Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL370888344M
Compliance #: HL370885529C

Date Concluded: May 2, 2024

Name, Address, and County of Licensee Investigated:
Mercy Link LLC
15684 Harmony Way
Apple Valley MN, 55124
Dakota County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Kris Detsch, RN
Special Investigator

Finding: Inconclusive

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

Initial Investigation Allegation(s):
The facility failed to provide supervision to the resident. As a result, the resident overdosed on drugs.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. The facility provided immediate assistance to the resident at the time of the drug overdose, and he recovered. However, sometime prior to the incident the resident overdosed from drugs while he was out in the community and a staff member observed the resident with drug paraphernalia. The facility lacked documentation when these instances occurred, and it was unclear if further interventions would have prevented the resident's drug overdose.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the case worker. The investigation included review of resident records, incident reports, facilities policies, court

documentation, hospital records, and employee files. Also, the investigator observed toured the facility, observed the resident's rooms and smoking areas.

Resident resided in an assisted living facility. His diagnoses included schizophrenia and bipolar disorder (manic depression). The resident's service plan included assistance with medications, and behavior management. The resident's nursing assessment indicated he dressed, groomed, and bathed himself without staff assistance. He was able to communicate his needs. He walked independently.

The facility incident report indicated an unlicensed personnel (ULP) checked on the resident, but he did not respond when they knocked on his door. The ULP broke down the door and found the resident lying in his bed, barely breathing. The resident's skin color was blue. The ULP observed drugs in the resident's hands and called emergency services (911). Emergency responders provided cardiopulmonary resuscitation (CPR) measures. A second resident was in the room with using drugs with the resident, who left the room when emergency responders began CPR on the resident and passed out in the living room. Emergency responders transported both residents to the hospital.

Hospital records indicated the resident was unresponsive when emergency responders arrived at the facility, so they administered intravenous (IV) naloxone, a medication to reverse the effect of drug overdose. Upon receiving the medication, the resident began to breath. The resident told hospital physicians he took three Percocet (opioid) tablets and snorted them. The resident told them he had also consumed alcohol. The resident did not return to the facility upon his hospital discharge 18 days later.

During an interview, the ULP said he was at the facility and saw the resident less than two hours prior to the incident. The ULP said there was another staff member working during day, so he left for a short time because he had to come back to work the evening shift. Upon his return (less than two hours later), he checked on all the resident's. The ULP said the resident did not answer when he knocked on his door. He entered the room and saw the resident lying on the bed with pills on his chest and a straw in his mouth. The resident was unresponsive and had fluid coming from his mouth, so he performed CPR. Prior to this incident, the ULP said he observed the resident with drug paraphernalia of pills and aluminum. The ULP said he could not recall the time of the previous incident, but he took the items and reported the incident to the facility nurse.

During an interview, the nurse said the resident did not believe he required medications and often refused to take them. The resident had increased drug seeking behavior when he was not taking his medications regularly. The nurse said there were court orders for the resident to comply with his medication management plan, however the court orders ended. The facility attempted to get the court orders reinstated. The nurse said she worked with the resident's mental health providers, and case managers to develop safety plans for him, but he was still able to come and go freely from the facility into the community. The nurse said before the

overdose at the facility occurred, there was one other overdose while the resident was in the community. The resident went to the hospital, however he returned to the facility the same day. Upon his return, he agreed to drug abuse therapy. He also agreed to attend psychology appointments. The nurse said she made appointments for him, but he canceled those appointments and the psychology department declined to make any more for him. The nurse said she made attempts to get the psychology department to re-instate him, however he was able to make his own decisions and refused to comply. The nurse said she put interventions in place to monitor his safety including hourly safety checks from staff. The nurse said she was unaware the resident used drugs while at the facility.

During an interview, the licensed assisted living director (LALD) said another intervention included transportation. They told the resident they would drive him to any place he wanted to go outside the facility, as opposed to him walking. The resident left the facility at times unattended because he knew he had the right to do so. The facility implemented a sign-in sheet for the resident to sign in and out when he left the facility, and he usually complied with using it. Regarding the facility overdose incident, the LALD said he spoke to the staff member who worked the morning shift. The LALD said the staff member told him she saw the resident one hour before the overdose. The resident told her he was going for a smoke break and would be back in five minutes, but he did not return to the facility for approximately thirty minutes. The staff member told the LALD the resident appeared to be his usual self when he returned.

During an interview, a family member said the resident recovered from the incident and entered a drug treatment program.

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

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

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

Vulnerable Adult interviewed: No, attempted but did not reach.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility coordinated care with the resident's case workers and provided education to facility staff.

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
Minnesota Board of Executives for Long Term Services and Supports
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37088	A. BUILDING: _____ B. WING _____	C 03/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCY LINK LLC	15684 HARMONY WAY 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 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: #HL370885529C/#HL370888344M On March 29, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were four residents receiving services under the provider's Assisted Living Care license. The following correction orders are issued for #HL370885529C/#HL370888344M, tag identification 730, 1640, 1690, 1760.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident:	0 730		

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0 730	Continued From page 1 (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service	0 730		

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0 730	Continued From page 2 termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, resident records lacked documentation of incidences of street drug use for one of one resident (R1) reviewed. R1 overdosed on street drugs while in the community. Also, a staff member observed R1 with drug paraphernalia while at the facility. The date and time these incidences occurred were unclear because the licensee lacked documentation of the incidences. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1's diagnoses included schizophrenia, bipolar disorder, and acute psychosis. Facility incident report dated September 1, 2023, at 4:10 p.m., indicated unlicensed personnel (ULP)-B knocked on R1's bedroom door, but R1 failed to respond. ULP-B broke down R1's door and found him lying on his bed, unconscious, with drugs in his hands, and barely breathing. R1's skin was blue. ULP-B called 911. Emergency responders took R1 to the hospital.	0 730		

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0 730	Continued From page 3 On April 1, 2024, at 1:32 p.m., licensed assisted living director (LALD)-A said R1 admitted into licensee from a crisis facility. R1 had a history of an opioid addition, but R1 was not using drugs at the time of admission. LALD-A said R1 did not use drugs for approximately the first year after admission, but started using drugs three months prior to the incident on September 1, 2023. Additionally, LALD-A said approximately three weeks prior to the drug overdose on September 1, 2023, R1 overdosed on drugs while he was in the community. A community member alerted 911 and they took R1 to the hospital. He returned to licensee the same day. On April 1, 2024, at 3:01 p.m., ULP-B said he observed R1 smoking pills with aluminum, and he took it from him. ULP-B said R1 was outside at the time of the incident and was unsure when the incident occurred, but it was before the incident on September 1, 2023. ULP-B said it was the first incident of R1 smoking pills he observed, and he reported it to the nurse. R1's progress notes from July 1, 2023, to September 11, 2023, lacked documentation R1 overdosed on street drugs while in the community. Progress notes lacked documentation of the incident when staff observed him smoking pills with aluminum. On April 2, 2024, at 8:12 a.m., surveyor requested LALD-A to provide R1's incident reports from June 2023 to August 2023. On April 3, 2024, surveyor called LALD-A because surveyor had not received R1's incident reports. LALD-A said he sent the document request to registered nurse (RN)-C, and she would provide documentation on April 4, 2024.	0 730		

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0 730	Continued From page 4 On April 4, 2024, at 12:10 p.m., RN-C said she was unaware of the document request. RN-C said she would contact LALD-A and send documentation. Surveyor received no further incident reports for R1. On April 2, 2024, at 10:53 a.m., RN-C said R1 overdosed on street drugs while he was in the community. RN-C said she assessed him when he returned. RN-C said she was unsure of the date the incident occurred. RN-C said staff did not tell her R1 used street drugs at the facility. On May 1, 2024, at 10:46 a.m., LALD-A sent surveyor an email indicating he could not find licensee policy for record retention. Time period for correction: seven (7) days	0 730		
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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01640	Continued From page 5 (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 revise the service plan to include hourly safety checks for two of two residents (R1, R2) reviewed. R1 and R2 had an identified safety intervention of hourly safety checks as a result of the abuse assessment. The service was a verbal direction and there was no system in place for staff to document they completed safety checks. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's diagnoses included schizophrenia, bipolar disorder, and acute psychosis. R1's service plan dated December 14, 2022, included services for housekeeping, socialization, meals, minimal activities of daily living, medications, and mental health. The service plan lacked hourly safety checks. R1's individual abuse prevention plan (IAPP)	01640		

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01640	Continued From page 6 dated December 14, 2022, indicated R1 had a history of illegal drug use. The IAPP indicated staff would check him hourly to ensure he was safe when he was in his room. R2's diagnoses included schizophrenia. R2's service plan dated December 23, 2023, included services for medication administration. R2's service plan lacked further services, including hourly safety checks. R2's IAPP dated December 23, 2023, indicated R2 had a history of illegal drug use and history of overdose. The IAPP indicated staff would check him hourly to ensure he was safe when he was in his room. On March 29, 2024, at 12:17 p.m., surveyor sent licensed assisted living director (LALD)-A an email and requested staff documentation of the services they provided for R1. On April 1, 2024, at 11:07 a.m., LALD-A sent surveyor R1's records. The records included a medication administration record, but no further service delivery record documentation. On April 2, 2024, at 10:53 a.m., registered nurse (RN)-C said R1 had a history of overdosing on drugs. RN-C said she directed staff members to do hourly checks, and added hourly checks on his IAPP. RN-C said staff do not document completed safety checks. On April 8, 2024, at 2:04 p.m., LALD-A emailed surveyor a message indicating the licensee provides a document titled, House Rules and Boundaries, to all residents upon admission. On April 10, 2023, at 8:59 a.m., surveyor asked	01640		

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01640	Continued From page 7 LALD-A if R2's service plan was complete because the plan lacked services, other than medication. LALD-A said he was unsure and would have to check because the county provides a list of services on a "6790 form." No further information provided. Licensee's document titled, House Rules and Boundaries, no date, indicated staff will conduct room checks every hour. The policy further indicated the purpose of hourly room checks is for the safety and wellbeing of the residents. Licensee's policy titled, Service Plan, dated May 26, 2020, indicated licensee would implement individualized service plans for all residents and provide services as required by the service plan. Additionally, license would revise the service plan based on reassessment of the resident. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01690 SS=H	144G.71 Subdivision 1 Medication management services (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must	01690		

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01690	Continued From page 8 address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a current medication administration policy and procedure plan to include Narcan, a medication used for opioid overdose, for residents (R) with illicit drug use and opioid abuse. R1 and R2 overdosed in R1's room and the licensee staff found R1 unresponsive. R1 required cardio pulmonary resuscitation (CPR) and assistance from emergency responders (911). Both went to the hospital. 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	01690		

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01690	Continued From page 9 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: Center for Disease (CDC) information located at www.cdc.gov/stopoverdose/naloxone/index.html, April 21, 2023, indicated if someone is at increased risk for opioid overdose, you should carry naloxone (Narcan) and keep it at home. Naloxone quickly reverses an overdose by blocking the effects of opioids. The Minnesota Department of Health, webpage titled Naloxone, updated April 19, 2024, https://www.health.state.mn.us/communities/opioids/basics/naloxone.html, includes information about Naloxone, training resources and a Naloxone finder for sources to obtain the medication. R1's diagnoses included schizophrenia, bipolar disorder, and acute psychosis. R1's service plan dated December 14, 2022, included services for housekeeping, socialization, meals, minimal activities of daily living, medications, and mental health. R1's individual abuse prevention plan (IAPP) dated December 14, 2022, indicated R1 had a history of illegal drug use. The IAPP directed staff to call 911 immediately if they suspect a drug overdose. Staff should check R1 hourly when his was in his room. The IAPP indicated R1 was impulsive and made poor decisions when he used illicit drugs. The IAPP directed staff to call nurse and management when they suspect R1 was using illicit drugs.	01690		

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01690	Continued From page 10 R1's medication administration record (MAR) dated August 1 through August 31, 2023, lacked an order for Narcan administration. R2's diagnoses included schizophrenia. R2's service plan dated December 23, 2023, included services for medication administration. R2's IAPP dated December 23, 2023, indicated R2 had a history of illegal drug use and history of overdose. The IAPP indicated staff would check him hourly to ensure he was safe when he was in his room. INCIDENT OF DRUG OVERDOSE WITH R1 AND R2 R1 Facility incident report dated September 1, 2023, at 4:10 p.m., indicated unlicensed personnel (ULP)-B knocked on R1's bedroom door, but R1 failed to respond. ULP-B broke down R1's door and found him lying on his bed, unconscious, with drugs in his hands, and barely breathing. R1's skin was blue. ULP-B called 911. Emergency responders took R1 to the hospital. R1's progress note dated September, 2023, at 8:08 p.m., indicated R1 overdosed and was at the hospital. R1's hospital record dated September 2, 2023, indicated R1 took three Percocet (opioid) tablets and consumed alcohol. When emergency responders arrived at the licensee, R1 was unresponsive and required intravenous Narcan. Upon them administering it, R1 began to breath. They administered an additional dose, and he woke up. The hospital records indicated R1 reported this was not his first overdose, however	01690		

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01690	Continued From page 11 it was the first overdose he became unresponsive with. R1 admitted September 2, 2023. The hospital placed R1 on a 72 hour hold (three day required stay). R1 attended inpatient therapy. R1 discharged on September 19, 2023. R1 did not return to licensee. On April 8, 2024, at 11:56 a.m., the surveyor spoke to licensed assisted living director (LALD)-A and requested any policies the licensee had on substance abuse. On April 8, 2024, at 2:04 p.m., LALD-A emailed the surveyor a message indicating licensee did not have a substance abuse policy, but they provide a documented titled, House Rules and Boundaries, to all residents upon admission. On April 9, 2024, at 4:24 p.m., LALD-A sent the surveyor an email indicating he spoke to registered nurse (RN)-C, and they do have a Narcan medication policy form. LALD-A sent the surveyor R1's medication protocol form dated September 1, 2024, completed the same day R1 overdosed and went to the hospital, although R1 did not return to licensee. R1's form titled Medication Protocol for Narcan, signed and dated by a registered nurse (RN) on September 1, 2023. The form indicated "Written Instructions For [R1]" and included identification of respiratory depressing, call 911, verify Narcan on the MAR, position for access to the nose, administer per "procedure below", observe for responsiveness, if no response administer a second dose is available, document event and report to the nurse and administrator. The signature on the form was illegible.	01690		

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01690	Continued From page 12 R2 Facility incident report dated September 1, 2023, at 4:10 p.m., indicated ULP-B found R2 on the bed alongside R1 who was unconscious. R2 left the room, then "passed out" in the living room. The incident report indicated R2 appeared to have overdosed, so 911 responders took him to the hospital. R2's nurses reassessment dated September 1, 2023, no time, indicated R2 returned to the facility from the hospital after he overdosed. The nurse received a phone call from facility staff because they suspected R2 of using drugs. The nurse told facility staff to call emergency services (911). The assessment indicated R2 was alert and taken to the hospital. The assessment indicated on September 4, 2023, nursing left a voicemail to psychology for R2 to have a follow up appointment due to a drug overdose. The assessment indicated staff would continue to observe and report any issues. The bottom of the form indicated communication and coordination of care included staff meeting, psychiatry appointment, care team meeting to address concerns, and "also Narcan." The signature on the form was illegible. On April 22, 2024, at 3:02 p.m., surveyor sent an email requesting licensee's Narcan policy and procedure for R2. On April 24, 2024, at 10:24 a.m., LALD-A sent the surveyor an email indicating he attached R2's Narcan policy and procedure, however there was no attachment for R2's Narcan policy and procedure. The surveyor responded to LALD-A on April 24, 2024, at 11:12 a.m., the surveyor did not receive the Narcan policy for R2. On April 25, 2024, at 11:19 a.m., LALD-A sent surveyor R2's Narcan policy form dated September 1, 2023.	01690		

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01690	Continued From page 13 R2's form titled Medication Protocol for Narcan, signed and dated by a RN on September 1, 2023. The form indicated "Written Instructions For [R2]" and included identification of respiratory depressing, call 911, verify Narcan on the MAR, position for access to the nose, administer per "procedure below", observe for responsiveness, if no response administer a second dose is available, document event and report to the nurse and administrator. The signature on the form was illegible. R2's MAR dated September 1, 2023, through September 30, 2023, lacked Naloxone (Narcan) medication. R2's subsequent MAR's for October 2023, November 2023, and December 2023, listed Narcan, but was not available to document until start date of December 29, 2023, for administration. R2's medication list dated April 10, 2024, indicated licensee obtained an order for Naloxone HCL (Narcan). The start date for the medication was December 29, 2023. On April 1, 2024, at 1:32 p.m., LALD-A said R1 admitted into licensee from a crisis facility. R1 had a history of an opioid addition, but R1 was not using drugs at the time of admission. LALD-A said R1 did not use drugs for approximately the first year after admission, but started using drugs three months prior to the incident on September 1, 2023. Additionally, LALD-A said approximately three weeks prior to the drug overdose on September 1, 2023, R1 overdosed on drugs while he was in the community. A community member alerted 911 and they took R1 to the hospital. He returned to licensee the same day.	01690		

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01690	Continued From page 14 On April 1, 2024, at 3:01 p.m., ULP-B said he observed R1 smoking pills with aluminum, and he took it from him. ULP-B said R1 was outside at the time of the incident and was unsure when the incident occurred, but it was before the incident on September 1, 2023. ULP-B said it was the first incident of R1 smoking pills he observed, and he reported it to the nurse. ULP-B said R1 obtained the pills from an acquaintance of R1's family member. ULP-B said on September 1, 2023, he discovered R1 unresponsive, with pills on his chest, and a straw in his mouth. ULP-B said he performed CPR to R1, and 911 responders took him to the hospital. ULP-B said another R2 was also in the room, and appeared to have overdosed but he was still alert. R2 also went to the hospital. ULP-B said it was the first time R2 overdosed, and he has not had any further incidences. On April 2, 2024, at 10:53 a.m., RN-C said she got Narcan in the house after the incidents on September 1, 2023. On April 24, 2024, at 1:22 p.m., RN-C acknowledged the start date for Naloxone (Narcan) was December 29, 2023, and said she did not put the order into the computer until they received it from the physician. RN-C said she wrote the Narcan policy for R1 on September 1, 2023, after the incident because she was unsure if R1 would return to licensee. RN-C said she was not aware of any other instances of R1 using street drugs or having drug paraphernalia at licensee prior to the incident on September 1, 2023. Time period for correction: Seven (7) days	01690		

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01760	Continued From page 15	01760		
01760 SS=G	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 transcribe a physician's order for staff to administer naloxone (medication used for overdose) for one of one resident (R2) reviewed. R2 overdosed on street drugs and required hospitalization. R2 returned to licensee with a physician's order for Naloxone and the licensee failed to transcribe the order four approxmiately four months. 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).	01760		

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01760	Continued From page 16 The findings include: R2's diagnoses included schizophrenia. R2's service plan dated December 23, 2023, included services for medication administration. Facility incident report dated September 1, 2023, at 4:10 p.m., indicated unlicensed personnel (ULP)-B found R2 on the bed alongside R1 who was unconscious. R2 left the room, then "passed out" in the living room. The incident report indicated R2 appeared to have overdosed, so 911 responders took him to the hospital. R2's nurses reassessment dated September 1, 2023, no time, indicated R2 returned to the facility from the hospital after he overdosed. The nurse received a phone call from facility staff because they suspected R2 of using drugs. The nurse told facility staff to call emergency services (911). The assessment indicated R2 was alert and taken to the hospital. The assessment indicated on September 4, 2023, nursing left a voicemail to psychology for R2 to have a follow up appointment due to a drug overdose. The assessment indicated staff would continue to observe and report any issues. The bottom of the form indicated communication and coordination of care included staff meeting, psychiatry appointment, care team meeting to address concerns, and "also Narcan." The signature on the form was illegible. R2's physician order dated September 1, 2023, indicated the licensee should administer naloxone (Narcan) 4 milligrams (mg) /0.1 milliliter (ml) nasal spray. Licensee should administer the medication, as needed, to reverse the effects of opioid drugs (street drugs).	01760		

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01760	Continued From page 17 R2's medication administration record (MAR) dated September 1, 2023, through September 30, 2023, lacked naloxone (Narcan) medication. R2's subsequent MARs for October 2023, November 2023, and December 2023, listed Narcan, but was not available to document until start date of December 29, 2023, for administration. The medication was greyed out on the printed MARs until December 29, 2023. R2's medication list dated April 10, 2024, indicated licensee obtained an order for naloxone HCL (Narcan). The start date for the medication was December 29, 2023. On April 24, 2024, at 1:22 p.m., registered nurse (RN)-C said she was unsure why the medication was "grey" on the MAR's. RN-C said it was because the medication was not scheduled and only listed as needed (PRN). RN-C acknowledged other PRN medications listed on the MAR were not "grey". RN-C acknowledged the start date for naloxone (Narcan) was December 29, 2023, and said she did not put the order into the computer until they received it from the physician. RN-C said she would double check to see if naloxone started prior to December 29, 2023. On April 30, 2024, at 2:58 P.M., RN-C said she did not know why the naloxone order was not listed as a medication on R2's September MAR. RN-C said she assessed R2 after the hospital staff and provided naloxone training to staff members the following day. RN-C said she did not know why the start date for naloxone was dated December 29, 2023, because the order was received September 1, 2023. RN-C said R2 did not have any further incident reports since September 1, 2023 to December 31, 2023.	01760		

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01760	Continued From page 18 The licensee was non-compliant with documenting incident occurrences in the residents' record. See tag 730. Licensee's policy titled, Medication Administration, date May 29, 2020, indicated the licensed nurse would assess medications and assure all medications were current and ordered by the prescriber. Time period for correction: Seven (7) days	01760		