Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL307582085M

Date Concluded: March 13, 2023

Compliance #: HL307583734C

Name, Address, and County of Licensee Investigated:
Ecumen Seasons at Apple Valley
15359 Founders Lane
Apple Valley, MN 55124
Dakota County

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

Evaluator's Name: Brooke Anderson, RN Michele R. Larson, RN
Special Investigators

Finding: Not Substantiated

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

Initial Investigation Allegation(s):
The facility neglected a resident after they were administered double doses of their morning and evening medications.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. No medication errors occurred. The resident's service plan was followed, and medications were administered in accordance with physician orders.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also interviewed the resident's family. The investigation included review of the resident's facility medical records, hospice records, and

external medical records. Also, the investigator observed unlicensed staff performing direct resident cares, including medication administration.

The resident resided in the memory care unit of the facility with diagnoses of Alzheimer's disease and was enrolled in hospice services. The resident's service plan identified that the resident received assistance with medication management.

While completing an evening medication pass, unlicensed personnel (ULP) observed what appeared to be signatures or dates on the bubble pack(s) that contained the resident's medications. The writing was illegible, and it appeared to the ULP, that the resident had received their PM dosing of medications along with their AM medications. The ULP became concerned that a medication error had occurred. The ULP immediately contacted the facility nurse, a triage nurse, and facility administration. Nursing staff directed the ULP to hold the resident's evening medication doses and notify hospice of the alleged errors.

The hospice nurse and her supervisor arrived at the facility at midnight to monitor the resident's condition until the morning nursing staff arrived. Hospice records indicated hospice staff monitored vital signs every 15 minutes for the first two hours, then every 30 minutes, then every hour for the remainder of the night. Vital signs remained stable and no noted change in condition of the resident was observed during the night.

Immediately the following morning, the facility conducted an internal investigation into the alleged medication errors. The investigation included further review of the resident's physician orders, medication cards, medication counts, and interviews with the staff member who signed off on the medications and wrote on the card. All medication counts in comparison to signatures and dates were accurate. It was determined that no medication errors occurred, but illegible date(s) had been written on the medication cards. It was determined that the resident's medications were administered as prescribed.

The hospice nurse was interviewed and confirmed she came to the facility the evening of the alleged error to monitor the resident's conditions. The hospice nurse indicated the resident remained stable and after a more thorough review, it was determined that no medication errors occurred.

The resident's family was interviewed and reported no concerns with the care provided at the facility.

In conclusion, neglect was not substantiated.

"Not Substantiated" means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment 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: No. Unavailable for interview
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility immediately conducted an internal investigation.

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
	30758	A. BUILDING: _____ B. WING _____	C 12/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECUMEN SEASONS AT APPLE VALLEY	15359 FOUNDERS LANE APPLE VALLEY, MN 55124

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL307583735C/#HL307582086M #HL307583734C/#HL307582085M #HL307583663C/#HL307582101M On December 28, 2022, 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 135 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL307583735C/#HL307582086M, #HL307583734C/#HL307582085M, #HL307583663C/#HL307582101M, tag identification, 1360, 1370, 1440, 1640, 1730, 1750, 1760, 2310.	0 000	The Minnesota Department of Health documents the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that 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. Per Minnesota Statute §144G.30, Subd. 5 (c), the assisted living facilities must document any action taken to comply with the correction order. A copy of the provider ' s records documenting those actions may be requested for follow-up surveys. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider ' s Plan of Correction." The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144G.31, Subd. 2 and 3.	
01360 SS=E	144G.61 Subdivision 1 Instructor and competency evaluation requirem	01360		

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01360	Continued From page 1 Instructors and competency evaluators must meet the following requirements: (1) training and competency evaluations of unlicensed personnel who only provide assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), must be conducted by individuals with work experience and training in providing these services; and (2) training and competency evaluations of unlicensed personnel providing assisted living services must be conducted by a registered nurse, or another instructor may provide training in conjunction with the registered nurse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure competency evaluations were conducted by a registered nurse (RN) for two of five unlicensed personnel (ULP-E, ULP-M) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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). Findings Include: ULP-M ULP-M's employee record was reviewed. ULP-M was hired March 28, 2022, to perform direct cares for the licensee's residents.	01360		

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01360	Continued From page 2 Review of ULP-M's training record indicated on April 28, 2022, ULP-M was trained by a licensed practical nurse (LPN) on medication administration. ULP-E ULP-E's employee record was reviewed. ULP-E was hired August 15, 2022, to perform direct cares for the licensee's residents. Review of ULP-E's training record indicated ULP-E was trained by an LPN in the following areas: *measuring vital signs (temperature, blood pressure, oxygen saturation, weights, respirations; *non-sterile dressing change; *abdominal thrust (Heimlich maneuver); *activities of daily living (ADL's)-mobility, perineal care,bathing, foot care, nail care, compression stocking application, oral care, dentures, eating assistance, preparation of modified diets, thickened liquids, toileting; *catheter cares, ostomy cares; *gait belt, transfers, range of motion (ROM) upper/lower body, repositioning, falls; * mechanical lifts; *blood glucose monitoring, insulin administration; * nebulizer administration; *continuous positive airway pressure (CPAP) device; *oral medication administration of tablets, pills, capsules, liquids; *sublingual or buccal medication administration; *inhalant medication administration; *topical medication administration; *eye drops and eye ointment applications; *ear drops (otic); *nasal sprays; *transdermal patches;	01360		

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01360	Continued From page 3 *vaginal cream administration; *rectal suppositories; *oxygen administration (oxygen concentrator); *oxygen refill; *oxygen-liquid administration. On page 60 of ULP-E's competency training record, an LPN typed the following: "I attest I have ranked and recorded competency review scores and comments for ULP-E for the assisted living new hire ULP competency skills checklist on September 30, 2022, to the best of my ability. This also serves as the 30-day supervisory visit with the RN." On December 28, 2022, at 4:00 p.m., RN-D stated she signed off on ULP competencies. On January 17, 2023, at 2:00 p.m., director of nursing (DON)-J stated facility RN's signed off on ULP competencies. The licensee document titled, Job Description, Licensed Practical Nurse, indicated the LPN would provide nursing care to residents within the scope of practice of an LPN. The licensee policy titled, Training Unlicensed Personnel for Medication, Treatment, and Therapy Administration, dated August 1, 2021, indicated before the RN delegated the task of assistance with self-administration, or medication administration, treatment and therapies, the RN would instruct the ULP on performing tasks to determine that ULP were competent to perform tasks. TIME PERIOD TO CORRECT: Twenty-one (21) days.	01360		

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01370	Continued From page 4	01370		
01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and	01370		

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01370	Continued From page 5 (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a registered nurse (RN) trained and evaluated staff competency in all required topics for three of five unlicensed personnel (ULP-A, ULP-E, ULP-M) with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was 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). Findings Include: ULP-A ULP-A's employee record was reviewed. ULP-A was hired April 5, 2021, to perform direct cares for the licensee's residents. ULP-A's employee training records lacked evidence she successfully completed practical skills evaluations as required for training in accordance with Minnesota assisted living Statute 144G.61, Subd. 2 (a), in the following areas: -documentation requirements for all services provided; -reports of changes in the resident's condition to the supervisor designated by the facility; -basic infection control; -maintenance of a clean and safe environment; -appropriate and safe techniques in personal	01370		

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01370	Continued From page 6 hygiene and grooming; -standby assistance techniques and how to perform them; -medication, exercise, and treatment reminders; -basic nutrition, meal preparation, food safety, and assistance with eating; -preparation of modified diets as ordered by a licensed health professional; -communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; -awareness of confidentiality and privacy; -understanding of appropriate boundaries between staff and residents and the resident's family; -procedures to use in handling various emergency situations; and -awareness of commonly used health technology equipment and assistive devices. ULP-M ULP-M's employee record was reviewed. ULP-M was hired March 28, 2022, to perform direct cares for the licensee's residents. ULP-M's employee training records lacked evidence she successfully completed practical skills evaluations as required for training in accordance with Minnesota assisted living Statute 144G.61, Subd. 2 (a), in the following areas: -documentation requirements for all services provided; -reports of changes in the resident's condition to the supervisor designated by the facility; -basic infection control; -maintenance of a clean and safe environment; -appropriate and safe techniques in personal hygiene and grooming; -standby assistance techniques and how to	01370		

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01370	Continued From page 7 perform them; -medication, exercise, and treatment reminders; -basic nutrition, meal preparation, food safety, and assistance with eating; -preparation of modified diets as ordered by a licensed health professional; -communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; -awareness of confidentiality and privacy; -understanding of appropriate boundaries between staff and residents and the resident's family; -procedures to use in handling various emergency situations; and -awareness of commonly used health technology equipment and assistive devices. ULP-E ULP-F's employee record was reviewed. ULP-E was hired August 15, 2022, to perform direct cares for the licensee's residents. On December 28, 2022, at 11:25 a.m., ULP-E was observed administering medications to a licensee resident. ULP-E's employee training records lacked evidence he successfully completed practical skills evaluations as required for training in accordance with Minnesota assisted living Statute 144G.61, Subd. 2 (a), in the following areas: -documentation requirements for all services provided; -reports of changes in the resident's condition to the supervisor designated by the facility; -basic infection control; -maintenance of a clean and safe environment; -appropriate and safe techniques in personal	01370		

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01370	Continued From page 8 hygiene and grooming; -standby assistance techniques and how to perform them; -medication, exercise, and treatment reminders; -basic nutrition, meal preparation, food safety, and assistance with eating; -preparation of modified diets as ordered by a licensed health professional; -communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; -awareness of confidentiality and privacy; -understanding of appropriate boundaries between staff and residents and the resident's family; -procedures to use in handling various emergency situations; and -awareness of commonly used health technology equipment and assistive devices. On December 28, 2022, at 4:00 p.m., RN-D stated she signed off on ULP competencies. The licensee policy titled, Training Unlicensed Personnel for Medication, Treatment, and Therapy Administration, dated August 1, 2021, indicated before the RN delegated the task of assistance with self-administration, or medication administration, treatment and therapies, the RN would instruct ULP on performing tasks to determine ULP were competent to perform tasks. TIME PERIOD TO CORRECT: Twenty-one (21) days.	01370		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs	01440		

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01440	Continued From page 9 (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for three of five unlicensed personnel (ULP-A, ULP-E, ULP-M) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	01440		

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01440	Continued From page 10 or has the potential to affect a large portion or all of the residents). Findings Include: ULP-A ULP-A's employee record was reviewed. ULP-A was hired April 5, 2021, to perform resident direct cares. ULP-A's record lacked evidence an RN conducted direct supervision of ULP-A performing delegated tasks within 30 days that ULP-A first performed delegated tasks for residents. ULP-M ULP-E's employee record was reviewed. ULP-M was hired March 28, 2022, to perform resident direct cares. ULP-M's record lacked evidence an RN conducted direct supervision of ULP-M performing delegated tasks within 30 days ULP-M first performed delegated tasks for residents. ULP-E ULP-F's employee record was reviewed. ULP-E was hired August 15, 2022, to perform resident direct cares. On December 28, 2022, at 11:25 a.m., ULP-E was observed administering oral medications to a resident residing in the memory care unit. ULP-E's record lacked evidence an RN conducted direct supervision of ULP-E performing delegated tasks within 30 days of ULP-E first performed delegated tasks for residents.	01440		

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01440	Continued From page 11 On December 28, 2022, at 4:00 p.m., RN-D stated RN's assessed and signed off on new ULP's on competencies after the new ULP's shadowed other ULP's. RN-D stated, "the whole check-off took six to eight hours to complete." The licensee policy titled, Delegation of Nursing Tasks, dated August 1, 2021, indicated an RN or licensed health professional (LHP) may delegate nursing tasks to ULP after they have successfully completed the training required for ULP, have been trained in the services to be provided, and have demonstrated to the RN or LHP the ability to competently follow procedures for the resident and possess the knowledge and skills consistent with the complexity of the tasks. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01440		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (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.	01640		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECUMEN SEASONS AT APPLE VALLEY	15359 FOUNDERS LANE APPLE VALLEY, MN 55124

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01640	Continued From page 12 (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 included signatures or other authentication by the residents and the licensee to document the agreement on the services to be provided for four of four residents (R1, R2, R3, R4) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was 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). Findings Include: Minnesota (MN) Statute 144G.70, subd. 4 (b) requires resident service plans, and any revisions, must include a signature or other authentication by the license and by the resident documenting agreement on the services to be provided. R1 R1's medical record was reviewed. R1 was admitted to the facility on January 31, 2020. R1's diagnoses included Alzheimer's disease and acute anxiety attack.	01640		

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01640	Continued From page 13 R1's service plan dated October 6, 2022, indicated R1 received assistance with personal cares, toileting, meals, escorts, medication management, laundry, two-hour safety checks, behaviors, and transfers. R1 used a wheelchair for mobility. R1's service plan lacked a date and signature, or other authentication by R1 and the licensee documenting the agreement on the services to be provided. R2 R2's medical record was reviewed. R2 was admitted to the facility on June 28, 2013. R2's diagnoses included Alzheimer's disease, glaucoma, and macular degeneration. R2's service plan dated August 16, 2022, indicated R2 received assistance with personal cares, toileting, meals, escorts, medication management, laundry, two-hour safety checks, repositioning, and transfers. R2 used a wheelchair for mobility. R2 received hospice care through the licensee's hospice agency. R2's service plan lacked a date and signature, or other authentication by R2 and the licensee documenting the agreement on the services to be provided. R3 R3's medical record was reviewed. R3 was admitted to the facility on August 25, 2016. R3's diagnoses included Alzheimer's disease, glaucoma, and paranoid personality disorder. R3's service plan dated July 8, 2022, indicated R3 received assistance with personal cares,	01640		

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01640	Continued From page 14 toileting, orientation, escorts, meals, hearing aids, compression stockings, laundry, housekeeping, medication management, repositioning, and two-hour safety checks. R3 used a wheelchair for mobility and a Hoyer lift for transfers with the assist of two staff persons. R3's service plan lacked a date and signature, or other authentication by R3 and the licensee documenting the agreement on the services to be provided. R4 R4's medical record was reviewed. R4 was admitted to the facility on January 20, 2018. R4's diagnoses included legal blindness, glaucoma, and chronic obstructive pulmonary disease (COPD). R4's service plan dated September 27, 2022, indicated R4 received assistance with personal cares, meals, compression stockings, laundry, medication management, oxygen, and daily safety checks. R4's service plan lacked a date and signature, or other authentication by R4 and the licensee documenting the agreement on the services to be provided. On December 28, 2022, at 4:00 p.m., registered nurse (RN)-D stated she and the clinical director developed service plans every 90 days, or whenever a resident experienced a change in condition. TIME PERIOD TO CORRECT: Seven (7) days.	01640		

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01730	Continued From page 15	01730		
01730 SS=F	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 (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.	01730		

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01730	Continued From page 16 (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 ensure medication refills were ordered on a timely basis, as required, in the medication management plan for four of four residents (R1, R2, R3, R4) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was 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). Findings include: R1 R1 was admitted to the facility on January 31, 2020, with diagnoses included but not limited to dementia with Lewy bodies and atrial fibrillation. R1's service plan dated July 15, 2022, included but was not limited to assistance with medication management. R1's service plan indicated R1's medications were provided by an outside pharmacy and could not be on a cycle fill due to R1's hospice status. R1's service plan indicated staff were to check a medication's status for any refills. Facility to manage medication needs through pharmacy other than primary pharmacy. R1's individualized medication management plan	01730		

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01730	Continued From page 17 dated July 15, 2022, indicated unlicensed personnel (ULP) were responsible to notify licensed nurses for any medication refills. Facility nurses were responsible for ensuring medication refills were obtained in a timely manner. R1's electronic medication administration record (eMAR) dated July 2022, indicated R1 was prescribed lorazepam, 0.5 milligrams (mg) sublingual, at bedtime (HS) for anxiety. Review of R1's July 2022 eMAR indicated R1 was never administered her scheduled lorazepam on the following dates in July: 3, 10, 11, 12, 13, 14, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26; (17 missed doses). R1's July eMAR indicated R1's lorazepam was not administered due to "medication not available." R1's eMAR dated December 2022, indicated R1 was prescribed tramadol, 50 mg by mouth (PO). Take ½ tablet (25 mg) PO, HS for pain. Review of R1's December 2022 eMAR indicated R1 was never administered her scheduled tramadol on the following dates in December: 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14; (11 missed doses). R1's December eMAR indicated R1's tramadol was not administered due to "medication not available." R2 R2 was admitted to facility on June 28, 2013, with diagnoses included but not limited to Alzheimer's disease and glaucoma. R2's service plan dated August 16, 2022, received assistance with medication management. The service plan indicated R2 was	01730		

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01730	Continued From page 18 enrolled in a hospice program. R2's individualized medication management plan dated August 16, 2022, indicated ULP were responsible to notify licensed nurses for any medication refills. Facility nurses were responsible for ensuring medication refills were obtained in a timely manner. R2's eMAR dated June 2022, indicated R2 was prescribed the following medications: timolol maleate, 1 drop into left eye twice daily (BID) for glaucoma, and A&D topical ointment; apply topically to right outer ear BID for irritation. Review of R2's June 2022 eMAR indicated R2 was never administered her scheduled timolol maleate on the following dates in June: 1-21, 29; (29 missed doses). R2's June 2022 eMAR indicated R2's tramadol was not administered due to "medication not available, pharmacy notified." Review of R2's MAR dated June 2022 indicated R2 was never administered her scheduled topical A&D ointment on the following dates in June: 1-28, 30; (53 missed doses). Review of R2's MAR dated July 2022 indicated R2 was never administered her scheduled topical A&D ointment on the following dates in July: 1-31 (51 missed doses). R2's July 2022 eMAR indicated R2's topical A&D ointment was not administered due to, "medication not available, pharmacy notified." R2's hospice note, dated July 12, 2022, at 12:10 p.m., indicated "resident reports feeling bored d/t not being able to participate in watching TV or reading d/t diminished eye sight."	01730		

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01730	Continued From page 19 R3 R3 was admitted to facility on August 25, 2016, with diagnoses included but not limited to Alzheimer's disease, chronic kidney disease and dry eye syndrome. R3's service plan dated June 8, 2022, indicated R3 received assistance with medication management. R3's service plan indicated R3 was in a hospice program. R3's service plan indicated R3's medications were provided by an outside pharmacy and could not be on a cycle fill due to R3's hospice status. R3's service plan indicated staff were to check a medication's status for any refills. Facility to manage medication needs through pharmacy other than primary pharmacy. R3's individualized medication management plan dated June 8, 2022, indicated ULP were responsible to notify licensed nurses for any medication refills. Facility nurses were responsible for ensuring medication refills were obtained in a timely manner. R3's eMAR dated July 2022, indicated R3 was prescribed the following medication: restasis, 1 drop into both eyes BID for dry eye syndrome. Review of R3's MAR dated July 2022 indicated R3 was never administered her scheduled restasis eye drops on the following dates in July: 1-13, 17, 21, 23, 24, 26, 27; (23 missed doses). R3's July 2022 eMAR indicated R3 was never administered her eye drops due to, "med not available, pharmacy." R4	01730		

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01730	Continued From page 20 R4 was admitted to the facility on September 1, 2015, with diagnoses included but not limited to chronic congestive heart failure, dependence on supplemental oxygen, and shortness of breath. R4's service plan dated September 27, 2022, indicated R4 received assistance with medication management. R4's individualized medication management plan dated December 20, 2022, indicated ULP were responsible to notify licensed nurses for any medication refills. Facility nurses were responsible for ensuring medication refills were obtained in a timely manner. R4's eMAR dated December 2022, indicated R4 was prescribed the following scheduled medication: Metamucil PO daily for constipation. Review of R4's December 2022, eMAR indicated R4 was never administered her scheduled Metamucil on the following dates in December: 10-13, 18, 20; (9 missed doses). R4's December 2022 eMAR indicated R4 was never administered her scheduled Metamucil due to, "med not available, pharmacy notified." On December 28, 2022, at 4:00 p.m., RN-D stated, "it might be considered a missed med and we put it in the service report," after the investigator asked RN-D how ULP document held resident medications. The licensee's policy titled, Documentation of Medication Administration on the MAR, dated January 2014, indicated staff follow the agency's protocols for notifying the RN of medications that are not administered consistent as prescribed.	01730		

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01730	Continued From page 21 TIME PERIOD TO CORRECT: Seven (7) days.	01730		
01750 SS=H	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure three of five unlicensed personnel (ULP-A, ULP-E, ULP-M) were trained by the registered nurse (RN) and demonstrated competency for administering medications. 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 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:	01750		

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01750	Continued From page 22 R1 R1 was admitted to the facility on January 31, 2020. R1's diagnoses included Alzheimer's disease. R1's service plan dated July 15, 2022, R1 required assistance with medication management. R2 R2 was admitted to facility on June 28, 2013. R2's diagnosis included Alzheimer's disease and glaucoma. R2's service plan dated August 16, 2022, R2 received assistance with medication management. ULP-A ULP-A was hired April 5, 2021, to perform resident direct services under the licensee's assisted living with dementia care license. ULP-A's training records lacked evidence ULP-A has been trained by the RN and demonstrated competency in medication administration. R1's medication administration record (MAR), dated June 2022, indicated ULP-A administered R1's morning medications on June 1, 14, and June 30, 2022. R1's MAR for July 2022, indicated ULP-A administered R1's morning medications on July 21, 25, and 28, 2022. ULP-M ULP-M was hired March 28, 2022, to perform resident direct services under the licensee's	01750		

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01750	Continued From page 23 assisted living with dementia care license. ULP-M's training record indicated a licensed practical nurse trained ULP-M in medication administration. ULP-M's training record lacked evidence ULP-M had been trained by RN and demonstrated competency in medication administration. R2's MAR dated June 2022, indicated ULP-M administered R2's evening medications on June 12, 21, 25, 26, and 27, 2022. R2's MAR dated July 2022, indicated ULP-M administered R2's evening medications on July 5, 18, 24, and 25, 2022. ULP-E ULP-E was hired August 15, 2022, to perform resident direct services under the licensee's assisted living with dementia care license. ULP-E's training record indicated a licensed practical nurse (LPN) trained ULP-E in medication administration. ULP-E's training record lacked evidence ULP-E had been trained by RN and demonstrated competency in medication administration. R1's MAR, dated December 2022, indicated ULP-E administered R1's morning medications on December 24, 2022. On December 28, 2022, at 11:25 a.m., the surveyor observed ULP-E complete a medication pass. On December 28, 2022, at 4:00 p.m., RN-D	01750		

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01750	Continued From page 24 stated the facility had a training binder for ULPs. RN-D stated she signed off ULP competencies after she observed them pass medications. The license's Delegation of Nursing Tasks policy dated August 1, 2021, indicated a registered nurse may delegate medication administration to unlicensed personnel only after the RN instructed the unlicensed personnel in the proper methods to administer medications, and the unlicensed personnel demonstrated the ability to competently follow the procedures. TIME PERIOD TO CORRECT: Seven (7) days.	01750		
01760 SS=F	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 interview and record review, the licensee failed to ensure each medication administered by the assisted living facility was documented in the record when not administered	01760		

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01760	Continued From page 25 as prescribed, and included documentation of the reason why, and any follow-up procedures that were provided to meet the resident's needs for three of four residents (R1, R2, R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was 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). Findings Include: R1 R1's medical record was reviewed. R1 was admitted to the facility on January 31, 2020. R1's diagnoses included Alzheimer's disease and acute anxiety attack. R1's service plan dated October 6, 2022, indicated R1 received assistance with medication management. R1's record indicated R1 was prescribed the following medications: calmosetpine topical ointment, apply two times per day (BID) for skin irritation; Ensure nutritional supplement, one bottle by mouth (PO) BID; rivastigmine (Exelon), 4.6 milligrams (mg) 24-hour patch for dementia; acetaminophen, extra strength (ES), 500 mg PO; two tablets BID for polyarthritis; citalopram, 10 mg tablet, take one tablet PO daily for depression; diclofenac sodium (Voltaren), 1% gel-apply 2	01760		

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	30758	A. BUILDING: _____ B. WING _____	C 12/28/2022

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01760	Continued From page 26 grams (gm) to right shoulder BID for pain; divalproex (Depakote), 125 mg capsule; take one capsule PO BID for seizures; pantoprazole (Protonix), 40 mg tablet; take one tablet PO daily before meals for ulcers; lorazepam (Ativan) 0.5 mg tablet, take one tablet PO daily at bedtime (HS) for anxiety; mirtazapine (Remeron), 15 mg tablet; take one tablet PO daily HS for depression; tramadol (Ultram), 50 mg tablet, take ½ tablet (25 mg), PO daily HS for pain; trazadone (Desyrel), 100 mg tablet, take one tablet PO daily HS for insomnia; R1's medication administration records (MARs) dated June-December 2022, indicated the following medications were not documented as administered: Calmoseptine: (55 doses); Ensure: (51 doses); Rivastigmine: (26 doses); Acetaminophen: (53 doses); Citalopram: (23 doses); Diclofenac sodium: (46 doses); Diavalproex: 257 doses); Pantaprozole: (21 doses); Lorazepam: (21 doses); Mirtazapine: (6 doses); Tramadol: (29 doses); Trazadone: (26 doses); R2 R2's medical record was reviewed. R2 was admitted to the facility on June 28, 2013. R2's diagnoses included Alzheimer's disease, glaucoma, and macular degeneration. R2's service plan dated August 16, 2022, indicated R2 received assistance with medication	01760		

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01760	Continued From page 27 management. R2's record indicated R2 was prescribed the following medications: Amlodipine, 2.5 mg tablet; take one tablet PO daily for high blood pressure; Aspirin, 81 mg chewable tablet; chew and swallow one tablet PO daily for stroke; Escitalopram, 10 mg tablet; take one tablet PO daily for depression; Levothyroxine, 50 micrograms (mcg), take one tablet PO daily for hypothyroidism; Refresh eye drops, 0.5%; instill one drop into each eye BID for dry eyes; Senna S 50 mg-8.6 mg; take two tablets PO daily for constipation; Bactrim, 800 mg-160 mg take one tablet daily for prophylactic measures; Timolol, 0.5% ophthalmic solution; instill one drop into left eye BID for glaucoma; Acetaminophen, 325 mg, take two tablets PO three times per day (TID) for pain; Carvedilol, 3.125 mg tablet; take one tablet PO BID for pulse; Atorvastatin, 20 mg tablet; take one tablet PO HS for stroke; Mirtazapine, 45 mg tablet; take ½ tablet (22.5 mg) PO HS for depression; Tamsulosin, 0.4 mg tablet; take one capsule PO HS for urine retention; Trazadone, 50 mg tablet; take one tablet PO HS for insomnia; R2's MARs dated June-July 2022, indicated the following medications were not documented as administered: Amlodipine: (10 doses); Aspirin: (10 doses); Escitalopram: (10 doses);	01760		

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01760	Continued From page 28 Levothyroxine: (10 doses); Refresh Eye Drops: (18 doses); Senna: (10 doses); Bactrim: (10 doses); Timolol: (18 doses); Acetaminophen: (14 doses); Carvedilol: (12 doses); Atorvastatin: (8 doses); Mirtazapine: (8 doses); Tamsulosin: (8 doses); Trazadone: (8 doses) R3 R3's medical record was reviewed. R3 was admitted to the facility on August 25, 2016. R3's diagnoses included Alzheimer's disease, glaucoma, and paranoid personality disorder. R3's s service plan dated July 8, 2022, indicated R3 received assistance with medication management. R3's record indicated R2 was prescribed the following medications: Bupropion, 75mg tablet; take one tablet PO BID for major depressive disorder; Icy hot advanced pain relief cream: apply to wrists BID for pain; Quetiapine, 50mg tablet; take one tablet PO TID for agitation; Quetiapine, 25mg tablet; take one tablet PO every evening for agitation; Restasis 0.05% eye drops; instill one drop in both eyes BID for dry eye syndrome; Haloperidol 0.5mg; take one tablet sublingual on the evening for agitation; R3's MAR dated June-July 2022, indicated the following medications were not documented as administered:	01760		

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01760	Continued From page 29 Bupropion: (23 doses); Icy hot advanced pain relief cream: (19 doses); Quetiapine (19 doses); Restasis (19 doses); Haloperidol (4 doses); R4 R4 was admitted to facility on September 1, 2015, with diagnoses which included chronic congestive heart failure, dependence on supplemental oxygen and shortness of breath. R4's service plan dated September 27, 2022, indicated R4 received assistance with medication management. R4's record indicated R4 was prescribed the following medications: Allopurinol, 100mg tablet; take one tablet PO daily for gout; Aspirin, 81mg tablet; take one tablet PO daily for atrial fibrillation; Betoptic S, 0.25% suspension; instill one drop into both eyes BID for glaucoma; Bumetanide, 2mg tablet; take one tablet PO daily for edema; Diclofenac Sodium, 1% gel; apply to both knees BID for osteoarthritis; Digoxin, 0.125mg tablet; Take one tablet by mouth Monday, Wednesday and Friday for hypertension; Ferrous Gluconate, 324mg tablet; take one tablet PO daily for anemia; Fexofenadine, 180mg tablet; take one tablet PO daily for allergy relief; Fluticasone, 50mcg nasal spray; administer two sprays in each nostril daily for allergies; Gabapentin, 300mg capsule; take two capsules PO bid for pain;	01760		

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01760	Continued From page 30 Metoprolol, 100mg extended release (ER) tablet; take one tablet by mouth daily for hypertension; I-Vite, take one tablet PO BID for cataracts; Omeprazole, 20mg capsule; take one capsule by mouth daily for GERD; Spironolactone, 25mg tablet; take one tablet PO BID for congestive heart failure; Vitamin D3, 2000IU tablet; take one tablet PO daily for vitamin D deficiency; Acetaminophen, 500mg tablet; take two tablets PO BID for pain; Docusate Sodium 100mg soft gel cap; take one capsule PO daily for constipation; Metamucil, 3.4g wafers; take two wafers by mouth daily for constipation; Potassium Chloride, 20MEQ ER tablet; take one tablet PO daily for hypertension; Vision vitamin tablet; one tablet PO BID for cataract; Mucinex, 600mg ER tablet; take one tablet PO BID for cough, cold and allergy; Spironolactone, 25mg tablet; take one tablet PO BID for congestive heart failure; Amitriptyline, 10mg tablet; take two tablets PO at HS for depression; Melatonin, 5mg tablet; take one tablet PO at HS for insomnia; Ciprofloxacin, 250mg tablet; take one tablet PO BID for five days for antibiotic; Cephalexin, 500mg capsule; take one capsule PO three times a day for five days for antibiotic; R4's MAR dated June-December 2022, indicated the following medications were not documented as administered: Allopurinol: (29 doses); Aspirin: (29 doses); Betoptic S: (55 doses); Bumetanide: (29 doses);	01760		

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01760	Continued From page 31 Diclofenac Sodium: (55 doses); Digoxin: (10 doses); Ferrous Gluconate: (29 doses); Fexofenadine: (29 doses); Fluticasone: (29 doses); Gabapentin: (58 doses) I-Vite: (43 doses); Metoprolol: (29 doses); Omeprazole: (29 doses) Spironolactone: (48 doses); Vitamin D3: (39 doses); Acetaminophen: (57 doses); Docusate Sodium: (27 doses); Metamucil: (29 doses); Potassium Chloride: (32 doses); Vision vitamin: (18 doses); Mucinex: (59 doses); Amitriptyline: (32 doses); Melatonin: (32 doses); Ciprofloxacin: (1 dose); Cephalexin: (2 doses); On January 17, 2023, at 3:38pm p.m., DON-L indicated via an email, that the blank boxes on the MAR technically mean "missed" but it could be for a variety of reasons. It could be the system was down and it didn't sync, an agency team member was giving medications and used the paper MAR, or the medications weren't given. The licensee policy titled, Documentation of Medication Administration on the MAR, updated January 2014 indicated staff are to document by initially in the appropriate box or enter electronically that the medication has been administered at the appropriate date and time. Staff will document medication administration immediately after administering the medications. TIME PERIOD TO CORRECT: Seven (7) days.	01760		

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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 care and services according to acceptable health care, medical, or nursing standards for three of four residents (R1, R2, R3) with records reviewed. R1, R2, and R3 were allegedly administered double doses of their prescribed medications, yet the licensee never ensured a facility registered nurse (RN) remained on-site to monitor the residents. RN-D left the licensee's facility at 8:27 p.m., leaving unlicensed personnel (ULP) to monitor the residents until hospice nurse (RN)-G arrived onsite almost four hours later. Facility unlicensed personnel (ULP), were instructed to monitor the resident's vital signs and send them to the hospital if they experienced a change-in-condition. In addition, the licensee failed to retrain staff after the incident. 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).	02310		

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02310	Continued From page 33 Finding Include: R1 R1's medical record was reviewed. R1 was admitted to the facility on January 31, 2020. R1's diagnoses included Alzheimer's disease and acute anxiety attack. R1's service plan dated October 6, 2022, indicated R1 received assistance with personal cares, toileting, meals, escorts, medication management, laundry, two-hour safety checks, behaviors, and transfers. R1 used a wheelchair for mobility. R1 received hospice care through the licensee's hospice agency. R1's progress note dated July 6, 2022, at 10:45 p.m., and written by a facility triage RN, indicated a ULP (ULP-I), contacted her after a morning shift ULP (ULP-C) allegedly administered R1's entire days worth of medications during her morning shift. ULP-I indicated R1 was doing well. The triage RN advised ULP-I to complete a medication error form and vital signs, and to call back with any concerns. R1's record and facility documents lacked evidence a medication error form was completed regarding the incident. R1's progress note dated July 6, 2022, at 11:09 p.m., indicated ULP-I called triage RN to report R1 appeared, "distressed and clammy." R1's vital signs were: blood pressure-164/96; heart rate-64; and oxygen saturation-93%. The triage RN asked if R1 had any chest pain, which ULP-I replied, "oo yes." Triage called on-call hospice nurse (RN)-G to update her. RN-G advised triage RN to contact R1's physician who advised the facility administer R1's as needed (PRN) morphine. R1's progress	02310		

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02310	Continued From page 34 note indicated RN-G would arrive at the facility shortly. R2 R2's medical record was reviewed. R2 was admitted to the facility on June 28, 2013. R2's diagnoses included Alzheimer's disease, glaucoma, and macular degeneration. R2's service plan dated August 16, 2022, indicated R2 received assistance with personal cares, toileting, meals, escorts, medication management, laundry, two-hour safety checks, repositioning, and transfers. R2 used a wheelchair for mobility. R2 received hospice care through the licensee's hospice agency. R3 R3's medical record was reviewed. R3 was admitted to the facility on August 25, 2016. R3's diagnoses included Alzheimer's disease, glaucoma, and paranoid personality disorder. R3's s service plan dated July 8, 2022, indicated R3 received assistance with personal cares, toileting, orientation, escorts, meals, hearing aids, compression stockings, laundry, housekeeping, medication management, repositioning, and two-hour safety checks. R3 used a wheelchair for mobility and a Hoyer lift for transfers with the assist of two staff persons. R3 received hospice care under the licensee's hospice agency. Review of a facility document dated July 6, 2022, written by ULP-I, indicated ULP-I discovered R2's evening and bedtime medications were allegedly administered during the morning shift during her medication pass. ULP-I immediately contacted RN-D who agreed with ULP-I. ULP-I indicated it looked like all the residents were double dosed	02310		

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02310	Continued From page 35 when she checked the medication cart. ULP-I contacted a facility triage nurse who advised ULP-I to hold the resident's medications. Hospice nurse RN-G and her supervisor were called to assist ULP-I and other staff. ULP-I wrote, "every person's vitals were elevated and some were not feeling well to extreme!" Review of the facility's July 2022 schedule indicated on July 6, 2022, RN-D clocked in to work at 10:59 a.m., and clocked out at 8:27 p.m. RN-D did not clock back in to work until July 7, 2033, at 10:13 a.m. Review of the facility's internal investigation report dated July 7, 2022, at 11:00 a.m., indicated on July 6, 2022, at 8:21 p.m., RN-D sent an email to licensed assisted living director (LALD)-K, indicating RN-D received report from ULP-I indicating a ULP (ULP-C) "popped out" all of the evening and bedtime medications during the morning medication pass and initialed the medication cards indicating the medications were administered. The report indicated RN-D advised ULP-I to hold the resident's medications in case their evening and bedtime medications were administered during the morning shift. The report indicated ULP-I called triage after 8:30 p.m., after attempting to reach a facility RN. Hospice was notified R1, R2, and R3 may have been affected by the double dosing of medications. Triage instructed ULP-I to monitor the resident's vital signs every 15 minutes for the next two hours and report any changes in the resident's conditions. The evening shift ULP's stayed and worked the overnight shift to assist in monitoring the residents' conditions. The internal investigation concluded the resident's evening and bedtime medications were not administered by ULP-C as reported but it was due to illegible dates and	02310		

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02310	Continued From page 36 initials on the resident's medication cards. The internal investigation report indicated the facility did not have a policy or procedure in place relating to those types of incidents. On December 28, 2022, at 4:00 p.m., RN-D stated medication cards were initialed and dated when medications were punched out of the cards to administer to residents. RN-D stated ULP-I thought it looked as though resident's evening and bedtime medications were previously administered during the morning shift. RN-D stated although there was no documentation the medications were administered in the resident's MARs, she advised ULP-I to hold the resident's evening and bedtime medications due to being unsure if the medications were actually administered. RN-D stated she reported the incident to LALD-K. RN-D stated she left because, "it was time for me to leave." RN-D stated the next morning, July 7, 2022, the regional nurses told her they were taking over the investigation due to a medication error involving the second floor memory care residents. RN-D stated the licensee's regional nurses came in and reassessed residents, stating, "I did not do any assessments." On January 9, 2023, at 3:00 p.m., RN-G stated there was no facility RN onsite when she arrived at the facility around 12:00 a.m. RN-G stated she contacted a hospice supervisor to come to the facility to assist in monitoring hospice residents R1, R2, and R3. RN-G stated she and her supervisor monitored R1, R2, and R3, every 15 minutes for the first two hours, then every 30 minutes, then hourly until the following morning around 5:00 a.m. when staff arrived to work their shifts. RN-G stated, "I was there from 12:00 a.m. until 5:00 a.m." RN-G stated R1, R2, and R3	02310		

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02310	Continued From page 37 appeared to be at their normal baseline throughout the night and early morning. RN-G stated the facility never interviewed her or RN-G's supervisor during the facility's internal investigation. On January 10, 2023, at 3:30 p.m., ULP-I stated she and other ULP were not retrained after the alleged double dosing. On January 17, 2023, at 1:00 p.m., LALD-K stated staff were never retrained after the incident, stating the facility conducted an internal investigation and concluded the alleged medication error of double dosing never occurred, and therefore, the facility found no wrongdoing of staff. The licensee policy titled, Medication Error, dated August 2019, indicated medication errors included, but were not limited to: omission, wrong dose, wrong resident, wrong medication, wrong route of administration, wrong time, documentation errors, and transcription errors. A medication error report would be written by a nurse, ULP, or the person responsible for the medication error. The licensee policy titled, RN Assessments, dated August 2021, indicated the RN will complete all assessments based on the assessment schedule and as needed based upon resident condition. The RN would assess the resident if the resident had a change in condition. The licensee's policy entitled Delegation of Nursing Tasks, dated August 2021, indicated nursing tasks would be appropriately delegated to unlicensed personal using the nurse's professional judgement. The policy further	02310		

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02310	Continued From page 38 indicated that prior to delegating a task to unlicesned personnel, the RN must determine if the unlicensed personel is trained and competent to perform the task. TIME PERIOD TO CORRECT: Seven (7) days.	02310		