STATE LICENSING COMPLIANCE REPORT

Report #: HL307454341C

Date Concluded: August 7, 2024

Name, Address, and County of Facility Investigated:
Lino Lakes Assisted Living
725 Town Center Parkway
Lino Lakes MN, 55014
Anoka County

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

Evaluator's Name: Kris Detsch, RN
Special Investigator

The Minnesota Department of Health conducted a complaint investigation to determine compliance with state laws and rules governing the provision of care under Minnesota Statutes, Chapter 144G.The purpose of this complaint investigation was to review if facility policies and practices comply with applicable laws and rules. No maltreatment under Minnesota Statutes, Chapter 626 was alleged.

To view a copy of the correction orders, if any, please visit: https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html, or call 651-201-4201 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached state form.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30745	A. BUILDING: _____ B. WING _____	C 06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINO LAKES ASSISTED LIVING	725 TOWN CENTER PARKWAY LINO LAKES, MN 55014

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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: HL307453562C/HL307453401M HL307453403C/HL307453302M HL307454500C/HL307453941M HL307451753C HL307454341C On June 25, 2024, through June 27, 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 83 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for HL307454500C/HL307453941M tag identification 1760, 2360. The following correction orders is issued for HL307453562C/HL307453401M, HL307453403C/HL307453302M tag identification	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.	

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0 000	Continued From page 1 1760. The following correction orders are issued for HL307454341C tag identification, 1730, 1760, 1960. There are no correction orders issued for HL307451753C.	0 000		
01730 SS=G	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and	01730		

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01730	Continued From page 2 (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to perform a medication reconciliation to verify medications were administered as physician prescribed for one of five resident (R5) with record review. As a result, for approximately one month, R5 received inaccurate medications, including receiving an antidepressant medication that was discontinued, receiving a higher dose of her antipsychotic medication and sleep aid medication instead of the taper to reduce the dose. The licensee also failed to schedule ordered lab work and heart monitoring as the physician ordered. This practice resulted in a level three violation (a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	01730		

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01730	Continued From page 3 The findings include: R5's diagnoses included dementia, chronic kidney disease, and coronary artery disease. R5 admitted to the hospital on March 30, 2024. Following her hospital stay, she went to a TCU (transitional care unit) and returned to the licensee on April 23, 2024. R5's Service Plan-Addendum to Contract dated June 26, 2024, indicated R5 received medication administration three times per day. R5's admission nursing assessment dated April 23, 2024, indicated R5 required assistance medication management. The assessment indicated the licensee would administer medications according to physician orders and a licensed practical nurse (LPN)/registered nurse (RN) would manage those orders. The assessment indicated her current medications were reviewed and there were no duplicate therapies, significant interactions or problematic side effects observed or reported. RN-B signed the assessment as completed on April 23, 2024. R5's Individualized Medication Management Plan dated May 29, 2024, indicated R5 required full medication management from staff. The plan indicated an RN would consult with medical providers to clarify instruction changes. The plan indicated the licensee would store medications, monitor medications and supplies, and reorder medications. MEDICATION RECONCILIATION R5's TCU discharge orders dated April 19, 2024, included order changes of the following medications: -Calcium Carbonate-Vitamin D Oral Tablet: Give	01730		

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01730	Continued From page 4 one tablet by mouth one time a day for osteoporosis. -Lexapro 20 milligrams (mg), discontinued completely -Losartan Potassium Oral tablet 50 mg: Give one- and one-half tablet (75 mg) by mouth one time a day for hypertension. -Melatonin Oral Tablet: Give 6 mg by mouth as needed for insomnia. -Metoprolol Succinate ER Oral Tablet Extended Release 24 Hour 50 mg tablet: Give one- and one-half tablet (75 mg) by mouth one time a day for hypertension. -Protonix Oral Tablet Delayed Release 40 mg: Give one tablet my mouth one time a day for gastroesophageal reflux disease (GERD) -Senna Oral Tablet 8.6 mg: Give one tablet by mouth at bedtime related to constipation. -Seroquel Oral Tablet: Give 25 mg by mouth at bedtime for bipolar disorder until April 19, 2024. -Seroquel Oral Tablet: Give 50 mg by mouth at bedtime related to bipolar disorder. Order start date April 20, 2024. -Trazodone Oral Tablet: Give 50 mg by mouth at bedtime for Insomnia for one week. Start taking the medication on April 13, 2024, and stop taking the medication on April 20, 2024. -Trazodone Oral Tablet: Give 25 mg by mouth at bedtime for Insomnia for one week. Start taking the medication on April 21, 2024, and stop taking the medication on April 28, 2024. Additional orders included: -Electrocardiogram (EKG) test three to four weeks after discharge. -Blood glucose testing two times a day before breakfast and supper. -Basic metabolic profile (BMP) lab draw: One time only until April 29, 2024. -Physical therapy (PT), and occupational therapy	01730		

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01730	Continued From page 5 (OT) to evaluate and treat. R5's progress notes dated May 21, 2024, at 12:39 p.m., indicated a nurse completed a medication reconciliation of R5's medications and noticed there were several medication discrepancies (from her current medication list and the medication orders upon discharge from the TCU). R5's medication administration record (MAR) dated April and May 2024, indicated nursing changed R5's medication list on May 21, 2024. Prior to that date, R5 received incorrect medication from April 23, 2024 until May 21, 2024: -Calcium Carbonate: R5 received the medication twice daily instead of once daily. -Lexapro: R5 received 20 mg daily and was not discontinued. -Losartan: R5 received 50 milligrams (mg) once daily, not 75 mg. -Melatonin: The MAR indicated R5 required 1 milligram (mg), not 6 mg. -Metoprolol Succinate: R5 received 100 milligrams (mg), instead of 75 mg. -Protonix: R5 had not received any dosages until after May 21, 2024. -Senna: R5 had not received any dosages until May 21, 2024. -Seroquel: R5 received 100 milligrams (mg), not the physician prescribed taper to 50 mg. -Trazodone: R5 received 100 milligrams (mg) until May 20, 2024, not the physician prescribed taper. The medication should have been discontinued completely on April 28, 2024. The licensee continued giving R5 Trazadone upon her return to licensee until the medication reconciliation on May 21, 2024, when they abruptly stopped the medication without doing a	01730		

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01730	Continued From page 6 medication taper. R5's treatment administration record (TAR) dated April and May 2024, indicated unlicensed personnel (ULP) checked R5's blood sugar levels once daily at 8:00 a.m. and documented the results on the TAR. The TAR lacked blood sugar results twice daily as ordered for R5 upon her return to licensee on April 23, 2024. R5's record lacked indication licensee ordered an EKG or BMP as ordered upon discharge orders from TCU on April 19, 2024. On May 27, 2024, nurse practitioner (NP)-G wrote an order to licensee for R5 to have a BMP completed. On June 4, 2024, NP-G wrote an order to licensee for R5 to have an EKG completed. On June 27, 2024, at 10:47 a.m., RN-B said the licensee should have completed a medication reconciliation upon R5's return to facility after discharge from TCU. RN-B said the license had a transition of nurses during this time. RN-B said in this circumstance, the licensee looked into it right away but could not find the discharge summary when R5 returned. RN-B said the licensee obtained the information and notified the NP. RN-B said R5 was unharmed from this occurrence. RN-B said a few months ago the licensee's building only had one RN and one LPN, and the RN completed the nursing assessments. RN-B said the licensee has now hired more nurses who could be accountable. On July 11, 2024, at 4:20 p.m., RN-F said she worked for the licensee during the time this incident occurred. She said she worked there with	01730		

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01730	Continued From page 7 RN-B and eventually the licensee hired one other nurse, but there was no division of job duties between the two of them. The two nurses were responsible for all residents in the building. RN-F said the nurses appeared to go from one crisis to another. RN-F said the responsibility to reconcile R5's medications should have been completed by RN-B because RN-B completed the nursing assessment upon R5's return, so it would have been her responsibility. RN-F said the process when a resident returned should have consisted of the following: knowing when the resident would return, obtain medications, review discharge paperwork, and complete a nursing assessment of the resident to determine what services they require. RN-F said this process is the responsibility of the nurse, but there was no process in place to determine which nurse. RN-F said the licensee did not always inform the resident's physicians if a resident did not receive their medications. RN-F said they did for the "important" ones (medications) if they were aware of them. RN-F said nurses did not always document when they spoke to a provider [NP-G] because the provider who came to the facility twice weekly. On July 16, 2024, at 2:06 p.m., NP-G said the licensee did not communicate R5 went to the hospital or when she returned. NP-G said she requested TCU discharge information from the licensee. NP-G assessed R5 on May 7, 2024, and R5's son was present for the visit. He expressed concerns about R5's blood pressure and wanted to know her current dosages of Lexapro and Seroquel. NP-G again asked the licensee's nursing staff to provide her with the discharge summary form the TCU because she needed to know what medications R5 required or what medications were changed while she was in	01730		

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01730	Continued From page 8 the TCU. NP-G had information from the hospital, not from the TCU and the hospital discharge summary indicated the Seroquel and Lexapro needed to be held due to risk of prolonged QT interval (heart's electrical activity, prolonged QT interval can be fatal). NP-G said these medications were held while R5 was in the hospital, then while she was in the TCU the Lexapro was discontinued completely and the Seroquel was started at a lower dosage. NP-G said she went to license on May 21, 2024, and met with a nurse because the licensee did not provide the discharge orders from the TCU. She reviewed the medication list and discovered there were ten medication discrepancies the licensee did not update into their medication system when R5 returned. NP-G said she ordered an EKG, and told the licensee to monitor R5's blood pressure and heart rate because if R5's QT level was prolonged, it could lead to a slow heart rate and cardiac arrest. TCU discharge orders indicated R5's Trazadone was tapered to discontinue. The medication should have been discontinued on April 28, 2024. Upon R5's return to the licensee, they continued to give her Trazadone 100 mg every night. They abruptly discontinued this medication on May 21, 2024. NP-G said she was unaware of this. NP-G said R5's BMP was not completed upon discharge from TCU, she ordered the licensee to complete it on May 28, 2024, approximately one month later. R5's BMP lab results were abnormal, but within R5's baseline. NP-G said R5's EKG results were alright. Trazodone information located at, www.webmd.com/drugs/2/drug-11188/trazodone-oral/details, reviewed on August 8, 2024, indicated stopping Trazodone too quickly could cause serious side effects such as anxiety,	01730		

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01730	Continued From page 9 agitation, and sleep problems. The licensee's policy titled, Medication Ordering and Receipt, dated January 31, 2024, indicated licensee would ensure medications were ordered and received from the pharmacy on a timely basis. Licensee would notify the pharmacy of all new, discontinued, or changed medication orders and medication records would be updated when new medications were ordered, changed, or discontinued. Time Period for Correction: Seven (7) days	01730		
01760 SS=I	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation and record review, the licensee failed to ensure medications were ordered so each resident received medications as prescribed by their physician, and failed to document medication administration for five of	01760		

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01760	Continued From page 10 five residents (R1, R2, R3, R4, R5) with records reviewed. As a result, harm occurred to R1 and R2. The licensees's lack of oversight in medication management had the potential to affect all residents. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1's diagnoses included diabetes, dementia, and bipolar disorder (mood disorder). R1's service plan dated June 26, 2024, indicated R1 received medication administration six times per day. R1's medication administration record (MAR) dated May 1, 2024, through May 31, 2024, was reviewed. R1 failed to receive the following medication due to the licensee not having supply: Lidocaine 4% patch (used to treat pain). Administration instructions read: Apply patch to left shoulder every morning. May 1, 2024, through May 31, 2024, the medication was not available for staff to administer. Multiple entries from staff indicated the medication was not in the medication cart. Lantus Solostar (long acting insulin). Administration instructions read: Inject 18 units subcutaneous once daily, rotate sites. R1 failed to receive Lantus on the following dates:	01760		

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01760	Continued From page 11 -May 5, 2024, "Med out." -May 21, 2024, "Med out by ordered." -May 22, 2024, "Still out should be here any time." -May 23, 2024, "Med out." -May 24, 2024, "Med out he needs badly." -May 25, 2024, "Skipped-med out of stock, nurse notified." R1's progress notes dated May 22, 2024, at 2:51 p.m., indicated registered nurse (RN)-B called the pharmacy regarding Lantus insulin. The note indicated the medication should arrive on the next medication delivery. R1's progress notes dated May 25, 2024, at 7:31 a.m., indicated R1's blood sugar was 354 and he was confused, "out of it", weak, and was shaky. He was "slobbering" at the mouth. The nurse told staff members to call emergency services (911). The note further indicated R1 was out of his Lantus insulin. R1's progress notes dated May 30, 2024, at 3:54 p.m., indicated R1 returned to licensee. His diagnosis from the hospital included acute kidney injury and pneumonia. R11 required insulin, antibiotic medication, and intravenous (IV) fluids while in the hospital. R2 R2's diagnoses included diabetes, hypertension, peripheral vascular disease, and cerebral infarction (stroke). R2's service plan dated June 26, 2024, indicated R2 received medication administration four times a day. R2's MAR dated May 1, 2024, through May 31, 2024, was reviewed. R2 failed to receive the following medication due to the licensee not having supply:	01760		

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01760	Continued From page 12 Basaglar Kwikpen Insulin (long acting insulin). Administration instructions read: Inject 40 units subcutaneous (sq) every morning. R2 failed to receive Basaglar Kwikpen on the following dates: -May 19, 2024, "Out of medication until the order comes in." -May 20, 2024, "Medication is out, checked carts and med room. Has been ordered, waiting for arrival." -May 21, 2024, medication documented as given. -May 22, 2024, medication documented as given. -May 23, 2024, "out of medication was order last week sometime by me." -May 24, 2024, "out of med ordered it last week." -May 25, 2024, "Insulin hasn't arrived yet." -May 26, 2024, "Re-ordered again 5-26". R4's blood glucose (sugar) level record dated April 1, 2024, through May 31, 2024: -May 19, 2024, was 129 -May 20, 2024, was 204 -May 20, 2024, was 414 staff documented, "Was high cause she ran out of insulin." -May 21, 2024, was 196 -May 21, 2024, was 155 -May 22, 2024, was 133 -May 22, 2024, was 281 -May 23, 2024, was 197 -May 23, 2024, was 166 -May 24, 2024, was 202 -May 24, 2024, was 233 -May 25, 2024, was 202 -May 25, 2024, was 340 -May 26, 2023, was 156 -May 26, 2024, was 179 -May 27, 2024, was 238 -May 27, 2024, was 230 R3	01760		

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01760	Continued From page 13 R3's diagnoses included Sjogren syndrome, lupus, arthritis, depression, dementia, and psychosis. R3's service plan dated June 26, 2024, indicated R3 received medication administration six times per day. R3's MAR dated April 1, 2024, through April 30, 2024, was reviewed. R3 failed to receive the following medication due to the licensee not having supply: Alendronate 70 milligram (mg) tablet take one tablet by mouth once weekly (used for osteoporosis). Administration instructions read: "Take 30 minutes before first food-drink -medication. Avoid lying down for 30 minutes." R3 failed to receive alendronate on the following dates: -April 2, 2024, "Can't find med in the cart." -April 23, 2024, "Not in cart." -April 30, 2024, "Can't find med." Clopidogrel 75 mg tablet daily (blood thinning medication used to prevent stroke and heart problems). Administration instructions read: "Take one tablet by mouth once daily." R3 failed to receive clopidogrel on the following dates: -April 25, 2024, "Not in med cart." -April 26, 2024, "meds were given on time just forgot to chart." -April 27, 2024, "Not in cart." -April 28, 2024, medication documented as administered. -April 29, 2024, "Given." -April 30, 2024, "meds were gone." Isosorbide Momo ER 25 milligram (mg) tablet (used to treat heart failure). Administration instructions read: "Take one tablet by mouth once daily." R3 failed to receive isosorbide on the	01760		

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01760	Continued From page 14 following dates: -April 26, 2024, "Meds were given on time just forgot to chart." -April 27, 2024, "Medication not available." -April 28, 2024, medication documented as administered. -April 29, 2024, "Med is out." -April 30, 2024, "Meds were all out." Melatonin 3 milligram (mg) tablet (used for insomnia). Administration instructions read: "Take two tablets (6 mg) by mouth at bedtime." R3's MAR indicated on April 2, 2024, through April 30, 2024, melatonin was out of stock. However, the MAR also indicated staff administered the medication on April 5, 14, 16,17, 25, and 26, 2024. R3's MAR lacked documentation R3 received any morning or afternoon medications on April 17, 18, and 22. R3's MAR indicated R3 did not receive pregabalin medication (used to treat neuropathic pain) on April 7, 2024, at 2:00 p.m. No explanation for missed dosage documented. R4 R4's diagnoses including heart failure, psychosis, and depression. R4's service plan dated June 25, 2024, indicated R4 received medication administration three times per day. R4's MAR dated April 1, 2024, through April 30, 2024, was reviewed. R4 failed to receive the following medication due to the licensee not having supply: Aripiprazole 10 milligrams (mg) tablet (used to treat depression and psychosis). Administration	01760		

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01760	Continued From page 15 instructions read: take one tablet by mouth once daily. R4 failed to receive aripiprazole on the following date: -April 21, 2024, "now out of med." Torsemide 20 milligram (mg) tablet (used to treat heart failure). Administration instructions read: take four tablets (80 mg) by mouth daily. R4 failed to receive torsemide on the following dates: -April 11, 2024, "Med not in cart." Melatonin 3 mg tablet (used to treat insomnia). Administration instructions read: Administer 3 mg by mouth at bedtime. R4 failed to receive melatonin on the following dates: -April 23 through April 30, 2024, "not in cart, med not here." R4's MAR lacked documentation R4 received any medications on April 17, 18, and 22, 2024. R5 R5's diagnoses included dementia, chronic kidney disease, and coronary artery disease. R5's service plan dated June 26, 2024, indicated R5 received medication administration three times per day. R5's MAR dated April 1, 2024, through April 30, 2024, was reviewed. R5 failed to receive the following medication due to the licensee not having supply: Bacitracin 55u/Gm ointment (used to treat skin infections). Administration instructions read: Apply topically to affected areas once daily. R5 failed to receive bacitracin on the following date: -April 24, "Med not in cart had other staff double check."	01760		

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01760	Continued From page 16 Quetiapine 100 mg (used to treat psychosis). Administration instructions read: Take one tablet by mouth once at bedtime. R5 failed to receive quetiapine on the following date: -April 25, "Med not in cart had other staff double check." Systane 0.3-0.4%Eve Drop (used to treat symptoms of Sjogren's syndrome). Administration instructions read: Instill one drop into each eye daily if needed. R5 failed to receive systane on the following dates: -April 25, 2024, "Can't find in med cart." -April 26, 2024, "Can't find in cart." On June 25, 2024, at 7:57 a.m., unlicensed personnel (ULP)-E said she passed medications to residents on one floor. ULP-E said resident's run out of medication "often." ULP-E said sometimes medications are not available because the resident's insurance does not cover the cost, and/or family will not pay for them. ULP-E said the ULP's who give the resident's their medications are not aware of the reason medications are unavailable. On June 26, 2024, at 3:00 p.m., director of nursing (DON)-D said the process for re-ordering medications includes the ULP pulling the sticker from the card of medication and placing it on a pharmacy fax sheet, then faxing the sheet to the pharmacy. The licensee keeps the "re-order" form in the second-floor office. DON-D said she was unsure how ULP's on other units, or shifts, would know the reason a medication was not delivered. DON-D said ULP's should communicate medication re-order status during end of shift report to other ULP staff. On June 27, 2024, at 10:47 a.m., registered	01760		

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01760	Continued From page 17 nurse (RN)-B acknowledged medication re-ordering system has been and is still a problem and said the licensee was working on it. RN-B said there was a rabbit hole for every medication such as no insurance or refills. RN-B acknowledged R1 required hospitalization due to elevated blood sugar levels. RN-B said there were two insulin pens in a refrigerator (kept off unit from where the R1 lived), at the time R1 went to the hospital. RN-B said ULP's have access to the refrigerator where licensee kept insulin. RN-B acknowledged lack of documentation in resident's MAR's and the documentation of missed medications due to the medications not being available. RN-B said the license hired more nurses who could be accountable, and the licensee changed process for ULP oversight. On June 27, 2024, at 11:09 a.m., pharmacist (P)-H said the licensee requested a refill of R1's insulin on March 3, 2024, and the pharmacy sent it to the licensee on March 4, 2024. The pharmacy received a second refill request on April 19, 2024; however, they were unable to send more insulin because they already sent a 75-day supply on March 3, 2024, which should have lasted until May 16, 2024. P-H said the pharmacy received a call on May 28, 2024, from RN-B who told them someone called and requested a refill on May 22, 2024, but the pharmacy did not have any documentation of that. P-H said they sent R1's insulin, stat, on May 28, 2024, and the insulin was delivered to the licensee at 10:50 a.m. P-H said the pharmacy sent a 36-day supply of insulin for R2 on April 11, 2024. On May 24, 2024, the pharmacy received a call from the licensee requesting a refill of insulin and the pharmacy sent out a supply the same day. The licensee then requested another refill a few days later on June 4, 2024, but the pharmacy	01760		

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01760	Continued From page 18 could not send out more because they had sent out a supply on May 24, 2024. On July 16, 2024, at 2:06 p.m., nurse practitioner (NP)-G said she was not informed R1 and R2 did not receive their insulin. NP-G said R1's creatine level was abnormal, and physicians diagnosed him with an acute kidney injury when he went to the hospital, which could have been related to high blood sugars. NP-G said R2 required multiple hypoglycemic medications to manage her diabetes. R2 had elevated blood sugar levels during the time she did not receive insulin. NP-G said the licensee did not inform her R2 did not receive insulin and/or her blood sugar levels were elevated. NP-G said R2 told her at a routine medical visit. NP-G said insulin management was important to maintain R2's health because she had a history of a stroke. NP-G said the licensee has way too many medication errors, and she has not seen any improvement from them. NP-G said she fears for the safety of her residents and her organization is contemplating their ability to provide services to the licensee. The licensee's policy titled, Medication Ordering and Receipt, dated January 31, 2024, indicated the licensee would ensure medications were ordered and received from the pharmacy on a timely basis. The licensee would notify the pharmacy of all new, discontinued, or changed medication orders and medication records would be updated when new medications were ordered, changed, or discontinued. The licensee's policy titled, Medication Management-Administration and Set up, dated August 1, 2021, indicated the licensee would document any medication administration accurately in each resident record.	01760		

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01760	Continued From page 19 TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure lab tests, and therapy services were completed as prescribed by a physician for one of one resident (R5) with record review. 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) 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: R5 admitted to the licensee for diagnoses	01960		

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01960	Continued From page 20 including dementia, chronic kidney disease, and coronary artery disease. R5 admitted the hospital on March 30, 2024. Following her hospital stay, she went to a TCU (transitional care unit) and returned to the licensee on April 23, 2024. R5's Service Plan-Addendum to Contract dated June 26, 2024, indicated R5 received medication administration three times per day and blood sugar checks daily. R5's treatment and therapy plan dated June 26, 2024, indicated licensee staff would administer medications according to physician orders and a licensed practical nurse (LPN)/registered nurse (RN) would manage those orders. The plan indicated R5 required blood sugar checks. R5's TCU discharge orders dated April 19, 2024, included the following orders: -Repeat electrocardiography (EKG) (heart monitoring test) in three to four weeks. The date on the order was April 15, 2024. -Basic metabolic profile (BMP) lab, due April 29, 2024. -Blood glucose checks two times a day related to type two diabetes. -Occupational therapy (OT) evaluation and treatment. -Physical therapy (PT) evaluation and treatment. -Diabetic foot check, report any redness/open areas to provider, every shift. R5's treatment administration record (TAR) dated April 1, 2024, through April 30, 2024, lacked identification staff competed blood glucose checks twice daily. The TAR indicated blood glucose checks were completed daily at 8:00 a.m. The TAR lacked identification nursing should complete a diabetic foot check every shift.	01960		

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01960	Continued From page 21 R5's progress notes dated April 1, 2024, through April 30, 2024, lacked documentation R5 returned to the licensee from TCU, and lacked documentation licensee coordinated scheduling to complete the BMP, EKG, and initiate PT/OT services. R5's progress notes dated May 1, 2024, through June 26, 2024, indicated when the licensee ordered R5's treatments to be completed: -May 1, 2024, medication reconciliation completed from R5's TCU discharge -May 29, 2024, nursing scheduled R5's BMP to be drawn by lab on May 31, 2024. (Outside the due date of April 29, 2024). -June 4, 2024, The licensee ordered EKG (outside the time frame allotted from TCU discharge orders). R5's physician order dated May 7, 2024, indicated nurse practitioner (NP)-G placed an order for the licensee to initiate PT/OT for R5. On June 27, 2024, at 10:47 a.m., RN-B said licensee should have completed a medication reconciliation upon R5's return to facility after discharge from TCU. RN-B said the license had a transition of nurses during this time. RN-B said in this circumstance, the licensee looked into it right away but could not find the discharge summary when R5 returned. RN-B said the licensee obtained the information and notified the NP. RN-B said no harm occurred to R5. On July 11, 2024, at 4:20 p.m., RN-F said the responsibility to reconcile her medications should have been completed by RN-B because she completed the nursing assessment upon her return, so it would have been RN-B's	01960		

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01960	Continued From page 22 responsibility. RN-F said the process when a resident returned should have consisted of the following: knowing when the resident would return, obtain medications, review discharge paperwork, and complete a nursing assessment of the resident to determine what services they require. RN-F said this process is the responsibility of the nurse, but there was no process in place to determine which nurse. On July 16, 2024, at 2:06 p.m., NP-G said the licensee requested orders to obtain PT/OT services because the original order for these services expired. NP-G said the licensee should have coordinated PT/OT services upon R5's return. NP-G said she was unaware there as a discrepancy with blood glucose checks, and she had not changed blood sugar orders. NP-G gave the licensee an order to complete a BMP and EKG because medication errors occurred when the licensee did not update R5's medication list upon her discharge from the TCU. The licensee's policy titled, Resident Record-Documentation, dated January 31, 2024, indicated licensee would document all medications, services, treatments and therapies for each resident. Time period for correction: Seven (7) days.	01960		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced	02360		

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02360	Continued From page 23 by: The facility failed to ensure two of two residents reviewed (R1, R2) were free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No plan of correction is required for this tag.	