Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306965563M
Compliance #: HL306969519C

Date Concluded: January 8, 2024

Name, Address, and County of Licensee Investigated:
Inver Grove Heights White Pine Assisted Living
9056 Buchanan Trail
Inver Grove Heights, MN 55076
Dakota County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Brooke Anderson, RN
Special Investigator

Finding: Substantiated, facility and individual 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 alleged perpetrator (AP), a facility unlicensed staff member, neglected a resident when the AP transferred a resident with a sit to stand mechanical lift and the resident slipped and dislocated their hip.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The individual and the facility were responsible for the maltreatment. The individual staff member/alleged perpetrator (AP) failed to follow the resident's care plan during a transfer and the resident fell. Following the fall, the resident complained of right hip pain. Nursing staff failed to monitor and assess the resident's ongoing and worsening complaints of pain. The resident was left in a recliner chair for the next 24 hours, as staff were unable to move the resident due to the resident's level of pain. The next day, the resident was admitted to the hospital and required a closed reduction right total hip arthroplasty (a surgical procedure to restore the function of a joint).

The investigator conducted interviews with facility staff members, including nursing staff, and unlicensed staff. The investigation included review of the resident's medical record, hospital records, personnel files, and facility policies. At the time of the onsite visit, the investigator toured the facility and observed interactions between staff and residents.

The resident resided in an assisted living facility. The resident's diagnoses included type two diabetes mellitus, congestive heart failure, and morbid obesity. The resident's service plan included two person staff assistance with transfers using a sit to stand mechanical lift, assistance with dressing, grooming, bathing, and medication management. The resident's assessment indicated the resident was cognitively intact and was able to provide accurate information.

The facility incident report indicated at 9:16 a.m. the AP transferred the resident using a sit to stand mechanical lift. The incident report indicated the resident's foot slipped, he felt unsteady, and was lowered to the ground. The incident report indicated there was no apparent injury and indicated range of motion (ROM), an assessment of flexibility and mobility of joints, was completed and intact before the resident was assisted off of the floor.

A progress note entered at 10:06 a.m. that morning indicated the nurse was notified the resident was on the ground after being lowered to the floor. The progress note included that nursing "put a sheet under him" and staff was able to get him into his recliner. The progress note indicated staff would continue checks on the resident every 30 minutes.

The resident's medical record included no evidence of 30-minute checks being implemented or completed by staff.

The resident's medical record lacked evidence of ongoing assessment of the resident's condition, pain level, or ability to complete ROM, from the time of the 10:06 a.m. progress note until a progress note entered at 9:28 p.m. that evening. The 9:28 p.m. progress note indicated staff contacted the licensed practical nurse (LPN) to report the resident had increased hip and leg pain. The note indicated the resident was in the recliner and the nurse directed staff to administer as-needed (PRN) Tylenol, ice, and pressure support to his hip and leg for comfort. The note indicated an x-ray was ordered to be completed in the morning and staff were to notify the nurse if the resident's pain worsened or continued.

At 9:41 p.m., a progress note indicated the LPN contacted the resident's family who agreed with the resident remaining at the facility, unless necessary, with staff assisting with interventions for pain. The family agreed to have emergency medical services (EMS) summoned if the resident experienced increased or worsening pain throughout the night. The LPN documented staff were instructed to continue with safety checks and offer comfort measures for pain relief, including PRN Tylenol every four hours throughout the night.

The resident's medical record included no evidence of continued safety checks or additional assessment of the resident.

The next progress note was written at 10:24 a.m. the following morning and indicated x-rays were unable to be obtained due to the resident being in the recliner. Staff were unable to assist the resident out of the recliner as they were "unable to get his socks and shoes on without causing him pain." EMS was contacted and transported the resident to the hospital for x-rays.

The facility's internal investigation documentation indicated after the fall, the nurse and five additional facility staff assisted the resident to his recliner. The documentation did not identify how staff transferred the resident. The documentation indicated at 4:00 p.m., the resident complained of right hip pain and the nurse requested an x-ray, however this was not documented in the resident's medical record. There was no documentation of an assessment by the nurse or indication the family was updated of the resident's increase in pain or that the x-ray was ordered. At 9:30 p.m. facility staff contacted the nurse as the resident had continued and worsening complaints of pain in his hip and leg. The nurse directed staff to administer Tylenol, ice, and pressure support to the resident. The incident report indicated the resident declined further intervention and the family was contacted, who agreed the resident should remain at the facility. The following morning, the x-ray technician was unable to obtain an x-ray as the resident could not be assisted out of the recliner due to pain and was sent to the hospital for evaluation.

The hospital record indicated the resident arrived at the emergency department with right hip pain that occurred while being transferred at the facility. The hospital record indicated the resident used a sit to stand mechanical lift for transfers and when the facility staff transferred the resident, staff did not have the resident's wheelchair nearby and left the resident hanging in the lift while they grabbed the resident's wheelchair. The resident slid out of the sit to stand lift, fell onto his right hip, and had an acute onset of pain. The hospital record indicated the resident had ongoing pain since the fall and was left in his recliner for 24 hours due to staff's inability to transfer the resident due to right hip pain. The hospital record further indicated the resident arrived at the emergency department soiled due to incontinence and signs of skin breakdown with trace (small) amounts of bleeding noted in the right inguinal fold (the fold or crease where the abdomen meets the inner thigh). The hospital records physical exam notes indicated the right lower extremity was shortened and externally rotated (indicative of dislocation or fracture) and significant pain was noted upon any attempted range of motion of the right hip. The resident was diagnosed with a dislocation of the right hip, seen by orthopedics, underwent surgery, and returned to the facility.

During an interview, the facility registered nurse (RN) stated when she arrived for her shift the morning of the fall, she saw the AP at the end of the hallway and the AP asked for help. The AP told the nurse the resident's foot slipped from the sit to stand board during a transfer and the AP lowered the resident to the ground. The RN stated four staff were able to get the resident up into the recliner. The RN recalled the resident complained of pain later that day and she

obtained an order for a hip x-ray. The RN stated she received a call later that night that the resident was still in his recliner and spoke with the on-call licensed practical nurse (LPN) who was coordinating a plan with staff. The RN stated when she arrived the next morning the resident was still in the recliner, so the ambulance was called, and the resident was sent to the emergency room for evaluation. The RN indicated the on-call LPN reported that the resident's family said if the resident was comfortable to keep him in the recliner. However, the RN felt this was a miscommunication and "sounds like [the family] didn't want him to sit in the recliner all night."

During an interview, the resident stated staff, on occasion, would tell him they were short staffed and transferred him using only one staff member. The resident stated more staff than the AP have transferred him alone using the sit to stand lift. The resident recalled the day of the incident, the AP was supposed to have two staff members for the transfer, but the AP completed the transfer alone. The resident stated when the AP lifted the sit to stand lift, he slipped and fell. The resident stated he went to the hospital and they put his hip back into place.

During an interview, the resident's family member stated they previously witnessed facility staff transfer the resident with only one staff member while using the sit to stand lift and reported this concern to facility management. The family recalled being informed that the resident fell out of the sit to stand lift, staff attempted to get the resident up but were only able to get him to his recliner. The family member stated the facility called later to update about the incident and told him the resident was comfortable and they were going to let the resident be in his recliner chair overnight. The family member stated when the resident arrived at the hospital, he was incontinent of feces and urine and the facility had not assisted with incontinent cares. The family indicated the resident did not refuse to go to the hospital and had they known the resident would be left in pain, feces, and urine, the family would have had him sent to the emergency room right away.

Review of the AP's employment record indicated the AP was recently trained and competency tested on facility policies and procedures, including following resident care plans and proper lift and transfer techniques. Following this incident, the AP and all additional facility staff were provided re-education.

Attempts to interview the AP were unsuccessful. At the time of the investigation the AP was no longer employed by the facility.

Facility staff who worked at the time of the incident were no longer employed at the facility and did not respond to requests for interview.

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: No, attempts to interview the AP were unsuccessful.

Action taken by facility:
The facility sent the resident to the emergency room, completed an internal investigation, and completed facility wide education after the incident.

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
Dakota County Attorney
Inver Grove Heights City Attorney

Inver Grove Heights Police Department
Minnesota State Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30696	A. BUILDING: _____ B. WING _____	C 10/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INVER GROVE HEIGHTS WHITE PINE	9056 BUCHANAN TRAIL INVER GROVE HEIGHTS, MN 55077

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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: #HL306969519C/#HL306965563M #HL306966506C/HL306968887M #HL306965883C On October 9, 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 63 residents receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL306969519C/#HL306965563M, tag identification 2310 #HL306965883C, tag identification 0470 #HL306966506C/HL306968887M, tag identification 0620, 1640, 1700, 1880, 1920	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 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. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements	0 470		

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0 470	Continued From page 1 (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a staffing plan to determine staffing levels to meet the needs of all residents who reside in the facility. 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	0 470		

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0 470	Continued From page 2 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living license. On October 9, 2023, a complaint investigation was initiated and the facility had a current census of 63 residents. During an entrance conference on October 9, 2023, at approximately 10:30 a.m., campus director (CD)-A stated the licensee had a staffing plan and the registered nurse (RN) reviewed it daily. During the entrance conference on October 9, 2023, at approximately 10:45 a.m., registered nurse (RN)-B stated the RN didn't complete the staffing plan alone. Meetings occur with corporate members and the meetings include discussion on how many mechanical lift transfers and diabetics resided at the facility. RN-B stated she was unsure if those meetings are documented. On October 10, 2023, at 3:00 p.m., CD-A stated the licensee didn't document the staffing plan. CD-A stated the meetings with the corporate staff were not documented. CD-A confirmed there was no staffing plan. The licensee's policy Staffing and Scheduling dated August 1, 2021, indicated the clinical nurse supervisor/RN will develop and implement a written staffing plan that provides an adequate	0 470		

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0 470	Continued From page 3 number of qualified direct- care staff to meeting the residents' needs 24-hours a day, seven- days a week. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 620 SS=E	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined	0 620		

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0 620	Continued From page 4 in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment and complete a thorough investigation for two of four residents (R3, R4) with records reviewed.	0 620		

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0 620	Continued From page 5 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 a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On September 27, 2021, at approximately 10:50 a.m., a request was made to licensed assisted living director (LALD)-A and registered nurse (RN)-B to review all vulnerable adult reports the licensee had made to the Minnesota Adult Abuse Reporting Center (MAARC) since February 1, 2023. R3 The licensee failed to immediately report to MAARC R3's unaccounted for narcotic loss and/or spillage on two occasions. R3's diagnoses included Parkinson's disease, anxiety disorder, and opioid dependence. R3's service plan, dated October 10, 2023, indicated R3 received medication management services. A licensee document dated July 29, 2023, indicated ULP-F witnessed the ULP-C take pills out of his pants pocket and give them to R3. The licensee document indicated ULP-F knew it was not R3's medications. The licensee document indicated one Oxycodone 10 milligram (mg) tablet was missing which created the imbalance in the	0 620		

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0 620	Continued From page 6 narcotic count. The document identified ULP-C took the medication and gave R3 a different medication. A police report dated July 29, 2023, indicated thirty of R3's Oxycodone tablets were stolen. A police report indicated R3 was a victim because she is out of a needed medication. On October 10, 2023, at 2:37 p.m., campus director (CD)-A stated ULP-C was terminated because of the missing narcotic medication. CD-A stated an internal investigation was completed; police were notified but a MAARC report was not completed because ULP-C did not actually hurt R3. In an email correspondence with CD-A on October 24, 2023, at 3:50 p.m., CD-A indicated R3 used to have Oxycodone scheduled for every 4 hours. R3 was sent six cards of medications when the pharmacy delivered medication. CD-A stated the licensee always kept one card in the medication cart and kept the rest in a lock box in the director's office. A full card of Oxycodone also went missing from the locked closet. R4 The licensee failed to immediately report to MAARC R3's unaccounted for narcotic loss and/or spillage. R4's diagnosis included Parkinson's disease, chronic low back pain, chronic major depressive disorder. R4's service plan dated January 15, 2021, indicated R4 oversaw all of his medications. R4 received safety checks, dressing and grooming assistance.	0 620		

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0 620	Continued From page 7 On October 23, 2023, at 2:00 p.m., CD-A stated R4 was in the hospital when the narcotic discrepancy occurred. CD-A stated a bottle of twenty narcotics went missing. RN-B and CD-A arrived at the facility and the police were notified. On October 17, 2023, at 1:04 p.m., RN-B and RN-E confirmed reports should have been submitted to MAARC regarding missing narcotics for R3 and R4. The licensee's Medication Loss or Spillage policy dated August 1, 2021, indicated if a drug is unaccounted for the registered nurse will investigate the situation. The investigation will be documented in required records and any state or federal required action will be taken, if necessary. The licensee's Vulnerable Adult Maltreatment-Prevention and Investigation Policy dated August 1, 2021, noted maltreatment is defined as neglect, abuse, and exploitation/theft. Staff who suspect maltreatment of a resident (abuse, financial exploitation, or neglect) should report to the Assisted Living Director or RN. If the Assisted Living Director or RN confirm the suspicion of maltreatment, they will contact Minnesota Adult Abuse Reporting Center (MAARC). Such report should be made no later than 24 hours after the maltreatment was first suspected. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to	01640		

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01640	Continued From page 8 (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure service plans were developed and implemented for one of four residents (R4) 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)	01640		

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01640	Continued From page 9 The findings include: R4's record lacked evidence that a service plan had been revised. R4's diagnosis included Parkinson's disease, chronic low back pain, chronic major depressive disorder. R4's service plan dated January 15, 2021, indicated R4 oversaw all of his medications. R4 received safety checks, dressing and grooming assistance. A police report dated February 27, 2023, indicated twenty of R4's Oxycodone pills went missing from a facility medication cart. During an email correspondence on October 26, 2023, RN-B indicated the licensee started medication management on 01/21/2023. R4 was sent to hospital and did not return on 02/13/2023. The service plan was not revised to reflect the addition of medication management as R4 was frequently in the hospital. The licensee's Service Plan Policy dated August 11, 2022, indicated service plans should be revised based on resident assessments. The service plan and revisions should include a signature by a licensee representative and the resident or resident's representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		

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01700	Continued From page 10	01700		
01700 SS=D	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an assessment was completed prior to initiating medication management services for one of four residents (R4) with records reviewed. This practice resulted in a level two violation (a	01700		

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01700	Continued From page 11 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: R4's records lacked evidence a medication assessment was completed by an RN to include all required content prior to initiating medication management services. R4's diagnosis included Parkinson's disease, chronic low back pain, chronic major depressive disorder. R4's service plan dated January 15, 2021, indicated R4 oversaw all of his medications. R4 received safety checks, dressing and grooming assistance. A police report dated February 27, 2023, indicated twenty of R4's Oxycodone pills went missing from a medication cart. During an email correspondence on October 26, 2023, RN-B indicated the licensee started medication management on 01/21/2023 and confirmed R4's service plan did not include the service of medication management and was not updated at the time the service of medication management was added. During an email correspondence on October 30, 2023, RN- B indicated the expectation would be to document when initiating the service of	01700		

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01700	Continued From page 12 medication administration and a medication management assessment or uniform assessment should be completed to document and comment on the changes. The licensee's Assessments, Reviews and Monitoring policy dated August 11, 2022, indicated prior to providing medication management services, the RN will conduct an assessment including medication set up, medication administration, storing and securing medications, coordinating refills and changes to prescriptions, and communicating with the pharmacy and the prescribers. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure security and accountability for the overall management, control, and disposition of prescribed medication. This had the potential to affect all 63 residents. 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	01880		

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01880	Continued From page 13 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 9, 2023, at 10:00 a.m. medication cards were observed unsecured in a room to the right of the main entrance. The door to the lobby was propped open. On October 26, 2023, at 11:45 a.m. RN-B stated staff are to be with medications unless the medications were locked in medication cart or over stock medication closet. The licensee's Medication Storage policy dated, August 1, 2023, indicated medications must be securly locked and permit only authorized personnel to have access. Medications will be stored to prevent diversion of medications. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) days	01880		
01920 SS=E	144G.71 Subd. 23 Loss or spillage (a) Assisted living facilities providing medication management must develop and implement procedures for loss or spillage of all controlled substances defined in Minnesota Rules, part 6800.4220. These procedures must require that when a spillage of a controlled substance occurs, a notation must be made in the resident's record explaining the spillage and the actions taken. The	01920		

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01920	Continued From page 14 notation must be signed by the person responsible for the spillage and include verification that any contaminated substance was disposed of according to state or federal regulations. (b) The procedures must require that the facility providing medication management investigate any known loss or unaccounted for prescription drugs and take appropriate action required under state or federal regulations and document the investigation in required records. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to follow the procedure for loss and spillage of a controlled substance for two of four residents (R3, R4), who received medication management. 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 a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: Facility documents dated August 3, 2023, indicated narcotics went missing "multiple" times. R3 R3's diagnoses included Parkinson's disease, anxiety disorder and opioid dependence.	01920		

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01920	Continued From page 15 R3's service plan, dated October 10, 2023, indicated R3 received medication management services. A licensee document dated July 29, 2023, indicated unlicensed personnel (ULP)-F witnessed ULP-C take pills out of his pants pocket and give them to R3. The document indicated one Oxycodone 10 milligram (mg) tablet was missing which created an imbalance in the narcotic medications. The document identified ULP-C took the medication and gave R3 a different medication. A police report dated July 29, 2023, indicated ULP-F witnessed ULP-C put medications in his pocket, took out the wrong pills and gave them to R3. The police report indicated R3 told ULP-F she was given the wrong pill. The police report indicated in the months prior, thirty of R3's Oxycodone pills had went missing. In the police report, ULP-C stated the resident used to receive pink Oxycodone and now received white Oxycodone. ULP-C denied taking the Oxycodone and putting it in his pocket. The police report indicated the case was closed due to a lack of corroborating evidence. No additional documentation was provided regarding the thirty missing Oxycodone pills for R3. On October 23, 2023, at 1:30 p.m., R3 stated ULP-C gave her pain medication. When ULP-C gave R3 the medication, R3 noticed the pill was the wrong shape and wrong color. R3 reported the wrong pill to ULP-F. Pharmacy documents indicated on June 7, 2023,	01920		

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01920	Continued From page 16 the pharmacy sent Oxycodone tablets to the facility that were pink in color, round, and had an imprint of M/10 on the pills. On July 3, 2023, and July 30, 2023, the pharmacy sent out Oxycodone tablets that were white in color, round, and had an imprint of P/10 on the pills. On October 10, 2023, at 2:37 p.m., campus director (CD)-A stated ULP-C was terminated because of the missing narcotic. CD-A stated an internal investigation was completed; police were notified but a MAARC report was not completed because ULP-C did not actually hurt R3. On October 17, 2023, at 1:00 p.m. RN-B stated when the licensee received narcotics from the pharmacy, the RN would sign for the narcotics and the narcotics were placed in the lock box. The narcotic count was then entered into the narcotic book. Two staff sign off in the narcotic book on the amount. RN-B stated if a narcotic goes missing the medication passer would fill out a narcotic imbalance sheet, management is notified, a police report is completed, a MAARC report is completed, and the licensee would complete an investigation. R4 R4's diagnosis included Parkinson's disease, chronic low back pain, chronic major depressive disorder. R4's service plan dated January 15, 2021, indicated R4 oversaw all of his medications. R4 received safety checks, dressing and grooming assistance. On October 23, 2023, at 2:00 p.m., CD-A stated a bottle of 20 narcotics went missing. CD-A stated R4 was in the hospital when the narcotics went	01920		

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01920	Continued From page 17 missing. When RN-B and CD-A arrived at the facility the police were notified. CD-A stated in April 2023 two narcotics went missing due to staff not completing the count. CD-A stated follow up was completed after each incident. No additional documentation regarding the 20 missing narcotics was provided by the facility. The licensee's Medication Loss or Spillage policy dated August 1, 2021, indicated if a drug is unaccounted for the registered nurse will investigate the situation. The investigation will be documented in required records and any state or federal required action will be taken, if necessary. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01920		
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide the care and services according to the acceptable health care medical or nursing standards of one of four resident (R1) who utilized a mechanical lift transfers for transfers. In addition, the licensee failed to complete incontinence cares after a fall which	02310		

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02310	Continued From page 18 resulted in R1 being left in his recliner for 24 hours. 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 type 2 diabetes mellitus, congestive heart failure, and morbid obesity. R1's service plan dated March 15, 2023, indicated the resident received services which included two person staff assistance with transfers using an EZ stand (mechanical lift), assistance with dressing, grooming, bathing, and medication management. A facility internal investigation dated February 23, 2023, indicated at 9:16 a.m. R1 was being transferred by unlicensed personnel (ULP)-C with an EZ stand (mechanical lift). R1 began to slip and ULP-C lowered R1 to the ground and called the registered nurse (RN)-B for assistance. RN-B assessed R1. R1 denied pain and was transferred with staff assistance to the recliner. RN-B notified the family and family did not want to send R1 to the hospital if he was comfortable. The February 23, 2023, internal investigation indicated at 4:00 p.m., RN-B checked on R1 and he reported right leg pain. RN-B contacted the	02310		

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02310	Continued From page 19 primary care provider for an x-ray. R1's progress notes dated February 23, 2023, at 9:28 p.m. indicated staff called licensed practical nurse (LPN)-E and reported R1 had increased hip and leg pain. R1 reported the pain was tolerable but uncomfortable. LPN-E instructed staff to administer the as needed Tylenol, offer ice and pressure support. R1's progress notes dated February 23, 2023, at 9:41 p.m. indicated LPN-E talked to R1's family and it was agreed that R1 was to remain in the facility and not be hospitalized unless R1 was not comfortable. As needed Tylenol to be given every 4 hours and LPN-E instructed staff to complete safety checks. A progress note dated February 24, 2023, at 10:24 a.m. indicated the x-ray technician attempted to complete the ordered x-ray but was unable to due to R1 being in the recliner. Staff attempted to use the EZ stand but R1 reported pain putting on socks and shoes, so staff were unable to transfer R1. R1 was sent to the emergency room for an x-ray. Hospital records dated February 24, 2024, indicated R1 was transferred with an EZ stand and staff left R1 hanging while they went to get the wheelchair. R1 slowly slid out of the EZ stand and landed on his right hip. Hospital records indicated R1 had ongoing hip pain and had been left in the recliner for 24 hours due staff's inability to transfer R1. R1 was diagnosed with a dislocated hip and required a closed reduction right total hip arthroplasty (a surgical procedure to restore the function of a joint). On October 9, 2023, at 10:00 a.m., registered	02310		

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02310	Continued From page 20 nurse (RN)-B verified ULP-C was the only staff transferring R1 when the incident occurred. RN-B verified she received a call in the middle of the night and R1 was in his recliner. The next day when RN-B arrived to work, R1 was "still in his recliner," RN-B called the ambulance and R1 was taken to the hospital. On October 9, 2023, at 10:00 a.m., campus director (CD)-A stated the licensee used team sheets, a communication book, and twice a day stand up to communicate changes in resident condition. CD-A stated the nurses updated the information right away. CD-A stated two staff were required when using a mechanical lift including an EZ stand and Hoyer lift and staff were educated upon hire. The licensee's undated EZ Stand Policy indicated two staff are required for EZ stand transfers. The licensee's Assisted Living Bill of Rights indicated residents have the right to care and services that are appropriate based in the resident's needs. Residents have the right to receive services by competent staff and sufficient numbers to adequately provide services in the service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial	02360		

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02360	Continued From page 21 exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of four residents reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility and an individual staff member, were responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		