Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306661800M
Compliance #: HL306669602C

Date Concluded: May 23, 2024

Name, Address, and County of Licensee Investigated:
Maplewoods Assisted Living
40170 County Road 257
Cohasset, MN 55721
Itasca County

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

Evaluator's Name: Barbara Axness, RN
Special Investigator

Finding: Inconclusive

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 they failed to administer the resident's medications according to physician orders. The resident did not receive her blood pressure medications, resulting in the resident having several falls due to uncontrolled blood pressure.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. Due to conflicting information provided, it was unable to be determined if a medication error occurred.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted the resident's case manager. The investigation included review of the resident's records, facility incident reports, and related facility policies and procedures. At the time of the onsite investigation, the investigator observed care and services in the facility.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia with behavioral disturbances, agitation due to dementia, and hypertension (high blood pressure). The resident' service plan included assistance with behavior management and medication administration. The resident's assessment indicated the resident had high blood pressure and staff were directed to administer prescribed medication and report signs of high blood pressure to the nurse.

The resident's medication administration record (MAR) indicated the resident received Hydralazine (a medication used to lower blood pressure) 25 milligrams (mg) three times per day. The MAR indicated the medication was administered as ordered.

The resident's record contained three fall incident reports that all occurred on the same day, over an eight-hour period. The resident fell in her bathroom at 5:45 a.m., fell again at 10:40 a.m., and fell a third time at 1:13 p.m. The resident sustained no significant injuries from the falls. The medical record indicated that during follow-up evaluation of the falls, staff discovered that the resident's blood pressure medication was not administered in the two days prior to the falls and the resident's blood pressure was elevated on the day that the falls occurred.

There was no medication error report completed related to the missing medication referenced on the incident reports and facility documentation provided contained conflicting information on if a medication error occurred.

During an interview, a facility nurse stated she was working the day the resident fell. The nurse noticed the resident's blood pressure was running higher than normal so she checked the medication cart and noticed that the resident's Hydrazine was documented as administered on the days prior to the falls, but it was still contained within the medication card (indicating it was not administered). The nurse thought this could have contributed to the higher blood pressures and notified nursing management of the identified potential error.

During an interview, facility administration stated there were discrepancies in documentation and they were unable to determine if a medication error occurred and if it was correlated to the resident's falls.

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

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

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:
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

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30666	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE WOODS ASSISTED LIVING	40170 COUNTY ROAD 257 COHASSET, MN 55721

(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 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: HL306661800M/HL306669602C HL306661460M/ HL306668896C On March 6, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 15 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL306661800M/HL306669602C, tag identification 2320. The following correction order is issued for #HL306661460M/ HL306668896C, tag identification 2320.	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.	
02320 SS=G	144G.91 Subd. 4 (b) Appropriate care and services	02320		

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02320	Continued From page 1 (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 interview and record review, the licensee failed to ensure care and services were provided according to acceptable health care and medical, or nursing standards and supervision for two of two residents (R1, R2) with records reviewed. The licensee failed to ensure dressings were compelted as prescribed. R1 had two wounds to her left lower extremeity, a mid-foot stage two pressure ulcer and another pressure ulcer on her ankle. In addition, the licensee failed to update the resident's provider of difficulties obtaining prescribed supplies for wound healing including a Rooke boot (a specialized vascular boot that helps prevent skin breakdown) and specialized mattress to help prevent skin breakdown. In addition, the licensee failed to update the provider on R1's refusal to comply with interventions to help the wound heal. The licensee failed to document follow-up actions taken in response to a reported medication error for R2. The licensee also failed to ensure a process was in place for notifying the nurse for out of range vital signs for R2. 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	02320		

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02320	Continued From page 2 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's diagnoses included cellulitis of left lower limb and type two diabetes with diabetic neuropathy. R1's service plan dated August 11, 2023, indicated the resident had twice daily wound care, wound care every two days, and weekly wound care supervision done by the licensed practical nurse (LPN). Progress notes included the following: -November 2, 2023, the nurse practitioner (NP) assessed the resident's wound on November 1. Orders to continue wound orders and add compression to left lower extremities with ace wrap on during the day off at night, elevate left lower extremity. -November 6, 2023, R1 was seen in house for a wound care visit. "(Licensed practical nurse) LPN comments: no concerns at this time, monitor left ankle as it is darker pink, continue to elevate." -December 12, 2023, registered nurse (RN)-A documented, "Resident was seen in house for routine wound care. RN comments: new pressure ulcer to left lateral ankle, stage 2. New orders: Dankins wet to dry to left ankle. Cleanse both pressure ulcers with gentle soap and water, blot dry. Moisten gauze with dankins and place into wound bed. Careful not to get on healthy skin, cover with ABD and wrap with kerilix twice a day. -December 15, 2023, a fax was received for an order for a powered pressure reducing air mattress, low air loss. Mattress was sent to [DME supplier] Facility to follow up.	02320		

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02320	Continued From page 3 -December 18, 2023, resident was seen for wound care and new orders were written. Staff were to change left ankle wound dressing every other day and as needed. After cleaning, apply a thick layer of santyl in wound bed, cover with Mepilex border dressing. The left lateral foot was to have the dressing changed every other day and as needed. After cleaning, cover with Mepilex border dressing. An order was placed for a Rooke boot to be worn at all times. -December 22, 2023, Resident was seen by wound care RN; nurse comments, "new open area observed to 4th toe - 0.4cm x 0.3cm implementing Beta-dine to toe. Paint daily and cleanse. Monitor wounds for worsening and for signs/ symptoms of infection. Report to NP and agency nurse. NP updated." RN put in for new orders, "Beta-dine - paint 4th toe on left foot daily with gauze and cleansing wound." -December 26, 2023, RN-A documented, "MN department of health called facility to inquire about residents new open pressure ulcer to left ankle. Asked about residents compliance with wound care and preventives. Informed that resident is compliant with wound care but is often not compliant with utilizing Prevalon boot. Provider now recommending rooke boot and new wound care orders initiated for area with recent apt. Resident is at times compliant with elevation if in her room, but is not complaint if any activities are taking place or if she doesn't feel like it. She did not request any other information." -December 27, 2023, the resident was seen in house for skilled nursing. "LPN comments: Wound care provided. No improvement." -January 1, 2024, RN-A documented the "ulcer to ankle has increased slightly in size since last week, with odor present, increased redness and drainage. Primary NP [nurse practitioner] and	02320		

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02320	Continued From page 4 wound care NP updated, awaiting further instructions." -January 2, 2024, staff called the medical equipment supplier to follow up on the status of the Rooke boot. "Will follow up if we don't hear anything in the next couple of days." -January 3, 2024, RN-A documented, "[DME supplier] called in regards to residents rooke boot. She states they have everything they need from the doctor and insurance has approved. They will be sending boot out in the mail. Due to it being a specialty item it may take a couple weeks to arrive" RN-A failed to update the resident's provider the boot and mattress still had not been obtained yet. -January 9, R1 was seen at the clinic for a wound care follow up. New orders were written to change the dressing on the left foot and ankle twice daily. After cleaning the area, staff were to moisten a gauze pad with Dakins and fold it into the wound base and then cover it with ABD and kerlix roll gauze. A call was placed to "set up for BKA [below the knee amputation.] -January 10, RN-A documented the resident was seen for a skilled nursing visit and the LPN commented the wound was healing slower and signs and symptoms of an infection were noted. -January 11, RN-A documented a home care nurse reported on January 10 that the resident had on the same dressing placed on January 8th. In addition the resident reported ten out of ten pain and required an as needed (PRN) pain medication. -A note dated February 5, but backdated to January 11, RN-A documented, "LPN from home care reported on 1/10/24 to RN in facility that resident had on same mepliex dressing that she had placed on 1/8/24. She reported the same amount of Mepilex in the box as there were on Monday and that dakins bottle is still sealed.	02320		

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02320	Continued From page 5 Resident had wound care orders changed from Mepilex to dankins wet to dry BID. Orders updated on 1/9/24 per apt instructions from apt on 1/8/24. Staff interviewed that worked morning of and night before. Afternoon staff omitted to not changing residents dressing due to thinking other staff had completed. AM staff confirmed they removed krilix/dressing prior to residents shower that morning and then placed Mepilex. When resident was interviewed she reported she doesn't remember if/how many times dressing had been changed. Mepilex was found in both residents room as well as having some in wound care cart. Dakins bottle was found open in residents bathroom and placed back into medication cart. LPN denies putting date or initial on dressings she completed 1/8/24. Complaints not substantiated, No maltreatment suspected. Staff instructed to date and initial bandages when changed. Pictures placed in residents room showing step by step directions of how wound care should be completed and as reminder/tool for staff." -January 12, the resident was "seen in house for skilled nursing visit. LPN comments: wound care provided. Educate staff that dakins goes in wound bed only..." -January 23, the resident was "seen in house for skilled nursing visit. LPN comments: educate staff to keep Dakins on wound bed only and to apply ace wrap in the AM." -February 5, R1 "saw provider for general surgery consult. MD comments: non healing left ankle ulcer. Left below the knee amputation scheduled for February 20th..." -February 12, RN-A documented R1 reported "wound care was not completed this AM. Previous dressing did not have kerlix, used ace wrap instead. Educate staff on proper wound care, will order supplies. AM staff did not	02320		

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02320	Continued From page 6 complete wound care due to skilled nursing visit." -February 20, the resident admitted to the hospital for a planned left below the knee amputation (BKA). -March 4, 2024, staff called DME supplier to "see what the status is on her pressure relieving mattress. Will update after this writer hears something back." The licensee provided evidence of wound care training for employees who provided wound care to R1. Dates of training for the eight employees ranged from July 2, 2022, to September 5, 2023. Additional training records indicated wound care training was provided on December 12, 2023, December 19, 2023, and December 22, 2023, for all employees. On March 13, 2024, at 9:35 a.m., clinical nurse supervisor (CNS)-H stated nursing had been working with staff on proper wound care and "reeducating the staff but we can't babysit everybody all the time, but the wound is improving there's no concerns." CNS-H stated R1 had "wanted an amputation, she asked for an amputation...the wound continued to show improvement so if we were so bad off on what we were doing, it wouldn't have improved at all and it would have gotten worse and worse." On March 13, 2023, at 4:50 p.m., registered nurse (RN)-A stated R1's wound care was "kind of a roller coaster, she kept having changes to the dressing and we had a rough patch there...but you'll see home care saying it's starting to improve." RN-A stated there were some instances where the dressing was done incorrectly and she had printed out pictures with step by step instructions to give staff a visual of how to complete it and kept educating staff on	02320		

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02320	Continued From page 7 how to do the dress. RN-A confirmed they did not have documentation of additional education done with the unlicensed personnel who had the most difficulty with doing the dressings correctly. On March 14, 2024, at 12:20 p.m., licensed assisted living director (LALD)-D stated she knew there was a concern when staff were using betadine versus the prescribed cleanser and they did one-on-one training with staff to ensure they knew the proper way to do wound care and after that, there weren't any concerns. On March 20, 2024, at 10:24 a.m., RN-A wrote in an email they had "called the company they ordered the boot from today (March 20) and they report the boot was delivered on January 15th via UPS. I was not made aware of the delivery. The wound care provider was not faxed. She does have the air mattress, the company reports delivered on February 16th, to which I was also not made aware of the delivery. She does have the air mattress, company reports delivered on Feb 16th, to which I also was not made aware of delivery. it took some time to obtain air mattress as you can see from OT [occupational therapy] notes, due to insurance and multiple changes to verbiage from NP [nurse practitioner] were needed to obtain. OT stayed on with resident specifically to handle obtaining DME [durable medical equipment] items needed for resident due to difficulty obtaining ." On March 20, 2024, at 10:30 a.m. case manager (CM)-E stated she only had contact with the facility in August when she did her annual in person visit and in February for her six month follow up. CM-E stated she did not get any updates between August to February from the facility that they were having issues obtaining the	02320		

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02320	Continued From page 8 boot or mattress. CM-E stated, "They should call me if they're having issues because I help with that stuff. I'm not sure why that would have been that hard, it shouldn't have been. We do boots all the time but I never received any calls from them." On March 20, 2024, at 11:25 a.m., case manager (CM)-F stated she was not notified of any issues with obtaining supplies or that there were any care concerns with the resident. CM-F stated she didn't know the resident was having an amputation, as the facility did not update her and only found out when she came to do a scheduled assessment. On March 20, 2024, at 1:00 p.m., RN-A confirmed the Rooke boot was never implemented as she was not aware it had arrived. RN-A stated she had contacted the resident's case managers and they were aware of the DME supplies that had been ordered. On March 20, 2024, RN-A provided documentation to show evidence the case manager was notified for the DME orders. The progress note dated October 20, 2023, indicated an administrative staff person "called [DME supplier] and stated that there is a $200 upgrade on some of her DME things through them...This writer left her case manager a message in regards to this matter..." The progress note did not identify which case manager was contacted and was dated before the order for Rooke boot and mattress were received on December 18 and December 15, 2023. REFUSALS R1's assessment dated December 13, 2023,	02320		

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02320	Continued From page 9 lacked an assessment of R1's refusals to comply with wound interventions and lacked any interventions for staff to use if the resident refused anything. The assessment indicated "staff to ensure Prevalon boot is on LLE at all times. May only come off for dressing changes. Document refusals to wear." The assessment further indicated on May 8, 2023, the resident "does not always wear her Prevalon boot." Staff were to ensure the resident had the Prevalon boot on at all times for pressure relief. The resident's left lower extremity was to be wrapped with an ace wrap daily and removed only at night. R1's record contained a service recap summary for the resident's use of ace wraps to the lower left leg. The record indicated the ace wraps were not completed on the following days: -November 6 the resident declined -November 10, "can not find in room or anywhere" -November 12, "where are ace wraps" Staff documented the ace wraps were removed in the evening. -November 13, "cannot find." -November 14, "can not find." -November 15, "not completed" -November 17, "unable to find wraps." Staff documented the ace wraps were removed in the evening. -November 19, wraps were not put on due to being wet -November 20, "did not get to" -November 21, "resident didn't have ace wraps on" -November 23, resident refused -November 24, resident refused -November 25, resident refused -November 26, "did not apply as this writer could not find them in her room." Staff documented the	02320		

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02320	Continued From page 10 ace wraps were removed in the evening. -November 27, resident refused -November 28, "cannot find" -November 29, staff documented the ace wraps were put on. Evening staff documented "resident didn't have ace wraps on." -November 30, "not done" -December 1, resident refused -December 2, ace wraps were not put on due to being wet -December 3, resident refused -December 4, resident refused -December 6, "resident was not wearing ace wraps" -December 7, resident refused -December 8, "resident was not wearing ace wraps" -December 9, resident refused -December 12, resident refused -December 13, "resident was not wearing ace wraps" -December 14, "resident declined this service. states that the pressure wrap causes pain to wounds on foot. did agree to elevation after lunch." -December 15, resident refused -December 16, resident refused -December 18, "resident is not wearing them" -December 19, resident refused -December 21, "resident declined. they hurt her foot." -December 22, "resident wasn't wearing ace wraps." -December 23, resident refused -December 24, staff documented ace wraps were put on in the morning, however evening staff documented they were not on. -December 25, resident refused -December 26, resident refused -December 27, resident refused	02320		

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	30666	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE WOODS ASSISTED LIVING	40170 COUNTY ROAD 257 COHASSET, MN 55721

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02320	Continued From page 11 -December 28, resident refused -December 29 resident refused -December 30, resident refused -December 31, resident refused -January 3, resident refused -January 4, resident refused -January 5, resident refused -January 6, resident refused -January 8, resident refused -January 10, resident refused -January 11, resident refused -January 13, resident refused -January 14, resident refused -January 16, resident refused -January 17, resident refused -January 18, resident "declined ace wraps. stated they hurt" -January 20, resident refused -January 21, resident refused -January 22, resident refused -January 23, "I forgot to do it" -January 24, resident refused -January 25, resident refused -January 26, resident refused having ace wraps put on. Staff documented the resident refused to have ace wraps removed at bed time. -January 30, resident refused -January 31, resident refused -February 2, resident refused -February 5, resident refused -February 7, resident refused -February 8, resident refused -February 11, resident refused -February 13, resident refused -February 14, resident refused -February 15, resident refused -February 16, resident refused -February 17, resident refused -February 18, resident refused -February 20, resident refused	02320		

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02320	Continued From page 12 R1's record contained a service recap summary for Prevalon boots to be on at all times for pressure relief to left lower foot. The record indicated the Prevalon boot was not used on part or all of the day on the following days: -November 2 resident refused -November 3 resident refused -November 7 resident refused -November 11 resident refused -November 12 resident refused -November 13 resident refused -November 15 resident refused -November 16 resident refused -November 19 resident refused -November 20, resident refused -November 21, resident refused -November 24, resident refused -November 25, resident refused -November 26, resident refused -November 28, overnight staff documented they "forgot to do it" -November 29, resident refused -November 30, resident refused -December 2, resident refused -December 4, resident refused -December 5, resident refused -December 6, resident refused -December 7, resident refused -December 8, resident refused -December 10, resident refused -December 11, resident refused -December 12 overnight staff documented "didn't do it sorry" -December 13, resident refused -December 14, resident refused -December 16, resident refused -December 17, resident refused -December 18, resident refused -December 20, resident refused	02320		

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02320	Continued From page 13 -December 21, resident refused -December 26, resident refused -December 27, resident refused -December 28, resident refused -December 29, resident refused -December 30, resident refused -December 31, resident refused -January 8, resident refused -January 13, resident refused -January 18, resident refused -January 23, resident refused "she does not like to wear it in day time" -January 24, resident refused -January 26, resident refused -January 28, resident refused as she said she wears it at night -January 29, resident refused -January 30, resident refused -February 6, resident refused -February 11, resident refused -February 13, resident refused "wore boot for approx 1 hour" -February 15, resident refused -February 18, resident refused, "took boot off resident saying it hurts. gave her pain pill" -February 20, resident refused On March 20, 2024, at 1:00 p.m., RN-A stated the provider was aware of the resident's refusals because it had been ongoing with the resident for a while. RN-A stated she would locate documentation to reflect the provider was updated. RN-A stated she was not sure why the assessment failed to detail the resident's history of refusals and the risks related to the resident's ongoing refusals. RN-A stated the resident had a right to refuse. On March 20, 2024, RN-A provided documentation to show evidence the provider	02320		

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02320	Continued From page 14 was updated of the resident's ongoing refusals for ace wraps and Prevalon boot in November, December, January, and February. RN-A provided documentation of nurse practitioner rounds from September 6, 2023, which indicated the resident was noncomplaint with the Prevalon boot. On March 21, 2024, at 9:15 a.m., RN-A confirmed they had not updated on the refusals because the provider was already aware. RN-A stated she didn't feel they need to update the provider since she knew the resident refused. R2 MEDICATION ERROR FOLLOW UP R2's diagnoses included dementia with behavioral disturbances, agitation due to dementia, and hypertension (high blood pressure). R2's service plan dated April 7, 2023, indicated the resident received services including behavior management and medication administration. R2's assessment dated March 5, 2024, indicated the resident had high blood pressure and staff would administer blood pressure medications as ordered. Staff were to report signs of high blood pressure to the nurse. R2's medication administration record (MAR) for January 2024 indicated R2 received Hydralazine (a medication used to lower blood pressure) 25 milligrams (mg) three times daily. The MAR indicated the medication was given as ordered on January 9 and January 10, 2024. R2's record contained three fall incident reports for January 7, 2024. R2 fell at 5:45 a.m. in her bathroom.	02320		

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02320	Continued From page 15 R2 fell at 10:40 a.m. in her bathroom. The resident was noted to have been agitated that morning. R2 fell at 1:13 p.m. in her room while trying to stand up and get her walker. A section titled "Where (sic) there any warning signs prior to the fall" included "resident had fall previously in the shift and was very upset-nurse was able to calm resident but after situation dissipated and stood up, she had this fall. Resident was ranting about how another resident was making her so angry. Very short fused entire day. Unknown until after following up with falls- 2 days worth of hydrazine was not given-had staff give resident's noon dose late; blood pressures were rocket high and resident's anxiety unmanaged with PRN medication." LPN-S completed the incident report on January 7, 2024, but it was not signed off by RN-A until January 16, 2024. R2's blood pressure on January 7, 2024, was noted to be: -At 11:04 a.m., her blood pressure was 145/82 -At 1:13 p.m. her blood pressure was 175/78 -At 1:30 p.m., her blood pressure was 189/92 -At 1:45 p.m., her blood pressure was 151/97 At 1:50 p.m., her blood pressure was 147/65 On March 12, 2024, at 12:30 p.m., licensed practical nurse (LPN)-S stated she was working when R2 had the series of falls on January 7, 2024. LPN-S stated she noticed the resident's blood pressure was running higher than it normally did so she went to the medication cart and "saw her Hydrazine was documented as given both days but not popped out, which would contribute to the higher blood pressures." LPN-S stated she texted the nursing group and she had disposed of the pills that were not given and still in the bubble pack.	02320		

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02320	Continued From page 16 On March 13, 2024, at 9:05 a.m., clinical nurse supervisor (CNS)-H stated the facility has "lots of falls" but was not sure why a medication error form or other documentation was completed after it was noted two days of Hydrazine were not given. CNS-H stated "I'm not sure why they'd put it in the incident report but not do a medication error." CNS-H stated the registered nurse case manger (RN-A) would be responsible for following up on incident reports and investigating medication errors and while as the CNS would be responsible for making sure procedures are followed, "I should expect my RN case manager to do what needs to be done with things like that." On March 13, 2024, at 4:15 p.m., RN-A stated the LPN had reported the resident did not get her blood pressure medications but when she went to follow up on the issue that Monday, there were no extra medications in the bubble pack. RN-A stated she did not do an investigation or take any further action since the medication was signed off as given and there were none left in the bubble pack. RN-A stated she did not do a medication error report or enter any documentation to explain what happened or what follow up was done after the fall report indicated medication was not given. On March 14, 2024, at 12:05 p.m. licensed assisted living director (LALD)-D stated, "I do know she [R2] got her medications. The incident report was worded wrong so when [RN-A] looked she did get her medications. I know they were not in the bubble pack and were charted as given." Text messages between CNS-H, LPN-S, RN-A, LALD-D, a lead unlicensed personnel, and another facility RN dated January 7, 2024, indicated LPN-S wrote "Two days were charged	02320		

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02320	Continued From page 17 [charted] she was given hydrazine but was still in bubble for both noons." The text chain also included the following: CNS-H wrote, "Let's put the icing on the cake for this weekend [unlicensed personnel] has two charted incident reports for "possible abuse" stating both [resident] and [resident] were likely not assisted all NOC [night] shift due to dried BM [feces] on both of them. [LPN-D] did day shift mention this to you at all?" LPN-D replied, "No they did not. But [R2] had four falls, one I have no clue for sure cause I was only told about it from [unlicensed personnel] No one was giving her her hypertension pill for two [expletive] days but charting it..." The licensee's Med Errors policy dated December 1, 2023, indicated a reportable med error would include but wasn't limited to when the medication was given at the wrong time or was not given at all or the medication was not documented appropriately. BLOOD PRESSURE REPORTING R2's blood pressure was noted to be out of range on the following dates: January 10, 2024, R2's blood pressure was 168/74 January 17, 2024, R2's blood pressure was 169/72 February 14, 2024, R2's blood pressure was 167/72 On March 13, 2024, at 9:20 a.m., CNS-H stated the blood pressure service had parameters that would direct staff to notify the nurse if the top number of the blood pressure was greater than 160 or less than 55. CNS-H stated she did not have documentation to show the nurse was notified for the out of range blood pressures.	02320		

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02320	Continued From page 18 On March 13, 2024, at 4:15 p.m., RN-A stated the parameters to notify the nurse would be if the top number was above 160 or the bottom number was above 90. RN-A was asked if there would be documentation to show the nurse was notified and what action was taken. RN-A stated, "No, we don't document that unless it's some kind of insane reading." RN-A stated a nurse was aware of the blood pressures on January 10 and January 17 because the LPN took them and sent a message to the care team about it. RN-A stated they did not have any documentation to show the ULP who documented the February 14, 2024, blood pressure reported it to a nurse. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		