MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility:
Fridley Assisted Living LLC
6352 Central Avenue
Fridley, Minnesota 55432
Anoka County

Report #: HL27980002

Date: January 22, 2016

Date of Visit: June 30, 2015
Time of Visit: 7:00 a.m. – 4:00 p.m.

By: Lisa Jacobsen, R.N., Special Investigator
Saira Sidi, R.N., Special Investigator

Type of Facility: ☐ Nursing Home ☐ HHA ☒ Home Care Provider/Assisted Living
☐ SLF ☐ ICF/IID ☐ Home Care
☐ Hospital ☐ Other: _____

☒ Facility Self Report ☒ Complaint

Allegation(s): **It is alleged** that a client was neglected when staff failed to administer his/her seizure medications for four days. The client was ultimately hospitalized due to seizures with tongue bites and oral cavity bleeding.

An unannounced visit was made at this facility and an investigation was conducted under:

☐ Federal Regulations for Hospital Conditions of Participation (42 CFR, Part 482)
☐ Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
☐ Federal Regulations for ICF/IID (42 CFR Part 483, subpart I)
☐ Federal Regulations for HHA (Home Health Agencies) (42 CFR, Part 484)
☐ Federal Regulations for CAH (Critical Access Hospital) (42 CFR, Part 485)
☐ Federal Regulations for EMTALA (42 CFR Part 489)
☐ State Licensing Rules for Boarding Care Homes (MN Rules Chapter 4655)
☐ State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)

☐ State Licensing Rules for Supervised Living Facilities (MN Rules Chapter 4665)
☐ State Licensing Rules for Home Care (MN Rules Chapter 4668)
☐ State Statutes for Maltreatment of Minors (MN Statutes, section 626.556)
☑ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
☑ State Statutes Chapters 144 and 144A

Conclusion:

Minnesota Vulnerable Adults Act (MN 626.557)

Under the Minnesota Vulnerable Adults Act (MN. 626.557):

☐ Abuse ☑ Neglect ☐ Financial Exploitation was:

◉ Substantiated ○ Not Substantiated ○ Inconclusive based on the following information:

The preponderance of evidence established that neglect of health care occurred when staff failed to administer the client's prescribed seizure medications resulting in the client having seizures and requiring hospitalization for medical treatment.

The client had diagnoses of dementia and epilepsy, and required assistance from staff with medication administration several times a day. The client had a physician's order for levetiracetam (a medication used to treat seizures with epilepsy) 500 milligrams twice a day, and divalproex (a medication used to treat seizures) 250 milligrams at bedtime. The client did not receive the levetiracetam for one and a half days (three doses) and the divalproex was not administered for three days.

According to *National Library of Medicine from the National Institute of Health,* the following "Precaution" was noted regarding the medication levetiracetam; "Do not stop taking levetiracetam without talking to your doctor, even if you experience side effects such as unusual changes in behavior or mood. If you suddenly stop taking levetiracetam, your seizures may become worse."

After the doses of levetiracetam and divalproex were omitted, the client was found sitting in a chair on the patio unresponsive to verbal stimulation. Vital signs were taken and the client was transferred to the hospital for evaluation.

The client had a witnessed seizure in the emergency room, became tachycardic (a faster than normal heart rate) and was admitted to the intensive care unit for close monitoring. Laboratory tests on admission indicated the client had a negative divalproex blood level. A levetiracetam level was also drawn, but not until after the client had received a loading dose of the levetiracetam. The client was diagnosed with acute encephalopathy (disorder of the brain that causes brain dysfunction), most likely secondary to seizures, followed by a prolonged postictal state (an altered stated of consciousness after a seizure). The client was discharged back to the facility after being hospitalized for ten days.

Direct care staff interviews/documentation revealed the client did not receive the anti-seizure medications due to the medications not being available. It could not be determined if direct care staff reported the medications not being available to a nurse, because conflicting information from interviews were obtained.

A physician interview revealed the following: The seizures "took a toll" on the client and it took the client awhile to recover from the postictal state. The client continued to have some underlying problems related to the encephalopathy upon discharge from the hospital, but was getting closer to her/his baseline. Normally one would expect someone to return to his/her normal baseline after seizures, but in someone with dementia, which the client had, it was harder to recover and get back to normal.

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ☐ individual(s) and/or ☒ facility is responsible for the

☐ Abuse ☒ Neglect ☐ Financial Exploitation. This determination was based on the following:

The facility was responsible for the neglect of health care. Although the facility had policies/procedures related to requesting, receiving, preparing, administering medications and verifying that prescription drugs were administered as ordered, multiple unlicensed staff, and a licensed nurse were either not aware of the policy/procedure, or did not follow the policy/procedure resulting in the client not receiving her/his medications as ordered. Problems were also identified with the adequacy of the facility's medication administration training of unlicensed personnel. In addition, although the facility had a procedure on how they would verify that medications were administered as ordered, there was a turnover of licensed nurses with no follow-through of supervision of unlicensed personnel related to medication administration. The cumulative effect of these failures resulted in not just one individual being responsible for the neglect but rather the facility.

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.

Compliance:

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) – Compliance Met
The facility was found to be in compliance with State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557). No state licensing orders were issued.

State Statutes Chapters 144 & 144A – Compliance Not Met
The requirements under State Statues for Chapters 144 &144A were not met.

State licensing orders were issued: ☒ Yes ☐ No If no, specify: _____

(State licensing orders will be available on the MDH website.)

Facility Corrective Action:

The facility took the following corrective action(s):

Definitions:

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

Minnesota Statutes, section 626.5572, subdivision 17 - Neglect
"Neglect" means:

(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and

(2) which is not the result of an accident or therapeutic conduct.

(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

The Investigation included the following:

Document Review: The following records were reviewed during the investigation:

☒ Medical Records

☒ Medication Administration Records

☐ Facility Incident Reports

☒ ADL (Activities of Daily Living) Flow Sheets

☐ Care Guide

☒ Treatment Sheets

☒ Physician Progress Notes

☒ Laboratory and X-ray Reports

☒ Physician Orders
☐ Social Service Notes

☒ Nurses Notes
☐ Meal Intake Records

☐ Activities Reports
☐ Weight Records

☐ Therapy and/or Ancillary Services Records
☒ Assessments

☐ Skin Assessments
☒ Care Plan Records

Other pertinent medical records:

☒ Hospital Records ☒ Ambulance/Paramedics ☐ Medical Examiner Records ☐ Death Certificate

☐ Police Report

Additional facility records:

☐ Resident/Family Council Minutes
☒ Personnel Records/Background Check, etc.

☒ Staff Time Sheets, Schedules, etc.
☒ Facility In-service Records

☒ Facility Internal Investigation Reports
☒ Facility Policies and Procedures

☐ Call Light Audits
☒ Other, specify: Medication Error Reports

Number of additional resident(s) reviewed: 5

Were residents selected based on the allegation(s)? ◉ Yes ○ No ○ N/A Specify: _____

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

○ Yes ◉ No ○ N/A Specify: The client was hospitalized.

Interviews: The following interviews were conducted during the investigation:

Interview with complainant(s): ◉ Yes ○ No ○ N/A Specify: _____

If unable to contact complainant, attempts were made on:
Date/time: _____ Date/time: _____ Date/time: _____

Interview with family: ◉ Yes ○ No ○ N/A Specify: _____

Did you interview the resident(s) identified in allegation: ○ Yes ◉ No ○ N/A Specify: The power of attorney for the client requested we not talk to the client regarding the error.

Did you interview additional residents: ◉ Yes ○ No

Total number of resident interviews: 4

Interview with staff: ◉ Yes ○ No ○ N/A Specify: _____

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: 12

Physician interviewed: ◉ Yes ○ No

Nurse Practitioner interviewed: ○ Yes ◉ No

Interview with Alleged Perpetrator(s): ○ Yes ○ No ◉ N/A Specify: No alleged perpetrator identified

Attempts to contact: Date/time: _____ Date/time: _____ Date/time: _____

If unable to contact was subpoena issued: ○ Yes , date subpoena was issued _____ ○ No

Were contacts made with any of the following:
☐ Emergency personnel ☐ Police Officers ☐ Medical Examiner ☐ Other: Specify _____

Observations were conducted related to:

☐ Wound Care	☒ Medication Pass	☐ Meals
☐ Personal Care	☐ Dignity/Privacy Issues	☐ Restorative Care
☐ Nursing Services	☐ Safety Issues	☒ Facility Tour
☐ Infection Control	☐ Cleanliness	☐ Injury
☐ Use of Equipment	☐ Transfers	☐ Incontinence
☐ Call Light	☐ Other: _____	

Was any involved equipment inspected: ○ Yes ○ No ◉ N/A

Was equipment being operated in safe manner: ○ Yes ○ No ◉ N/A

Were photographs taken: ○ Yes ◉ No Specify: _____

xc: Health Regulation Division – Home Care and Assisted Living Program
Minnesota Board of Nursing
Fridley City Police Department
Anoka County Attorney
Fridley City Attorney

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	H27980	A. BUILDING: _____ B. WING _____	C 07/30/2015

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FRIDLEY ASSISTED LIVING LLC	6352 CENTRAL AVENUE FRIDLEY, MN 55432

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0 000	Initial Comments *****ATTENTION****** HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: On June 30, 2015, a complaint investigation was initiated to investigate case #HL27980002. At the time of the survey, there were 49 clients that were receiving services under the comprehensive license. The following correction orders are issued.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state Statutes/Rules for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute/Rule number and the corresponding text of the state Statute/Rule 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/RULES.	
0 325	144A.44, Subd. 1(14) Free From Maltreatment Subdivision 1. Statement of rights. A person who receives home care services has these rights: (14) the right to be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable	0 325		

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0 325	Continued From page 1 Adults Act and the Maltreatment of Minors Act; This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure that one of six clients (C1) were free from neglect of health care when the client did not receive his prescribed medications as ordered and required medical treatment. This practice resulted in a level 4 violation (a violation that results in serious injury, impairment, or death), and is issued at an isolated scope (1 or a limited number of clients are affected). The findings included: C1's record was reviewed. C1's Individual Service Plan Agreement dated May 15, 2015 indicated that staff were to assist the client with medication administration in the morning, evening, bedtime and night. The Service Plan Agreement indicated the registered nurses (RN) delegated all medication administration to unlicensed personnel (ULP)s and the facility nurses would monitor the medication administration record on a weekly basis to ensure no errors in medication administration occurred and to ensure proper documentation. Staff were to notify the nurse in person or on-call with medication administration concerns. C1 had prescriber's orders for levetiracetam (used to treat seizures with epilepsy) 500 milligrams one tablet twice a day, and divalproex (a medication used to treat seizures) 250 milligrams at bedtime. C1's medication administration record for June of 2015 indicated the following medications were not administered as ordered: levetiracetam was not	0 325		

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0 325	Continued From page 2 administered as ordered June 16, 2015 at 8:00 a.m. and 8:00 p.m., and June 17, 2015 at 8:00 a.m., and divalproex was not administered June 14, 15, and 16, 2015 at 8:00 p.m. According to National Library of Medicine from the National Institute of Health, the following " Precaution" was noted regarding the medication levetiracetam; "Do not stop taking levetiracetam without talking to your doctor, even if you experience side effects such as unusual changes in behavior or mood. If you suddenly stop taking levetiracetam, your seizures may become worse. " A progress note dated June 22, 2015 (late entry for June 17, 2015) indicated the following: C1 was found sitting in a chair on the patio at noon on June 17, 2015, unresponsive to verbal stimulation. C1 was last seen approximately twenty minutes earlier and was standing in the bathroom getting ready for lunch. Vital signs were taken and C1 was transferred to the emergency room for evaluation. A hospital emergency room note dated June 17, 2015 indicated C1 had a witnessed seizure in the emergency room and the client became tachycardic and was admitted to the intensive care unit for close monitoring. Hospital blood work indicated the client had a negative divalproex blood level on admission to the hospital. A levetiracetam level was also drawn but was not until after the client had received a loading dose of the levetiracetam. A hospital history and physical dated June 17, 2015 indicated C1 had acute encephalopathy (disorder of the brain that causes brain dysfunction), most likely secondary to seizures followed by postictal state (an altered state of consciousness after a	0 325		

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0 325	Continued From page 3 seizure) taking into consideration subtherapeutic level of antiseizure medications, signs of tongue bite and oral cavity bleeding. C1 was discharged back to the facility on June 26, 2015. When interviewed July 6, 2015 at 10:00 a.m., licensed practical nurse (LPN)-H stated she had not been informed by the ULPs either verbally or in writing that some of C1's medications were not available, therefore not being administered. LPN-H stated the first she knew staff had not administered some of his medications was on June 17, 2015 when C1 was transferred to the hospital. When interviewed July 9, 2015 at 2:20 p.m., physician (O) stated C1's seizures caused acute encephalopathy or at least contributed to the encephalopathy. Physician (O) stated C1 continued to have some underlying problems related to the encephalopathy upon discharge from the hospital, but was getting closer to his baseline. Physician (O) stated the seizures "took a toll" on C1 and it took C1 awhile to recover from the postictal state. Physician (O) stated normally one would expect someone to return to their normal baseline after seizures, but in someone with dementia, which C1 had, it's harder to recover and get back to normal. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 325		
0 900	144A.4792, Subd. 1 Medication Management; Comprehensive Subdivision 1. Medication management services; comprehensive home care license. (a) This subdivision applies only to home care providers	0 900		

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0 900	Continued From page 4 with a comprehensive home care license that provide medication management services to clients. Medication management services may not be provided by a home care provider who has a basic home care license. (b) A comprehensive home care provider who provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and client and client representative, if any; disposing of unused medications; and educating clients and client representatives about medications. When controlled substances are being managed, the policies and procedures must also	0 900		

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0 900	Continued From page 5 identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 22. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the licensee failed to maintain and implement procedures for requesting and receiving prescription medications, preparing and administering medications and verifying that prescription drugs were administered as ordered for six of six clients reviewed. This practice resulted in a level 4 violation (a violation that results in serious injury, impairment, or death), for one of the five clients (C1) and the practice resulted in a level 2 violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety) for four of five clients and is issued at a pattern scope (more than a limited number of clients are affected). The findings included: C1's record was reviewed. C1's Individual Service Plan Agreement dated May 15, 2015 indicated that staff were to assist the client with medication administration in the morning, evening, bedtime and night. The Service Plan Agreement indicated the registered nurses (RN) delegated all medication administration to unlicensed personnel (ULP)s including subcutaneous injections of insulin. In addition, the Service Plan Agreement indicated that the facility nurses would monitor the medication administration record on a weekly basis to ensure no errors in medication	0 900		

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0 900	Continued From page 6 administration occurred and to ensure proper documentation. Staff were to notify the nurses in person or on-call with medication administration concerns. C1 had prescriber's orders for furosemide (used to treat edema/high blood pressure) 20 milligrams every day, levetiracetam (used to treat seizures with epilepsy) 500 milligrams one tablet twice a day, metoprolol (used to treat angina) 25 milligrams one half tablet (12.5 milligrams) every day, omeprazole (used to treat gastric reflux) 20 milligrams twice a day, tamsulosin (used to treat benign prostatic hypertrophy) .4 milligrams every day, acetaminophen (a medication used to relieve pain) 500 milligrams two tablets three times a day, atorvastatin calcium (a medication used to lower cholesterol levels) 740 milligrams one tablet every day and divalproex (a medication used to treat seizures) 250 milligrams at bedtime. C1's medication administration record for June of 2015 indicated the following medications were not administered as ordered: furosemide was not administered on June 16, 2015 and June 17, 2015 at 8:00 a.m. levetiracetam was not administered as ordered June 16, 2015 at 8:00 a.m. and 8:00 p.m., and June 17, 2015 at 8:00 a.m., metoprolol was not administered on June 14, 15, and 16, 2015 at 8:00 a.m. omeprazole was not administered on June 15, 2015 at 8:00 p.m. and June 16, 2015 at 8:00 a.m. and 8:00 p.m. and June 17, 2015 at 8:00 a.m., tamsulosin was not administered on June 15, and 17, 2015 at 5:00 p.m., acetaminophen was not administered on June 15, 2015 at 8:00 p.m., atorvastatin calcium was not administered on June 16 and 17, 2015 at 8:00 a.m., and divalproex was not administered June 14, 15, and 16, 2015 at 8:00 p.m.	0 900		

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0 900	Continued From page 7 A progress note dated June 22, 2015 (late entry for June 17, 2015) indicated the following: C1 was found sitting in a chair on the patio at noon on June 17, 2015, unresponsive to verbal stimulation. C1 was last seen approximately twenty minutes earlier and was standing in the bathroom getting ready for lunch. Vital signs were taken and the client was transferred to the emergency room for evaluation. A hospital emergency room note dated June 17, 2015 indicated C1 had a witnessed seizure in the emergency room and the client became tachycardic and was admitted to the intensive care unit for close monitoring. Hospital blood work indicated the client had a negative divalproex blood level and a sub-therapeutic INR (international normalized ratio) level on admission to the hospital. A levetiracetam level was drawn but was not drawn until after the client had received a loading dose of the levetiracetam. A hospital history and physical dated June 17, 2015 indicated C1 had acute encephalopathy (disorder of the brain that causes brain dysfunction), most likely secondary to seizures followed by postictal state (an altered stated of consciousness after a seizure) taking into consideration subtherapeutic level of anti-seizure medications, signs of tongue bite and oral cavity bleeding.. C1 was discharged back to the facility on June 26, 2015. When interviewed July 1, 2015 at 12:45 p.m., ULP-K worked the day shift on June 14, 2015. ULP-K stated she did not have the medication metoprolol to administer to C1 on June 14, 2015. ULP-K stated she contacted the pharmacy to let them know to send it to the facility. ULP-K stated she did not contact the nurse regarding the omission of the metoprolol. ULP-K stated things	0 900		

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0 900	Continued From page 8 had been really "crazy" the last month, with the clients' medications stating sometimes pills were not available to be administered. When interviewed July 2, 2015 at 1:40 p.m., ULP-I stated she worked the evening shift of June 14, 2015 and did not have one of C1's medications available to administer. ULP-I stated she contacted the pharmacy. The pharmacy told her it was a medication not gotten through that pharmacy. ULP-I stated she did not contact a nurse regarding the omission nor did she leave a note or pass it on in shift report that the client did not have a medication available. ULP-I stated she "ran out of time." When interviewed July 1, 2015 at 2:35 p.m., ULP-J stated she worked the day shift of June 15, 2015. ULP-J stated some of C1's medications were not available to be administered. ULP-J stated she contacted the pharmacy and told to deliver them as soon as possible. ULP-J stated when she left at the end of her shift, the medications were not delivered yet, so she brought it to licensed practical nurse (LPN)-H's attention. ULP-J stated she did not work again until June 17, 2015 during the day shift and C1 was still out of some of his medications. ULP-J stated she contacted the pharmacy again and was not given a straight answer as to why the medications were not delivered. ULP-J stated she reported the pharmacy's response to LPN-H. Around noon that day, C1 was sent to the hospital due to being unresponsive. When interviewed June 30, 2015 at 2:55 p.m., ULP-L worked the evening shift on June 15, 2015. ULP-L stated that on June 15, 2015, she noted that C1 did not have some of his medications. ULP-L stated she called LPN-H	0 900		

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	H27980	A. BUILDING: _____ B. WING _____	C 07/30/2015

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0 900	Continued From page 9 who told her to contact the pharmacy. ULP-L contacted the pharmacy and the pharmacy stated they did not have orders for C1's medications, so ULP-L left a note listing the medications C1 needed. ULP-L stated typically the nurses did the medication reordering for the clients. When interviewed July 2, 2015 at 3:30 p.m., ULP-M stated she worked the day shift on June 16, 2015. ULP-M stated there was a note on the medication cart listing C1's medications that were not available. ULP-M stated she gave the note to licensed practical nurse (LPN)-H. When interviewed June 30, 2015 at 3:35 p.m.., ULP-F stated she worked June 16, 2015 on the evening shift and some of C1's medications were not available to be administered. ULP-F stated she documented on the medication administration record that the medications were not administered. ULP-F stated there was not a procedure for reordering medications prior to the incident with C1 being transferred to the hospital. When interviewed July 6, 2015 at 10:00 a.m., LPN-H stated she had not been informed by the ULPs either verbally or in writing that some of C1's medications were not available, therefore not being administered. LPN-H stated the first she knew that C1 was not being administered some of his medications was on June 17, 2015 when C1 was transferred to the hospital. LPN-H stated she was not aware of what the protocol was when medications were not available. When interviewed June 30, 2015 at 3:20 p.m., LPN-E stated that the pharmacy was transitioning to an automatic cycle refilling system for medication reorders. LPN-E stated she sent an electronic message to the pharmacy with a list of	0 900		

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0 900	Continued From page 10 clients names that the pharmacy should not refill on their automatic cycle refill, because they got their medications from a different pharmacy. LPN-E stated C1's name was on the list. LPN-E stated registered nurse (RN)-D informed her that C1 was transitioning to the Veterans Administration pharmacy. LPN-E state she assumed the next time medications would be re-ordered for C1 would be through the Veterans Administration pharmacy. When interviewed July 8, 2015 at 9:15 a.m., RN-D stated C1 initially got his medications through the local pharmacy, but the plan was for C1 to re-establish care through the Veterans Administration and eventually receive his medications through the Veterans Administration pharmacy. RN-D stated he did not recall telling anyone to stop having C1's medications refilled at the local pharmacy. A facility procedure dated March 10, 2015 indicated the following: "Nursing will be ordering medications effective immediately. If a resident is out of a medication, please check with nursing to see if it has been ordered, if not one is available, CALL (pharmacy name) to find out order status. If it hasn't been ordered please fax the order to the pharmacy and leave the order sheet on nursing desk." COUMADIN NOT ADMINISTERED: C1 had a diagnosis of atrial flutter and coronary heart disease. C1 had a prescriber's order dated June 3, 2015 for Warfarin (a medication used as a blood thinner to prevent heart attacks, blood clots and strokes) 2.5 milligrams to be given Tuesdays, Thursdays, Fridays, Saturdays and Sundays and Warfarin 2 milligrams to be given Mondays and Wednesdays with an INR to be	0 900		

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0 900	Continued From page 11 drawn in one week (June 10, 2015). C1's MAR for June of 2015 indicated 2.5 milligrams of Warfarin was administered on Wednesday June 3, 2015 instead of 2 milligrams as ordered. An Anticoagulation record indicated C1's INR was drawn on June 10, 2015 and the result was 1.97 (the desired therapeutic range was listed as 2.0-3.0). C1's June 2015 MAR indicated the last dose of Warfarin was given on June 10, 2015. When interviewed July 8, 2015 at 2:15 p.m., LPN-H indicated that it appeared C1's INR result was faxed to the physician, but that there was no follow-up with the physician for continued Warfarin orders. LPN-H stated it was her understanding that C1 did not receive another dose of Coumadin after June 10, 2015 until C1 was hospitalized on June 17, 2015. Hospital Records for C1 were reviewed and C1's INR level on June 17, 2015 was 1.1. (According to WebMD: A normal INR is approximately 1.0. People taking the blood thinner typically have a target INR of 2.0 to 3.0. OBSERVATION DURING MEDICATION PASS: C2's record was reviewed. C2 had a prescriber's order dated February 4, 2015 for Docusate/Senna (a stool softener/laxative) 100 milligram/8.6 milligram one tablet orally every day. During an observation of a medication pass on June 30, 2015 at 7:15 a.m., C2 was observed to receive one Docusate/Senna 50 milligrams/8.6 milligram tablet. When interviewed July 8, 2015 at 2:15 p.m., LPN-H stated she was unaware of the discrepancy in C2's Docusate/Senna dose. ADDITIONAL MEDICATIONS NOT ADMINISTERED BECAUSE NOT AVAILABLE: C3's record was reviewed. C3 had a prescirber's	0 900		

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0 900	Continued From page 12 order dated April 10, 2015 for Tylenol 650 milligrams at bedtime. C3's MAR for June 2015 indicated the client's Tylenol was not administered because it was "N/A" (not available) on June 1, 2, 6, 8 and 10, 2015. C4's record was reviewed. C4 had a prescriber's order dated March 30, 2015 for metoprolol 25 milligrams twice a day and a prescriber's order dated December 24, 2014 for aspirin 81 milligrams one every morning. C4's MAR for June 2015 indicated the client's metoprolol was not administered because it was not available on June 15, 2015 and the client's aspirin was not administered because it was not available/waiting on (pharmacy name) on June 26, 27, 28 and 29, 2015. C5's record was reviewed. C5 had a prescirber's order dated June 23, 2015 for mupirocin or Bactroban (a cream used to treat skin infections) 2% cream apply three times daily to face for a skin lesion. C5's MAR for June 2015 indicated the Bactroban cream was not administered as ordered because it was "not available" or "could not find" on June 24, at 8:00 a.m., June 25 at 8:00 a.m. and 2:00 p.m., June 26 at 2:00 p.m. and 8:00 p.m., June 27 at 8:00 a.m. and 8:00 p.m., June 28 at 8:00 a.m. and 8:00 p.m. and June 29 at 8:00 a.m. C6's record was reviewed. C6 had a prescriber's order for Cymbalta (an antidepressant) 40 milligrams daily. C6's June 2015 MAR indicated the Cymbalta was not administered as ordered because it was not available on June 3, 4, 11 and 12, 2015. A memo to all staff titled, "Medication Order Reminder" dated March 10, 2015 indicated the	0 900		

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0 900	Continued From page 13 following: "Nursing will be ordering medications effective immediately. If a resident is out of a medication, please check with nursing to see if it has been ordered, if no one is available, Call (pharmacy name) to find out order status. If it hasn't been ordered please fax the order to the pharmacy and leave the order sheet on nursing desk." TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900		
0 930	144A.4792, Subd. 7 Delegation of Medication Administration Subd. 7. Delegation of medication administration. When administration of medications is delegated to unlicensed personnel, the comprehensive home care provider must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each client and documented those instructions in the client's records; and (3) communicated with the unlicensed personnel about the individual needs of the client. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure that when medication	0 930		

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0 930	Continued From page 14 administration of medications was delegated to unlicensed personnel, that the unlicensed personnel (ULP) demonstrated to the registered nurse (RN) their ability to competently follow the medication administration procedure for two of six ULP's reviewed. This practice resulted in a level 2 violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety), and is issued at an isolated scope (1 or a limited number of staff are involved). The findings included: ULP-F's training records were reviewed. ULP-F was hired to provide direct care to clients and medication administration on November 5, 2014. ULP-F's record had a document titled "Employee Medication Training" which indicated ULP-F was "trained" by RN-D on April 14 and 22, 2015 regarding medication administration procedures. The area titled "Date Observed/Delegated" was blank. ULP-K's training records were reviewed. ULP-K was hired to provide direct care to clients and medication administration on January 2, 2014. ULP-K's record had a document titled " Employee Medication Training" which indicated ULP-K was "trained" by RN-D on April 13, 2015 regarding medication administration procedures. The area titled "Date Observed/Delegated" was blank. When interviewed June 30, 2015 at 3:35 p.m., ULP-F stated RN-D reviewed the medication procedures with her, but stated the RN did not observe her passing medications to ensure she was following the procedure. ULP-F stated other ULPs that passed medications observed her. When interviewed July 8, 2015 at 9:15 a.m., RN-D stated the medication administration	0 930		

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0 930	Continued From page 15 training for ULPs included classroom training, shadowing another medication passer and then the RN would observe them doing a medication pass. The licensee's policy titled "Delegation of Nursing Tasks, Treatments of Therapy Tasks" which was undated indicated the following, "A Registered Nurse may delegate medication administration to unlicensed personnel only after the RN has: a. Instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures." TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 930		

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
H27980	A. Building B. Wing	10/26/2015

Name of Facility	Street Address, City, State, Zip Code
FRIDLEY ASSISTED LIVING LLC	6352 CENTRAL AVENUE FRIDLEY, MN 55432

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix 00325 Reg. # 144A.44, Subd. 1(14) LSC	Correction Completed 10/26/2015	ID Prefix 00900 Reg. # 144A.4792, Subd. 1 LSC	Correction Completed 10/26/2015	ID Prefix 00930 Reg. # 144A.4792, Subd. 7 LSC	Correction Completed 10/26/2015
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
7/30/2015	