Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL265854623M
Compliance #: HL265857785C

Date Concluded: June 20, 2023

Name, Address, and County of Licensee Investigated:

Edgewood Sartell LLC
677 Brianna Drive
Sartell, MN 56377
Stearns County

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

Evaluator's Name: Erin Johnson-Crosby, RN
Special Investigator

Finding: Substantiated, facility responsibility

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

Initial Investigation Allegation(s):
The facility neglected a resident when facility staff administered the incorrect medications to the resident. The resident was admitted to the hospital and required treatment due to medication overdose.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. Although an individual staff member administered incorrect medications to the resident, the error was immediately reported to the on-call registered nurse (RN). The on-call RN failed to assess, monitor, and evaluate the resident's condition. The on-call RN did not contact the facility nurse, the resident's family, or physician of the medication error. Facility policies and procedures were not followed. The facility failed to identify the root cause of the medication error and failed to take action to mitigate further errors. In addition, staff working the day after the medication error occurred, administered scheduled morning

medications and failed to immediately report a change in the resident's condition, resulting in a delay in care.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of medical records, medication errors, incident reports, facility policies and procedures, and hospital records. Also, the investigator observed the facility's medication administration process.

The resident resided in an assisted living facility. The resident's diagnoses included dementia, congestive heart failure, and atrial fibrillation. The resident's assessment indicated the resident required assistance with bathing, toileting, dressing, and medication administration. The assessment identified the resident as alert, forgetful, and required reminders.

The resident's progress notes, from the day the medication error occurred, indicated unlicensed personnel (ULP #1) contacted the on-call RN and said the resident was given incorrect medications by ULP#2, which included Tylenol #3 (narcotic pain medication), Keppra (seizure medication), Melatonin (natural compound for sleep), Seroquel (antipsychotic medication), Zyrtec (allergy medication) 10 mg, and Atogepent (migraine medication) 60 mg. The on-call RN instructed ULP #1 to check the resident's blood pressure and pulse, re-check again in thirty minutes, then call her back. ULP #1 followed the RN's instructions and contacted her after the second check of the resident's blood pressure and pulse. The on-call RN then directed ULP#1 to re-check the resident's blood pressure and pulse in one hour and call her back. There was no documentation of the third check being completed and no further documentation of follow up by the on-call RN. No documentation was entered during the overnight shift of further assessment or additional follow-up of the resident's condition and there was no documentation of notification to the facility RN, the resident's family, or physician of the error.

The next morning, the resident's medication administration record (MAR) indicated the resident received her scheduled morning medications. Two of the scheduled medications administered were Losartan and Metoprolol, both high blood pressure medications.

The resident's progress notes indicated after the noon meal, staff reported the resident had been in bed all day, moaning and not responsive. The nurse assessed the resident, found the resident's pulse rate was 45 (normal pulse rate is 60-100) and sent the resident to the emergency room. The progress notes indicated the hospital emergency room nurse noted the resident's pulse rate was in 30's - 40's and two rounds of Narcan (opioid antagonist used to treat overdose) were administered.

The resident's hospital records indicated the resident was minimally responsive that morning at the facility. Initially, the resident opened her eyes and moaned, and this was not her baseline status. The resident was admitted to the telemetry (continuous heart monitoring) unit due to a low heart rate and possible placement of a temporary pacemaker. The resident was hospitalized for two days. The resident's hospital discharge diagnoses included acute

encephalopathy (damage or disease that affects the brain), and unintentional medication overdose.

The facility's internal investigation indicated ULP#2 administered incorrect medications to the resident. ULP#2 reported she was distracted by another resident while passing medications. However, ULP#2 immediately reported the error to ULP #1, who immediately contacted the on-call RN. The internal investigation did not include interviews with additional staff involved or analysis of the medication error, communication breakdown, lack of nursing assessment, lack of follow-up and monitoring, notification failure, or failure of staff to report a change in condition.

During an interview, ULP#1 stated he was informed by ULP#2 they had administered incorrect medications to the resident. He then contacted the on-call RN to report the medication error. ULP#1 stated the RN directed him to take R1's blood pressure and pulse two or three times after the incident.

During an interview, with the on-call RN she stated she was notified by facility staff that the resident received incorrect medications. The RN directed staff to hold the resident's metoprolol and digoxin (blood pressure medications) and to check the resident's pulse and blood pressure. The RN directed staff to call her back after a third set of vitals was completed, however, she could not verify if this was completed, as it was not documented. The RN acknowledged she did not contact a physician or the facility nurse about the error. The RN stated she documented the error in the resident's medical record and in the communication log for on-coming facility staff. The RN assumed a facility nurse would be onsite the next morning and would follow up on the incident. The RN thought the resident should have been monitored for 24 hours and the morning blood pressure medications should have been held.

During an interview, ULP #3 indicated she worked the following morning and administered the resident's morning medications as ordered. ULP#3 was aware the resident received incorrect medications the evening prior but was not told to withhold any medications. ULP#3 stated the resident was usually very active but was not that day.

During an interview, the facility licensed practical nurse (LPN) who worked the morning after the medication error occurred, indicated she did not have time to check facility messages before her shift due to staffing issues. Instead of working as the nurse at the facility, the LPN had to assist in providing direct care in the memory care unit across the street. The LPN indicated if she would have worked as scheduled, she would have been able to check messages and would have known about the medication error. The LPN verified after the noon meal, staff called to notify her the resident had been in bed all day, was not acting herself, was moaning, and not responsive. The LPN directed staff to take vital signs. The resident's pulse was 45 (normal range 60-100). The LPN stated the resident did not look well and responded slowly in one-word answers. The resident was sent to the emergency room due to the change of condition and low pulse rate.

During an interview, the facility RN said she was not notified of the medication error until the next day. The RN indicated all staff should check messages before providing care, as that was how changes were communicated. The RN was not aware if anyone checked on the resident throughout the night or the next morning. The RN verified the on-call nurse should have immediately contacted her, the physician, the resident's family, and blood pressure medications should have been held the following morning. The RN indicated ULP should have immediately notified a nurse when a change in the resident's behavior or condition was observed. The RN stated "the ball was dropped" regarding communication between the on-call nurse and facility nursing staff.

During an interview, the resident's family member stated they were not contacted by the facility about the medication error until the next day, right before the resident was hospitalized.

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

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

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

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility filed a MAARC report and provided re-education to the staff member who administered medications incorrectly.

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
Stearns County Attorney
Sartell City Attorney
Sartell Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26585	A. BUILDING: _____ B. WING _____	C 04/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD SARTELL LLC	677 BRIANNA DRIVE SARTELL, MN 56377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER 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: #HL265857785C/#HL265854623M #HL265858893C/#HL265855169M On April 26, 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 47 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for #HL265857785C/#HL265854623M tag identification 0620, 2320, 2360, and 3000.	0 000		
0 620 SS=D	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma	0 620		

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0 620	Continued From page 1 (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. 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 and complete a thorough investigation for one of one resident (R1) 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: The MAARC report dated January 23, 2023, indicated on January 20, 2023, R1 received another resident's medications. On January 21, 2023, facility staff notified the licensed practical nurse (LPN) R1 was lethargic and was not acting normal. R1 was transported and admitted to the hospital for further treatment. R1's diagnoses included dementia, congestive heart failure and atrial fibrillation. R1's service plan was requested but not provided.	0 620	Assisted Living Provider 144G. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.	

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0 620	Continued From page 2 R1's admission assessment dated December 22, 2022, indicated R1 was alert, but forgetful and required reminders at times. The assessment indicated the resident required assistance with bathing, toileting, dressing, and medication administration. R1's progress notes dated January 20, 2023, at 9:51 p.m., indicated unlicensed personal (ULP)-D notified registered nurse (RN)-C that R1 was given another resident's medications by ULP-I which included Tylenol #3 25/500 milligram (mg) (pain medication), Keppra 1,000 mg (seizure medication), Melatonin 10 mg (natural compound for sleep), Seroquel (antipsychotic medication) 75 mg, Zyrtec (allergy medication) 10 mg, and atogepent (migraine medication) 60 mg. R1's progress notes continued on January 20, 2023, indicated R1's blood pressure was 71/43 and pulse was 51 and R1 reported feeling tired. Approximately, 30 minutes later R1's blood pressure was 111/52 and pulse of 65 and indicated to recheck R1's blood pressure and pulse in one hour. R1's medical record did not include follow up for approximately 12 hours following the medication error, despite nurse notification of the incident. R1's progress notes also failed to include notification to R1's family or physician of the error. R1's medication administration record (MAR) dated January 21, 2023, at 8:41 a.m., indicated R1 received the following medications included but not limited, Losartan 50 mg (high blood pressure), and Metoprolol 100 mg (high blood pressure). R1's progress note dated January 21, 2023, at	0 620		

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0 620	Continued From page 3 1:07 p.m., indicated R1 had been in bed all day, per staff report at 12:30 p.m. Staff reported R1 had been moaning and was not responding. R1's vitals were 112/67, pulse of 45. R1 was sent to the emergency room (ER) for further evaluation. R1's progress note dated January 21, 2023, the ER nurse reported to staff R1 continued to have bradycardia (low pulse) in the 30's and 40's and was given two rounds of Narcan (medication for narcotic overdose). R1 was placed on oxygen and admitted to the hospital. R1's hospital records indicated R1 was minimally responsive throughout the morning at the facility. R1 would open her eyes, and moan. R1's family reported to hospital staff R1 was usually alert and talkative. The records also indicated R1 was admitted to the telemetry (continuous cardiac monitoring) floor for bradycardia (slow heart rate) and possible placement of a temporary pacemaker. Intravenous (IV) fluids were started to help allow a wash out of the inadvertent drugs given to R1 last night. R1's hospital discharge summary dated January 23, 2023, indicated discharge diagnoses of acute encephalopathy (function of the brain is affected by an agent or condition), and unintentional medication overdose with Tylenol No. 3, Keppra, melatonin, seroquel, atogepant and Zyrtec. Upon admission to the hospital R1 was unresponsive and bradycardic. The licensee's internal investigation indicated ULP-I gave incorrect medications to R1. ULP-I stated she was distracted by another resident while passing medications. ULP-I was re-trained in medication administration. The internal investigation did not include interviews with additional staff involved or a root cause analysis of the medication error, communication	0 620		

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0 620	Continued From page 4 breakdown, or staff's failure to report a change in condition. On April 28, 2023, at 8:30 a.m., RN-H stated she was not notified of the medication error until January 21, 2023. RN-H verified the internal investigation included only one staff interview and did not address the break down in communication or a resident change in condition. RN-H stated she should have completed the MAARC report when she was notified of the medication error and not two days later. The licensee's Abuse Prevention, Intervention, Reporting and Investigation policy dated February 2023, indicated all reports of resident verbal, sexual, physician and mental abuse; exploitation; involuntary seclusion; neglect or misappropriation of resident property are promptly and thoroughly investigated. All instances of maltreatment should be reported as soon as possible and not more than 24 hours form the time of the initial report. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
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.	02320		

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02320	Continued From page 5 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide care and services in accordance with the service plan, when staff failed to administer medications as ordered, resulting in medication error for one of one resident (R1) reviewed. R1 received another resident's medication and was hospitalized for an unintentional drug overdose. The licensee also failed to ensure continuity of care was provided by trained and competent staff when the medication error was immediately reported to an on-call nurse who did not ensure proper follow-up or assessment was completed and failed to notify R1's family and physician of the error. In addition, staff failed to immediately report a change in the resident's condition, resulting in a delay of care. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 R1's diagnoses included dementia, congestive heart failure and atrial fibrillation. R1's service plan was requested but not provided. R1's admission assessment dated December 22, 2022, indicated R1 was alert, but forgetful, and	02320		

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02320	Continued From page 6 required reminders. The assessment indicated the resident required assistance with bathing, toileting, dressing, and medication administration. R1's progress notes dated January 20, 2023, at 9:51 p.m., indicated unlicensed personal (ULP)-D notified registered nurse (RN)-C that R1 was given another resident's medications by ULP-I which included Tylenol #3 25/500 milligram (mg) (narcotic pain), Keppra 1,000 mg (seizure), Melatonin 10 mg (natural compound for sleep), Seroquel (antipsychotic) 75 mg, Zyrtec (allergy) 10 mg, and atogepent (migraine) 60 mg. R1's blood pressure was 71/43 (normal range 120/80) and pulse was 51 (normal range 60-100) and R1 reported feeling tired. The RN informed facility staff to hold R1's ordered metoprolol and digoxin (blood pressure medications). Approximately 30 minutes later, R1's blood pressure was 111/52 and had a pulse of 65 and indicated to recheck R1's blood pressure and pulse in one hour. R1's record did not include a re-check of blood pressure or pulse. No further follow up was documented in R1's medical record for approximately 12 hours following the medication error until R1 was sent to the emergency room. R1's progress notes failed to include notification to the facility RN, R1's family, or physician of the error. R1's medication administration record (MAR) dated January 21, 2023, at 8:41 a.m., indicated R1 received the following medications which included but was not limited to: Losartan 50 mg (high blood pressure medication), and Metoprolol 100 mg (high blood pressure medication). R1's progress note dated January 21, 2023, at	02320		

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02320	Continued From page 7 1:07 p.m., indicated R1 had been in bed all day per staff report at 12:30 p.m. Staff reported R1 had been moaning and not responding. R1's vitals were 112/67, pulse of 45. R1 was sent to the emergency room for further evaluation. R1's progress note dated January 21, 2023, the ER nurse reported to staff R1 continued to have bradycardia (slow heart rate) in the 30's and 40's and was given two rounds of Narcan (medication used to reverse the effects of opiod narcotics). R1 was placed on oxygen and was admitted to the hospital. R1's hospital records indicated R1 was minimally responsive during the morning at the facility R1 would open her eyes, and moan. R1's family reported to hospital staff R1 was usually alert and talkative. The records indicated R1 was admitted to the telemetry (continuous cardiac monitoring) floor for bradycardia (slow heart rate) and possible placement of a temporary pacemaker. Intravenous (IV) fluids were started to help wash out of the inadvertent drugs given to R1 last night. R1's hospital discharge summary dated January 23, 2023, indicated discharge diagnoses of acute encephalopathy (damage or disease to the brain), and unintentional medication overdose with Tylenol No. 3, Keppra, melatonin, seroquel, atogepant and Zyrtec. Upon admission to the hospital R1 was unresponsive and bradycardic. The licensee's medications error report dated January 20, 2023, indicated R1 received the incorrect medications and an on call RN was notified. The report also indicated on January 21, 2023, R1 had been lethargic, not responding, and did not eat breakfast or lunch. R2 was sent to the hospital for evaluation. The licensee's internal investigation indicated ULP-I gave incorrect	02320		

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02320	Continued From page 8 medications to R1. ULP-I stated she was distracted by another resident while passing medications. ULP-I was re-trained in medication administration. The internal investigation did not include interviews with any other staff involved or a root cause analysis of the medication error, communication breakdown, or staff's failure to report a change in condition. On April 26, 2023, at 10:30 a.m., ULP-D stated another staff member (ULP-I) informed him R1 was given incorrect medications. ULP-D directed the other staff member to get R1's vitals and ULP-D called the on-call RN to report the error. ULP-D verified the RN directed him to take R1's blood pressure and pulse two or three times after the incident. On April 26, 2023, at 10:00 a.m., RN-C stated she was the RN on call the evening of January 20, 2023 from 7:00 p.m., to January 21, 2023, at 7:00 a.m. RN-C verified the company she is employed by takes calls when a RN is not at the facility. RN-C stated ULP-D notified her R1 received incorrect medications. RN-C directed facility staff to hold R1's metoprolol and digoxin (blood pressure medications) and to check R1's pulse and blood pressure. RN-C stated she could make decisions and withhold medications when a facility nurse was not on site. RN-C stated she directed staff to call her back after the second set of vitals, however, she did not know if that was done as it was not documented. RN-C stated she did not contact a physician and did not contact a facility nurse. RN-C stated she documented the error in R1's medical record and in the communication log for facility staff. RN-C assumed a facility nurse was coming in January 21, 2023, at 8:00 a.m., and would follow up. RN-C noticed the next morning R1 received all of	02320		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD SARTELL LLC	677 BRIANNA DRIVE SARTELL, MN 56377

(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 9 her ordered medications and stated R1 should have been monitored for 24 hours and the blood pressure medications scheduled for the next morning, should have been held. On April 26, 2023, at 11:30 a.m., ULP-E stated when she arrived R1 was sleep walking, which was abnormal and was very tired. ULP-E verified she was aware R1 received incorrect medications the evening prior. ULP-E stated she gave the medications as ordered as there was not a nurse on site when R1 received her medications on January 21st. ULP-E verified she gave all of R1's medication as the medications were not on hold and was not provided any direction to withold medication. ULP-E stated she had no idea giving R1 the ordered medications would make her worse. ULP-E stated R1 was usually very active in the community but was not that day. On April 27, 2023, at 12:00 p.m., licensed practical nurse (LPN)-G stated she worked the morning after the medication error on January 21, 2023, providing direct care in the memory care unit across the street from R1's assisted living facility. LPN-G stated she did not have time before her shift to check facility messages. LPN-G verified around 12:30 p.m., that day she checked messages and noticed R1 received the incorrect medications the evening prior. At that same time, ULP-E called to notify LPN-G that R1 had been in bed all day, was not acting herself and was moaning. LPN-G directed ULP-E to take vital signs. R1's pulse was 45. LPN-G stated R1 did not look well, was responding slow and in one word answers, and stated she did not feel well. LPN-G stated R1 was sent to the emergency room due to the change of condition and a low pulse.	02320		

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02320	Continued From page 10 On April 28, 2023, at 8:30 a.m., the facility RN-H stated she was not notified of the medication error until the next day. RN-H stated all staff should check messages before providing cares as that is where changes are documented and communicated with staff. RN-H was not aware if anyone checked on R1 throughout the night or the next morning. RN-H stated "the ball was dropped" regarding communication between the on-call nurse and facility nurses. RN-H verified the on call nurse should have immediately contacted her, the physician, and R1's family. RN-H also stated ULP-E should have notified a nurse right away when she noticed R1 was acting differently. RN-H verified there was not facility wide training provided after the incident to educate staff when to report a change in condition or medication error procedures. RN-H verified three medications errors had occurred with residents given another resident's medications within the last year. On April 26, 2023, at 1:00 p.m., R1's family member (FM)-F stated they were not contacted about the medication error until the next day, right before R1 was hospitalized. The licensee's undated Change in Condition policy did not include for staff to notify a nurse if a resident is acting different than their normal baseline status. The licensee's Medication Errors and Reporting policy, dated March 2023, indicated a medication error is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the heath care profession, patient, or consumer. The policy indicated a significant medication error was an error that required medical intervention or	02320		

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02320	Continued From page 11 resulted in harm or death. No further information was 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: Based on observations, interviews, and document review, the facility failed to ensure one of one residents (R1) reviewed. R1 was neglected. Findings include: On May 4, 2023, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	02360		
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	03000		

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03000	Continued From page 12 vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (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	03000		

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03000	Continued From page 13 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 (R5) 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: The MAARC report dated January 23, 2023, indicated on January 20, 2023, R1 received another resident's medications. On January 21, 2023, facility staff notified the licensed practical nurse (LPN) R1 was lethargic and was not acting normal. R1 was transported and admitted to the hospital. R1's diagnoses included dementia, congestive heart failure and atrial fibrillation. R1's service plan was requested but not provided. R1's admission assessment dated December 22, 2022, indicated R1 was alert, but forgetful and required reminders at times. The assessment indicated the resident required assistance with	03000		

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03000	Continued From page 14 bathing, toileting, dressing, and medication administration. R1's progress notes dated January 20, 2023, at 9:51 p.m., indicated unlicensed personal (ULP)-D notified registered nurse (RN)-C that R1 was given another resident's medications by ULP-I, which included Tylenol #3 25/500 milligram (mg) (pain medication), Keppra 1,000 mg (seizure medication), Melatonin 10 mg (natural compound for sleep), Seroquel (antipsychotic medication) 75 mg, Zyrtec (allergy medication) 10 mg, and atogepent (migraine medication) 60 mg. R1's progress notes continued on January 20, 2023, indicated R1's blood pressure was 71/43 and pulse was 51 and R1 reported feeling tired. The RN informed facility staff to hold R1's ordered metoprolol and digoxin. Approximately, 30 minutes later R1's blood pressure was 111/52 and pulse of 65 and indicated to recheck R1's blood pressure and pulse in one hour. The progress notes did not include follow up for approximately 12 hours after the medication error, despite nurse notification of the error. R1's progress notes failed to include notification to the facility RN, R1's family, or physician of the error. R1's medication administration record (MAR) dated January 21, 2023, at 8:41 a.m., indicated R1 received the following medications included but not limited to: Losartan 50 mg (treats high blood pressure), and Metoprolol 100 mg (treats high blood pressure. R1's progress note dated January 21, 2023, at 1:07 p.m., indicated R1 had been in bed all day per staff report at 12:30 p.m. Staff reported R1 had been moaning and not responding. R1's vitals were 112/67, pulse of 45. R1 was sent to	03000		

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03000	Continued From page 15 the emergency room for further evaluation. R1's progress note dated January 21, 2023, the ER nurse indicated R1 continued to have bradycardia (low pulse) in the 30's and 40's and was given two rounds of Narcan (medication for narcotic overdose). R1 was placed on oxygen and admitted for further treatment. R1's hospital records indicated R1 was minimally responsive during the morning at the facility. R1 would open her eyes, and moan. R1's family reported to hospital staff R1 was usually alert and talkative. The records also indicated R1 was admitted to the telemetry (continuous cardiac monitoring) floor for bradycardia (slow heart rate) and possible placement of a temporary pacemaker. Intravenous (IV) fluids were started to help allow a wash out of the inadvertent drugs given to R1 last night. R1's hospital discharge summary dated January 23, 2023, indicated discharge diagnoses of acute encephalopathy and unintentional medication overdose with Tylenol No. 3, Keppra, melatonin, seroquel, atogepant and Zyrtec. Upon admission to the hospital R1 was unresponsive and bradycardic. The licensee's internal investigation indicated ULP-I gave incorrect medications to R1. ULP-I stated she was distracted by another resident while passing medications. ULP-I was re-trained in medication administration. The internal investigation did not include interviews with any additional staff involved or a root cause analysis of the medication error, communication breakdown, or staff's failure to report a change in condition. On April 28, 2023, at 8:30 a.m., RN-H stated she was not notified of the medication error until	03000		

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03000	Continued From page 16 January 21, 2023. RN-H verified she should have completed the MAARC report when she was notified of the medication error and not two days later. The licensee's Abuse Prevention, Intervention, Reporting and Investigation policy dated February 2023, indicated all reports of resident verbal, sexual, physician and mental abuse; exploitation; involuntary seclusion; neglect or misappropriation of resident property are promptly and thoroughly investigated. All instances of maltreatment should be reported as soon as possible and not more than 24 hours form the time of the initial report. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	03000		