's not written it's not done, but yes, we did go back and do an analysis of why it happened and how we can prevent it moving forward." LALD-U stated it was determined the prescription should have been reordered two weeks prior. LALD-U was asked if they had looked at the date it was last filled, February 2, 2023, with a 90 day supply and that if it was given as ordered, they should have run out prior to June 18, 2023. 90 days from February 2, 2023 would be on May 3, 2023. LALD-U stated it was because there was an oversupply of his medication. LALD-U was asked if there was an oversupply, why did they run out of the medication and LALD-U was not sure. LALD-U was asked if a MAARC report was filed for potential neglect and stated, "There was talk about doing a MAARC report, that failed to go through but we spoke about that and were working with the doctor getting it redone so he could have it soon. It was failed to be reported because we were working on it." On July 6, 2023, at 2:20 p.m., CNS-K indicated she faxed the provider about the missed medications but never got a response back or acknowledgement he reviewed it. CNS-K later found out updating the provider via fax was no longer in practice and a different provider had signed the order for the refill. CNS-K was asked if the new ordering provider was aware R12 had missed several doses of Brilinta and CNS-K said	03000		

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03000	Continued From page 63 the resident's wife updated the provider. CNS-K confirmed they hadn't updated the provider since she figured they were already aware. CNS-K felt the facility's Medication Monday process, where she reviews the medication carts for things that need to be reordered, was working well and since she began doing medication reordering, they hadn't been running out of medications. CNS-K was asked why several residents reviewed showed various medications not given due to being out and stated, "I couldn't tell you why meds are still running out." CNS-K was asked if there had been any system or process issues identified as the root causes of ongoing medication issues related to omissions or other factors to errors. CNS-K confirmed no root cause was identified and did not think any systems issues were contributing to the recurring med errors and stated, "The root cause of the errors is they [staff] were not following the MAR they weren't doing a double check or a single check so that was on each individual person that isn't a system failure that's them not doing it. The systems are fine, it's the people." CNS-K provided verbal retraining to staff and felt it was effective and indicated she used the same teaching method for all staff. CNS-K was asked if more individualized training that was more specific to how staff learn or respond was provided, if staff weren't absorbing the verbal training and CNS-K replied, "No, we've not experimented with different ways of how they learn." As of July 7, 2023, a MAARC report had not been filed by the licensee. The licensee's Vulnerable Adults and Maltreatment - Communication, Prevention, and Reporting policy, dated January 16, 2017, reflected reporting under a home care license,	03000		

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03000	Continued From page 64 not an assisted living with dementia care license. The policy indicated "Consistent with the Minnesota Vulnerable Adults Act and Home Care Regulations, Twin Diamond Operator dba Diamond Willow and Keystone Bluffs prohibits the maltreatment of home care clients. Maltreatment is defined as neglect, abuse, and exploitation/theft. To support this prohibition, Twin Diamond Operator dba Diamond Willow and Keystone Bluffs educates clients, family members, and staff (mandated reporters) about how to report suspected maltreatment internally and to the Minnesota Adult Abuse Reporting Center (MAARC)." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	03000		