Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL327301763M
Compliance #: HL327303391C

Date Concluded: March 20, 2023

Name, Address, and County of Licensee Investigated:
Stanton House with Services
4847 Bryant Avenue North
Minneapolis, MN 55430
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Jennifer Segal RN, BSN
Special Investigator

Finding: Substantiated, individual responsibility

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

Initial Investigation Allegation(s):
It is alleged the alleged perpetrator (AP), facility staff, neglected the resident when the AP administered the resident another residents' medications and the resident required hospitalization.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The AP was responsible for the maltreatment. The resident ingested another residents prescribed medication when the AP left the other residents' medications unattended at the dining table. As a result, the resident was hospitalized for two days with hypoglycemia (low blood sugar) and hypokalemia (low sodium).

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident's facility record, ambulance and hospital records, facility policies and procedures, and staff training. The

investigator toured the facility, observed resident and staff interactions, and the facility medication administration system.

The resident resided in an assisted living facility with diagnoses including heart failure, atrial fibrillation, chronic kidney disease and schizoaffective disorder. The resident's service plan included assistance with medication management including ordering, set up, and administration

A facility medication error report indicated at 8:40 a.m. the resident came out to the table for breakfast. The report indicated when staff were serving the resident breakfast the resident picked up a cup of "pills" belonging to another resident. The physician was notified at 1:40 p.m., 5 hours following the documented time of the medication error.

Review of paramedic report indicated the paramedics arrived at the facility at 2:15 p.m. The report indicated the resident was unresponsive and had a low blood sugar of 30. Staff reported to the paramedics the resident had received another resident's medication approximately 45 minutes prior to staff calling 911, which was around 1:30 p.m. The resident received, in error, lisinopril (blood pressure), glipizide (antidiabetic) Janumet (combination antidiabetic), loratadine (antihistamine) and omeprazole (reflux). The paramedic report indicated staff stated the resident dozed off, became less responsive, fell asleep, and staff were unable to wake the resident.

Although the paramedic report indicated the facility staff reported the resident received the other resident's medication in error at approximately 1:30 p.m., the facility medication error report indicated the medication error occurred at 8:40 a.m. at breakfast. A screen shot of an untimed and undated text message, provided by the facility nurse, indicated the AP notified the facility nurse of the medication error, which the nurse indicated was at 8:00 a.m.

The residents medical record lacked any documentation the medication error occurred. In addition, there was no documentation the resident was monitored in the five hours following the medication error and calling paramedics.

The resident's hospital records indicated the resident arrived at the emergency department at 2:51 p.m., with altered mental status, hypoglycemia, and hypokalemia. The resident had an allergy to two of the medications received in error. The physician contacted Poison Control and determined the resident should be admitted to the hospital due to the residents increased risk of death from low blood sugar, altered mental status, and medical history of chronic kidney disease. The resident was admitted to the hospital and returned to the facility 2 days later.

A handwritten note by the facility nurse 5 days following the medication error indicated the error was reviewed and determined the AP had given another resident sitting at the breakfast table their medication. The resident came to the breakfast table and "picked up and swallowed; it was obvious that [resident] had thought that the medication was set up for her."

During interview the facility nurse stated she was unable to specify the exact time of medication error because she was out of the country and in a different time zone when the error occurred. The nurse stated she did not document the incident because she was out of the country, however, after the medication error occurred, she directed staff to monitor the resident and the nurse stayed in communication with staff when she was out of the country.

During interview the AP stated the medication error occurred sometime around 8:30 a.m.- 9:00 a.m. The AP stated the resident sat down next to another resident, picked up the resident's medications, and swallowed them. The AP stated after the medication error she called the facility nurse and was directed to "monitor" and check the residents blood pressure. The AP stated later that day around lunchtime the AP noticed the resident was sweating, shaking, and weak. The AP stated another staff member called 911, however, the AP was unable to recall the other staff working that day. The AP stated after the resident took the other resident's medication the resident was monitored. However, the AP indicated she did not document anything regarding the medication error or monitoring in the resident's medical record.

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

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

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
Neglect means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
Staff reeducated not to leave medication with a resident until medication is swallowed

Action taken by the Minnesota Department of Health:

The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:

The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Hennepin County Attorney
Minneapolis City Attorney
Minneapolis Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32730	A. BUILDING: _____ B. WING _____	C 01/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANTON HOUSE W SERVICES INC	4847 BRYANT AVENUE NORTH MINNEAPOLIS, MN 55430

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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: #HL327301763M/#HL327303391C #HL327304704M #HL327308057C On January 18 - 26, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were six residents receiving services under the provider's Assisted Living License. The following immediate correction order is issued for #HL327301763M/#HL327303391C and #HL327304704M/#HL327308057C tag identification 1290. The immediacy of 1290 was removed on January 26, 2023, however, non-compliance remains at a scope and severity of I. The following correction orders which are not	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.	

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0 000	Continued From page 1 immediate are issued for #HL327301763M/ HL327303391C and #HL327304704M/#HL327308057C tag identification 0620, 2310, 2360, and 3000.	0 000		
0 620 SS=I	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment according to the facility policy for one of one resident (R1) reviewed on two separate occasions for medication errors, both required hospitalizations. This had the potential to affect all six residents residing in the facility. 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 Findings include:	0 620		

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0 620	Continued From page 2 R1's service agreement, dated August 1, 2021, indicated R1 received medication administration from facility staff which included preparing, administering and documenting administration or refusal to take the medications. R1's facility medication error report dated June 17, 2022, at 8:40 a.m., indicated R1 came out to the table for breakfast when R1 picked up and swallowed a cup of "pills" belonging to another resident. R1's paramedic report dated June 17, 2022, at 2:06 p.m., indicated facility staff called 911 when staff realized R1 swallowed another residents medication. When the paramedics arrived at 2:15 p.m., R1 was unresponsive with a blood sugar of 30. The report indicated R1 took another resident's medications that included Lisinopril (medication for heart failure), Glipizide (medication for diabetes), Janumet (medication for diabetes), loratadine (allergy medication), and omeprazole (acid reflux). The report indicated the doses of the medications were unknown. R1's hospital record dated June 17, 2022, at 2:51 p.m., indicated R1 arrived at the emergency department with altered mental status, hypoglycemia, and hypokalemia when staff administered R1 another residents' medications. R1 had allergies to two of the medications received in error. The record indicated R1 required admission to the hospital because R1 was at increased risk of death from low blood sugar, altered mental status, and history of chronic kidney disease. R1 was admitted to the hospital and discharged back to the facility two days later. An untitled note documented by registered nurse	0 620		

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0 620	Continued From page 3 (RN)-D dated June 22, 2022, indicated R1's medication error was reviewed and when R1 went to breakfast table she "picked up and swallowed another resident's medications; it was obvious [R1] thought the medication was set up for her." During interview on January 20, 2023, at 2:15 p.m., RN-D stated she did not report the medication error to MAARC because she was out of the country when the medication error occurred. During interview on January 31, 2023, at 4:45 p.m., ULP-A stated she reported the medication error to RN-D on June 17, 2022, around 8:30 a.m. Second Medication Error A facility medication error report dated January 15, 2023, indicated R 1 was administered another resident's medication when ULP-B picked up a cup of medications for another resident and administered them to R1. ULP-B notified RN- D and was instructed to call 911. Review of R1's hospital record dated January 16, 2023, at 2:45 p.m., indicated R1 was transported by ambulance to the hospital on January 15, 2023, at 9:20 p.m., due to altered mental status and accidental drug overdose. Records also indicated R1 fell before discharging from the hospital and sustained facial injuries on January 16, 2023, at 2:45 p.m. A untitled note dated January 16, 2023, signed by RN-D indicated R1 was administered in error Baclofen (muscle relaxer), Clonazepam (anti-anxiety), Oxybutynin (overactive bladder), Valproic acid (antiseizure), venlafaxine (antidepressant), and Quetiapine (antipsychotic)	0 620		

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0 620	Continued From page 4 when ULP-B administered R1 another resident's medication. R1 was sent to the hospital and returned to the facility the following day. During observations on January 18, 2023, at 2:00 p.m., R1 stated she had injuries to her eye and jaw when she fell at the hospital two day prior. R1 stated she went to the hospital for lab work and before leaving the hospital fell resulting in facial injuries. R1's facility record was reviewed on January 18, 2023. R1's record lacked any documentation regarding a medication error, hospitalization, injuries to R1's eye/ jaw, and no reports were made to MAARC or the physician regarding a medication error or unknown injury. During interview on January 18, 2023, at 11:15 a.m., licensed assisted living director (LALD)-E stated the facility did not report either of R1's medication errors to MAARC. The investigator requested information or documentation of recent health changes, concerns, hospitalizations, medication errors, and/ or MAARC reports regarding R1. LALD-E stated R1 had no changes or reports to provide. During interview on January 20, 2023, at 2:15 p.m., RN-D stated ULP-B called her on January 15, 2023, approximately 8:30 p.m., to report ULP-B gave R1 another residents medication. RN-D stated she did not make a MAARC report because the facility was still investigating the incident. During interview on February 6, 2023, at 2:00 p.m., ULP-B stated she gave the wrong medications to R1 and realized the error after administering them to R1. ULP-B stated she	0 620		

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0 620	Continued From page 5 called RN-D and R1 was sent to the hospital. The undated facility policy titled Reporting Maltreatment of Vulnerable Adult indicated all facility staff are mandated reporters and a supervisor would investigate all incidences and determine if reportable and report to MAARC within 24 hours. TIME PERIOD TO CORRECT: Seven (7) days.	0 620		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to complete employee background studies prior to providing direct care services for 17 of 17 staff employed by the licensee. This had potential to affect all six residents receiving services from the licensee.	01290		

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01290	Continued From page 6 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 facility was notified of the immediate correction order on January 20, 2023. The immediacy of 1290 was removed on January 26, 2023, however, non-compliance remains at a scope and severity of I. Findings include: A background study notice from the Department of Human Services dated January 10, 2023, addressed to LALD, indicated unlicensed personnel (ULP)-F had a prior disqualification to provide direct care to residents. ULP-F did not submit the required information for a background study to be completed and the facility was directed to immediately remove ULP-F from providing any resident care. During interview on January 18, 2023 at 3:30 p.m. unlicensed personnel (ULP)-F stated she was covering the evening shift due to short staffing. ULP-F stated she was the only staff working after 5:00 p.m. and would be providing direct care to all residents. A search of the Minnesota Department of Human Services background study website (https://netstudy2.dhs.state.mn.us/Live/Employees/SearchRoster) conducted on January 19, 2023, at 12:51 p.m. indicated the facility had two staff	01290		

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01290	Continued From page 7 members with a background check cleared to provide direct care to residents. Review of the facility current staff roster dated January 20, 2023, indicated one of the staff with a cleared background study no longer worked at the facility and the other was the licensed assisted living administrator (LALD). During interview on January 20, 2023, at 4:30 p.m. LALD stated the facility was in compliance with background study requirements. The LALD stated she thought she had cleared background studies for all of the employees and would send copies of them to the investigator. No cleared background studies for the licensee's direct care staff were provided to the investigator as of January 23, 2023, at 1:00 p.m. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days.	01290		
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 document review, the facility failed to provide care and services according to acceptable health care standards	02310		

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02310	Continued From page 8 and medical or nursing standards, for one of one resident (R1) reviewed for significant medication errors. R1 was administered another resident's medication in error on two separate occasions, both requiring emergency medical treatment. The facility failed to investigate both medication errors to complete an individualized assessment to ensure R1 received the appropriate care and services. 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). Findings include: R1's service plan dated August 1, 2021, indicated R1 had diagnosis including heart failure and schizoaffective disorder. R1 received services including a registered nurse (RN) assessment every 90 days, and as needed for change in condition, including anytime resident returned from a hospital, had a change in condition, and/ or side effects from medications. In addition, staff assisted R1 with personal care including mobility, bathing, dressing and medication administration. R1's facility medication error report dated June 17, 2022, at 8:40 a.m., indicated R1 came out to the table for breakfast when R1 picked up and swallowed a cup of "pills" belonging to another resident. R1's paramedic report dated June 17, 2022, at	02310		

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02310	Continued From page 9 2:06 p.m., indicated facility staff called 911 when staff realized they gave R1 another residents medication. When the paramedics arrived at 2:15 p.m., R1 was unresponsive with a blood sugar of 30. The report revealed staff gave the resident another resident's medication including Lisinopril (medication for heart failure), Glipizide (diabetes medication), Janumet (diabetes medication) loratadine (allergy medication), and omeprazole (medication used to treat acid reflux) The report revealed the doses of the medications were unknown. R1's facility record contained no documentation staff monitored or assessed R1 during the five hours after the medication error and prior to calling the paramedics. R1's hospital record dated June 17, 2022, indicated the resident was hospitalized for a medication overdose. An untitled note dated June 17, 2022, by licensed assisted living director (LALD)-E indicated R1 went to hospital because R1 walked up to another resident at the table and picked up the medication cup and took the other resident's medications because R1 thought the medications were meant for R1. An untitled note dated June 20, 2022, by LALD-E revealed video footage reviewed from June 17, 2022, appeared R1 "did not seem to understand what she had done" when R1 took another residents medication. An untitled note dated June 22, 2022, signed by RN-D indicated R1's medication error was reviewed and indicated R1 went to the breakfast table and "picked up and swallowed medications;	02310		

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02310	Continued From page 10 it was obvious that [R1] thought that the medication was set up for her.[R1]" R1's nursing reassessment dated June 27, 2022, indicated R1 required assistance with mobility and personal care. Although the facility investigation indicated R1 was at risk for "taking" another residents medication, no changes were made to the reassessment. During observation on January 18, 2023, at approximately 11:00 a.m., R1 was using a walker and assistance of one staff to walk to the dining room table. R1 had bruising/injury to her eye and jaw. When R1 was asked how the injuries occurred R1 stated it was from a fall a couple days prior. During a follow up interview on January 18, 2023, at 2:00 p.m., R1 stated the injuries on her eye and jaw were from falling at the hospital 2 days prior. R1 said she went to the hospital for lab work and before leaving the hospital fell resulting in facial injuries. R1's facility records were reviewed on January 18, 2023. R1's medical record lacked any documentation regarding a medication error, hospitalization, and/or injuries to R1's eye/ jaw. A facility medication error report dated January 15, 2023, revealed R1 was administered another resident's medications. Unlicensed personnel (ULP)-B picked up a cup of medications for another resident and administered them to R1. ULP-B notified RN- D and was instructed to call 911. Review of R1's hospital record dated January 16, 2023, at 2:45 p.m., indicated the resident was	02310		

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	32730	A. BUILDING: _____ B. WING _____	C 01/26/2023

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02310	Continued From page 11 transported by ambulance to the hospital on January 15, 2023, at 9:20 p.m., due to altered mental status and accidental drug overdose. The hospital records revealed R1 fell before discharging from the hospital and sustained facial injuries on January 16, 2023, at 2:45 p.m. An untitled note dated January 16, 2023, signed by RN-D, indicated R1 was administered another residents medication in error which included Baclofen (muscle relaxer), Clonazepam (anti-anxiety medication), Oxybutynin (medication to treat an overactive bladder), Valproic acid (antiseizure medication), venlafaxine (antidepressant medication), and quetiapine (antipsychotic medication) when ULP-B administered R1 another resident's medication. R1 was sent to the hospital and returned to the facility the following day. The Stanton House Employee Write Up Form dated January 16, 2023, indicated ULP-B received a first warning for administering the wrong medication to the wrong resident. The report indicated ULP-B did not follow proper technique for medication administration contributing to the medication error. During interview on January 19, 2023, at 2:40 p.m., R1's case manager (CM)-J stated he was informed by hospital staff of the first medication error in June, 2022. CM-J stated he contacted the facility after he was informed of the 2022, medication error to discuss how future medication errors would be prevented, however, CM-J never received any follow up from the facility. CM-J stated he was unaware of the second medication error, and any injury prior to leaving the hospital. CM-J stated it was expected the facility would notify CM-J of any change in R1's health status,	02310		

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02310	Continued From page 12 especially if it results in hospitalization. During an interview on January 26, 2023, at 12:20 p.m., LALD-E stated the first medication error happened because R1 "swiped" the other residents medication off the table. LALD-E stated the second medication error should not have happened and staff were reminded during meetings to administer medication to one resident at a time and make sure the resident swallow's the medications before leaving the resident. LALD-E stated staff should not allow themselves to be "distracted" while administering medications. During interview on January 31, 2023, at 10:00 a.m., RN-D stated when discussing the medication error with administrative staff she began to cry because she "couldn't believe another medication error happened with the resident [R1]". RN-D stated she had little influence over the facility policy and procedures, and management did not include RN-D in staff meetings when medication errors were discussed with staff. RN-D stated she had concern with medication administration at the facility and notified management of the concerns several times. During an interview on January 31, 2023, at 4:30 p.m., ULP-A stated on the day of R1's medication error, June 17, 2022, she worked alone. ULP-A stated she called R1 out to the breakfast table between 8:00 a.m. and 8:30 a.m. When R1 came to the breakfast table she grabbed another resident's medication cup and swallowed the pills. ULP-A stated it happened fast and she was unable to stop R1. ULP-A stated she called RN-D around 8:30 a.m., and she was instructed to monitor R1 for changes and check the residents	02310		

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02310	Continued From page 13 vital signs every two hours. Around lunch time, ULP-A noticed R1 sweating and R1 stated she felt faint. ULP-A stated she gave R1 orange juice but R1's condition didn't improve so she called 911. ULP-A was unable to recall if any other staff worked that day, and what time she called 911. ULP-A stated she did not document any monitoring and/ or vital signs for R1 between the medication error and paramedics arrival. An email received from LALD-E on February 1, 2023, 1:45 p.m., indicated ULP-A worked alone on June 17, 2022, during the morning hours. In addition, RN-D was out of the country June 9 to June 22, 2022, however, RN-D could be reached by phone. During an interview on February 6, 2023, at 1:50 p.m., ULP-B stated she accidentally gave R1 another residents medications on January 15, 2023. ULP-B stated she left the other residents 4:00 p.m. medications on the dining room table with the other resident and expected he would take the medications with his meal around 5:00 p.m. The other resident did not take his medications and ULP-B left the medications on the table. ULP-B stated she called RN-D around 8:00 p.m., to report the other resident did not take his 4:00 p.m. medication. RN-D told ULP-B to dispose of the other resident's medications. ULP-B stated she went to throw the other resident medications away but accidentally brought the medication to R1 and administered the medication. Right after R1 swallowed the other resident's medications ULP-B called RN-D to report the incident. RN-D instructed ULP-B to monitor R1 and check vital signs, and then it was determined R1 would go to the hospital for evaluation and monitoring. ULP-B could not recall what time she called 911 because it was a busy	02310		

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02310	Continued From page 14 shift and she was distracted. There were no records to reflect R1 monitoring and/or vital signs. The facility policy titled Nursing Assessment and Reassessment of Residents, undated, indicated the RN would conduct a nursing assessment as needed based on changes and not to exceed 90 days from the last assessment. The assessment conducted anytime the resident returns from hospital, nursing home, change in condition, fall, unusual symptoms or side effects of medications the reassessment includes review service plan, evaluate medication management services and resident medications, communicate with provider. Assessment also includes the resident's vulnerability and susceptibility to maltreatment. The facility policy titled Medication administration by unlicensed personnel, undated, indicated the purpose to identify trained and competent staff to administer medication safely and accurately. Six rights of administration right individual, right medication, right dose, right time, right route, right documentation. It is essential to prepare medication for one resident at a time, give the medication as soon as prepared, do not talk to others and ask others not to talk to you when giving medications and always pay close attention. The facility policy titled Medication administration error policy, undated, indicated any medication administration error documented to prevent future errors and evaluate the risks to decrease errors. Actions include, immediate notification of error, immediate intervention, narrative of situation, report filed on resident and employee file indicating the error, actions taken and resident response.	02310		

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02310	Continued From page 15 Time Period for Correction: Seven (7) days.	02310		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure 1 of 1 resident reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual staff person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details. No plan of correction is required for this tag.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	
03000 SS=I	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless:	03000		

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03000	Continued From page 16 (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on observation, interview and record	03000		

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03000	Continued From page 17 review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment according to the facility policy for one of one resident (R1) reviewed on two separate occasions for medication errors, both required hospitalizations. This had the potential to affect all six residents residing in the facility. 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 Findings include: R1's service agreement, dated August 1, 2021, indicated R1 received medication administration from facility staff which included preparing, administering and documenting administration or refusal to take the medications. R1's facility medication error report dated June 17, 2022, at 8:40 a.m., indicated R1 came out to the table for breakfast when R1 picked up and swallowed a cup of "pills" belonging to another resident. R1's paramedic report dated June 17, 2022, at 2:06 p.m., indicated facility staff called 911 when staff realized R1 swallowed another residents medication. When the paramedics arrived at 2:15 p.m., R1 was unresponsive with a blood sugar of 30. The report indicated R1 took another resident's medications that included Lisinopril	03000		

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03000	Continued From page 18 (medication for heart failure), Glipizide (medication for diabetes), Janumet (medication for diabetes), loratadine (allergy medication), and omeprazole (acid reflux). The report indicated the doses of the medications were unknown. R1's hospital record dated June 17, 2022, at 2:51 p.m., indicated R1 arrived at the emergency department with altered mental status, hypoglycemia, and hypokalemia when staff administered R1 another residents' medications. R1 had allergies to two of the medications received in error. The record indicated R1 required admission to the hospital because R1 was at increased risk of death from low blood sugar, altered mental status, and history of chronic kidney disease. R1 was admitted to the hospital and discharged back to the facility two days later. An untitled note documented by registered nurse (RN)-D dated June 22, 2022, indicated R1's medication error was reviewed and when R1 went to breakfast table she "picked up and swallowed another resident's medications; it was obvious [R1] thought the medication was set up for her." During interview on January 20, 2023, at 2:15 p.m., RN-D stated she did not report the medication error to MAARC because she was out of the country when the medication error occurred. During interview on January 31, 2023, at 4:45 p.m., ULP-A stated she reported the medication error to RN-D on June 17, 2022, around 8:30 a.m. Second Medication Error A facility medication error report dated January	03000		

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03000	Continued From page 19 15, 2023, indicated R 1 was administered another resident's medication when ULP-B picked up a cup of medications for another resident and administered them to R1. ULP-B notified RN- D and was instructed to call 911. Review of R1's hospital record dated January 16, 2023, at 2:45 p.m., indicated R1 was transported by ambulance to the hospital on January 15, 2023, at 9:20 p.m., due to altered mental status and accidental drug overdose. Records also indicated R1 fell before discharging from the hospital and sustained facial injuries on January 16, 2023, at 2:45 p.m. A untitled note dated January 16, 2023, signed by RN-D indicated R1 was administered in error Baclofen (muscle relaxer), Clonazepam (anti-anxiety), Oxybutynin (overactive bladder), Valproic acid (antiseizure), venlafaxine (antidepressant), and Quetiapine (antipsychotic) when ULP-B administered R1 another resident's medication. R1 was sent to the hospital and returned to the facility the following day. During observations on January 18, 2023, at 2:00 p.m., R1 stated she had injuries to her eye and jaw when she fell at the hospital two day prior. R1 stated she went to the hospital for lab work and before leaving the hospital fell resulting in facial injuries. R1's facility record was reviewed on January 18, 2023. R1's record lacked any documentation regarding a medication error, hospitalization, injuries to R1's eye/ jaw, and no reports were made to MAARC or the physician regarding a medication error or unknown injury. During interview on January 18, 2023, at 11:15	03000		

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03000	Continued From page 20 a.m., licensed assisted living director (LALD)-E stated the facility did not report either of R1's medication errors to MAARC. The investigator requested information or documentation of recent health changes, concerns, hospitalizations, medication errors, and/ or MAARC reports regarding R1. LALD-E stated R1 had no changes or reports to provide. During interview on January 20, 2023, at 2:15 p.m., RN-D stated ULP-B called her on January 15, 2023, approximately 8:30 p.m., to report ULP-B gave R1 another residents medication. RN-D stated she did not make a MAARC report because the facility was still investigating the incident. During interview on February 6, 2023, at 2:00 p.m., ULP-B stated she gave the wrong medications to R1 and realized the error after administering them to R1. ULP-B stated she called RN-D and R1 was sent to the hospital. The undated facility policy titled Reporting Maltreatment of Vulnerable Adult indicated all facility staff are mandated reporters and a supervisor would investigate all incidences and determine if reportable and report to MAARC within 24 hours. TIME PERIOD TO CORRECT: Seven (7) days.	03000		