Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL380872722M
Compliance #: HL380872174C

Date Concluded: October 14, 2024

Name, Address, and County of Licensee Investigated:
Golden Bright Homes
2842 Raleigh Avenue
St. Louis Park MN, 55416
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Kris Detsch, RN
Special Investigator

Finding: Substantiated, facility and individual responsibility

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

Initial Investigation Allegation(s):
The facility neglected the resident when they failed to provide supervision and health care. As a result, the resident became suicidal and attempted to harm himself.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility and alleged perpetrator (AP) were responsible for the maltreatment. The resident had a history of self-harm. Although the resident was not physically injured and returned to the facility, the facility and AP failed to ensure specific measures were in place to minimize his risk of self-harm prior to the incident occurring and afterwards. The facility failed to receive physician orders upon the resident's admission and the resident's antipsychotic medication (Seroquel) on the medication administration record (MAR) did not match the clinic records of his prescribed medications. After the resident's hospitalization, the AP failed to ensure the resident's medical records contained accurate, transcribed inaccurate medication orders, including dosage

changes of the resident's psychotropic medications and double dosing his insulin with duplicate orders without a physician's order or consultation.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement and case workers. The investigation included review of the resident records, hospital records, law enforcement records, facility incident reports, personnel files, and related facility policy and procedures. Also, the investigator toured the facility and observed the resident's room and medications.

The resident resided in an assisted living facility. The resident's diagnoses included type two diabetes, depression, schizophrenia, and substance abuse disorder. The resident's service plan included assistance with medication management. The resident's nursing assessment indicated he was alert and orientated, but anxious and depressed. He required assistance with grooming and hygiene, but was independent with daily cares.

The facility failed to maintain records of the physician orders for the resident. The facility's medication list for the resident upon admission, when compared the resident's prescription list obtained by the investigator from the resident's clinic from the last office visit with the resident's psychiatrist and primary care provider, indicated the resident's initial medication list accurate with the resident's non-psychotropic medications, including insulin orders with sliding scale and some of the resident's psychotropic medications were accurate. The medication list failed to include the psychiatrist medication changes including a dose increase of Seroquel from 50 milligrams (mg) to 100 mg, the facility still maintained 50 mg; scheduling gabapentin (prescribed for anxiety) three times daily, where as the facility had listed gabapentin as needed three times daily; a new order from the visit for hydroxyzine (prescribed for anxiety) as needed three times daily; and the facility did not have listed an existing order for Naltrexone (anti-substance abuse medication) 50 mg as previously prescribed by the psychiatrist.

The resident's psychiatry records indicated the court system placed him on a mental health commitment with Jarvis (court order obtained to ensure compliance with medication management, including psychotropic medications).

The resident's medical record contained an individualized abuse prevention plan (IAPP) the facility completed upon his admission. The IAPP indicated the resident engaged in self-injurious behaviors and used substances. The IAPP failed to identify which substances the resident used, or his response to them and what specific self-injurious behaviors he exhibited. The IAPP lacked person centered individualized interventions to minimize his of risk of self-injury. The IAPP failed to identify the resident had a Jarvis.

The resident's medical record contained a care plan the facility completed upon his admission. The care plan contained actions the facility staff member would provide based on the resident's needs. The care plan indicated staff would give him "as needed" (PRN) medications, provide

one to one (1:1) staff interaction and re-direction to ensure his safety. The care plan failed to identify the resident engaged in self-injurious behaviors or used substances. The care plan failed to identify specific interventions for medication management to comply with the Jarvis, or the duration and frequency of when staff should provide 1:1 monitoring.

Several months after the resident's admission, the resident's progress notes indicated he told facility staff he felt suicidal and wanted medical assistance. Law enforcement arrived and took the resident to the hospital, where he remained there until the afternoon, then he returned to the facility.

Law enforcement records indicated the resident said he attempted to end his life the night prior to this incident by wrapping a towel around his neck. Law enforcement observed a towel hanging from the resident's closet door. The resident told law enforcement he was hitting himself with a closed fist in his own chest to cause himself injury. The resident told law enforcement he wanted to go to the hospital that night when he attempted to harm himself with the towel, however staff denied his request. The resident told law enforcement he borrowed a phone to call them for this incident.

Hospital records indicated the resident required psychotropic medications while in the hospital. The records indicated the resident said the facility would not allow him to use the phone and he felt suicidal "all the time". The records indicated the resident had a history of suicide ideation with a history of many suicide attempts and history of accidental drug overdose. The records indicated the resident reported his last drug use was methamphetamines a week prior and crack two weeks prior. The records indicated the hospital called the facility, but there was no response from the staff.

During an interview, a manger said the resident took his medications, then used marijuana, and said he was going to kill himself. The manager said the resident called emergency services (911). The manager said the resident made prior statements regarding self-harm, but these were only verbal statements and nothing physical happened. The manager said during these times the staff members sat with him, checked his blood sugar, and talked with him.

The AP completed a nursing assessment upon the resident's return to the facility from the hospital. The assessment indicated the resident reported feeling suicidal and unsafe, but the hospital evaluated him and returned him to the facility. The assessment indicated the facility would continue to provide support to management of his symptoms due to his mental health diagnoses. The nursing assessment indicated the AP made no changes to the resident's plan of care. The nursing assessment lacked specific actions to monitor the resident's safety upon his return after he reported feeling suicidal.

The resident's hospital discharge record, obtained by the facility and in the resident's record, indicated there were no medication changes. The discharge record included a list of the resident's medications to "ask your doctor about," but the medications listed differed from the

facility's initial medication list and medication administration record (MAR) prior to the hospitalization.

The resident's facility MAR listed the medications the facility gave him. There were multiple discrepancies and transcription errors, made by the AP, on the MAR following the hospitalization. Some of the medications transcribed in error included medications listed on the hospital discharge record. The facility MAR had two orders for fast-acting insulin, the same drug however one was transcribed with the drug generic name and the other transcribed with the drug trade name. The AP transcribed each with different dosage orders and instructions not prescribed by the resident's physician. The MAR lacked the sliding scale (insulin amount based on blood sugar levels) orders that ranged from 0 units to 5 units, with a maximum total administration of 60 units per day, and instead transcribed to administer 6 additional units with each insulin administration. The MAR failed to include the insulin order required after a snack. Due to the duplicate insulin transcription, the resident received an additional 8 units of fast-acting insulin three times a day. Facility staff signed administration of each order for insulin. Additionally, the AP transcribed the long-acting insulin to be 7 units higher than the prescribed amount. The MAR failed to include blood sugar checks four times per day as ordered. The AP also transcribed an additional administration of the resident's antipsychotic medication, Zyprexa to administer an additional 5 mg per day. The resident's previous medication transcription errors of Seroquel, gabapentin and hydroxyzine persisted.

The resident's clinic record indicated a note from endocrinology that the resident's type two diabetes (insulin resistance) was treated like type one diabetes (failure to produce insulin) due to chronically low insulin (blood sugar) levels.

The resident's record indicated the resident returned to the hospital seven days later. There was conflicting information within the facility's documentation regarding this incident, however the resident again expressed suicidal ideation, went to the hospital, and returned to the facility.

The AP documented on the two incident reports of each suicidal ideation occurrence she assessed the resident upon his return to the facility and his mood was "good" and the second occurrence he "felt better." The AP failed to update the resident's IAPP and failed to implement any new safety monitoring or interventions after the resident's second suicidal ideation and hospital visit.

The resident's clinic records indicated the resident had renewed yearly prescriptions approximately five months later. The facility's medical record failed to include the renewed prescription orders. The resident's MAR indicated the same transcription errors made by the AP with the resident's insulin continued. Additionally, the AP transcribed the resident's blood pressure medications with inaccurate dose administrations.

During an interview, the AP stated she started employment with the facility the month prior to the resident's hospitalizations. The AP said she met with the resident when he returned to the

facility after each incident. The AP said the hospital made no changes to his medications and she did not notice the medication discrepancies between the hospital medication list and the facility medications. (This included insulin and psychotropic medication). The AP said she did not contact the resident's physician or psychiatrist regarding his medications or updating them with the resident's suicidal ideations after these incidents occurred. The AP said she made no changes to the resident's care plan or service plan after these incidences. The AP said the resident was competent in directing his own cares and able to tell staff what he needed to keep himself safe.

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.

Mitigating Factors considered, Minnesota Statutes, section 626.557, Subd. 9c(f):

(1) The facility and AP did not follow an erroneous order, direction or care plan with awareness and failure to take action.

The facility and AP directed an erroneous order, direction, or care plan.

(2) The facility was not in compliance with regulatory standards.

The facility provided proper training and/or supervision of staff.

The facility provided adequate staffing levels.

(3) The AP failed to follow professional standards and/or exercise professional judgement.

The facility and AP failed to act in good faith interest of the vulnerable adult.

The maltreatment was not a sudden or foreseen event.

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: No. Declined formal interview.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
No action taken.

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
St Louis Park City Attorney
St Louis Park Police Department
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
	38087	A. BUILDING: _____ B. WING _____	C 09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN BRIGHT HOMES LLC	2842 RALEIGH AVENUE SAINT LOUIS PARK, MN 55416

(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: HL380872174C/HL380872722M HL380877842C/HL380875581M On September 12, 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 was one resident receiving services under the provider's Assisted Living license. The following correction orders are issued for HL380872174C/HL380872722M and HL380877842C/HL380875581M, tag identification 630, 690, 1290, 2360. The following correction orders are issued for HL380872174C/HL380872722M, tag identification 1760, 1820.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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0 630	Continued From page 1	0 630		
0 630 SS=I	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the individualized abuse prevention plans (IAPP) accurately reflected the resident's vulnerabilities, and failed to implement person centered, individualized interventions to minimize the risk of abuse/harm for two of two residents (R1, R2) with records reviewed. This deficient practice had the potential to cause serious injury. R1 had suicidal ideation and the licensee failed to implement measure to reduce his risk of self-harm. R2 used street drugs, and which escalated her violent behavior including assault and property destruction and required law enforcement intervention. Additionally, R2's record lacked evidence the licensee implemented safety measures to protect R1 from R2. This deficient practice had the potential to affect all residents, staff and visitors. 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,	0 630		

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0 630	Continued From page 2 or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1's diagnoses included type one diabetes, depression, substance abuse disorder, anxiety, and schizophrenia. R1's service plan dated August 2, 2023, indicated he required home health aide services twenty-four hours each day. R1's care plan dated August 2, 2023, indicated he required assistance with medication and behavior management. The care plan indicated staff were to redirect R1 for safety and provide "as needed" (PRN) medication and emotional health support by one to one (1:1) interaction, however the care plan failed to identify what behaviors required intervention. The care plan failed to identify the duration, frequency of 1:1 interaction. R1's individual abuse prevention plan (IAPP) dated August 2, 2023, indicated he was not at risk for physical or emotional abuse. The IAPP indicated the licensee would empower R1 to assert their rights and boundaries and to report any instances of physical abuse. The IAPP also indicated R1 was at risk for self-abuse due to substance use and self-injurious behavior. The assessment lacked further identification of which substances R1 used, or his response to them. The IAPP indicated staff would encourage and promote healthy coping mechanisms and stress management, but lacked identification of what those mechanisms were. The IAPP indicated	0 630		

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0 630	Continued From page 3 staff would offer a variety of activities that promote health and well-being as alternatives to substance use, but the IAPP failed to identify what those activities were. R1's psychiatry visit record dated October 10, 2023, indicated R1 had multiple psychiatric hospitalizations, but no suicide attempts or self-injurious. The visit record indicated R1 had a history of substance abuse including alcohol, cannabis, and cocaine. The physician assessed his suicide risk to be minimal, but indicated R1 had a history of suicidal ideation during periods of active substance use and psychiatric decompensation. The visit record indicated R1 was on a mental health commitment with Jarvis through February 23, 2024. The psychiatry visit note indicated licensed assisted living director (LALD)-A was present at the visit. The licensee failed to update R1's IAPP or care plan to include identified commitment and Jarvis, suicidal ideation with individualized interventions and substance abuse identification, symptoms and individualized interventions to prevent occurrences of use. R1's physician record dated October 11, 2023, indicated R1 went to the clinic with a staff member from the licensee, and they requested a medication list review form to be filled out. The record indicated R1 wanted to find a primary physician and became angry during the visit and left. R1's progress notes dated March 9, 2024, indicated R1 said he was feeling unwell and suicidal. R1 wanted to visit his psychiatrist in the hospital. Law enforcement took R1 to the hospital, and he returned to the licensee that	0 630		

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0 630	Continued From page 4 afternoon. Law enforcement records dated March 9, 2024, indicated whey they arrived, they observed R1's bedroom in disarray, and R1 told them he was having suicidal thoughts and attempted to kill himself the prior night by wrapping his bath towel around his neck. Law enforcement observed a towel hanging from his closet door. R1 told law enforcement he was hitting himself with a closed fist in his own chest in an attempt to cause injury to himself. R1's nursing assessment dated March 9, 2024, indicated R1 returned from the hospital. R1 reported feeling suicidal and unsafe, but the hospital evaluated him and returned him to the licensee. The assessment indicated the licensee made no changes to his plan of care, but would continue to ensure his safety. R1's record lacked an updated IAPP to identify R1's suicidal ideation with individualized interventions. R1's progress notes dated March 16, 2024, indicated R1 said he was feeling depressed and wanted to see a psychiatrist. R1 called emergency services (911) and went to the hospital, and returned the same day. R1's incident report dated March 16, 2024, indicated R1 was feeling suicidal. The report indicated when R1 returned from the hospital, he felt better and was in a good mood. R1's nursing assessment dated March 16, 2024, indicated R1 reported feeling unwell and anxious. R1 received an as needed "PRN" medication, but he was adamant about going to the hospital to	0 630		

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0 630	Continued From page 5 see a psychiatrist. R1 returned the same day. The assessment indicated the licensee made no changes to his plan of care. The assessment failed to identify R1 had suicidal ideation. R1's medical record lacked an updated IAPP to identify R1 had suicidal ideation and what specific interventions or actions/directions for staff to monitor or ensure his safety. R2 R2's diagnoses included bipolar disorder, hypothyroidism, and asthma. R2's service plan dated February 7, 2024, indicated she required home health aide services twenty-four hours each day. R2's care plan dated February 14, 2024, indicated she required assistance with dressing, grooming, and meals. R2's care plan lacked identification of what behaviors R2 exhibited, but indicated she required redirection, and for staff to "calm her" (with no other description of methods to calm), and play cards with her. The care plan failed to identify R2 was on court commitment and required to take medication, and follow up with psychiatry. R2's IAPP dated February 7, 2024, indicated R2 was not at risk for physical abuse. The IAPP indicated R2 could "stand up" for herself. The IAPP indicated the licensee was unaware of R2 being physically aggressive toward others. The IAPP indicated R2 engaged in self-injurious behaviors but failed to identify what those behaviors were. The IAPP indicated the licensee would encourage R2 to abstain from taking drugs by diverting her and occupying her with distractive activities. The IAPP failed to identify R2 was on court commitment and required to take	0 630		

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0 630	Continued From page 6 medication, and follow up with psychiatry. R2's nursing assessment dated May 20, 2024, indicated there were no changes to R2's mental/emotional health. The nursing assessment indicated there were no changes to R2's plan of care. The licensee provided 19 incident reports between June 3, 2024, through August 18, 2024. The reports indicated law enforcement responded seven times during this period. The incident reports indicated R2 had multiple incidents of aggression. A few egregious incident reports included: -Incident report dated July 23, 2024, indicated R2 was agitated, grabbed a "sharp item", and threatened to stab staff. The incident report indicated law enforcement arrived because they received a noise complaint regarding R2 being outside. Law enforcement calmed R2. -Incident report dated August 6, 2024, indicated R2 returned to the licensee, began to bang on the house doors and threatened to kill staff with a gun. -Incident report dated August 11, 2024, indicated R2 threatened to kill staff with a gun. The incident report indicated staff calmed R2. Law enforcement records dated June 2, 2024, through August 27, 2024, indicated law enforcement went to the licensee 51 times. Of the 51 response calls, law enforcement went to the licensee 23 times in August, 2024, sometimes multiple times in one day. These incidences were in regard to R2's behavior.	0 630		

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0 630	Continued From page 7 The licensee failed to updated R2's IAPP with R2's violent behaviors and threats to harm others with individualized interventions to reduce the potential for R2 to hurt herself or others. The licensee failed to update R1's IAPP with risk to be harmed by R2 during her violent behaviors with individualized interventions to keep him safe. On September 13, 2024, at 3:14 p.m., LALD-A said R2 was homeless prior to admission, and was compliant with the house rules when she arrived, however her behavior escalated a few months after. R2 used substances like marijuana and methamphetamines. During these times her behavior included taking off her clothes, running around, yelling at neighbors, and attacking staff verbally and physically. LALD-A said R2 verbally harassed R1. R2 damaged property. R2 told R1 and facility staff she would kill them, and they feared for their safety, so law enforcement took R2 to the hospital on August 18, 2024. LALD-A said the licensee will not accept R2 back as a resident. LALD-A said the direction for staff members to on how to manage R2's behavior included being patient and calm, and to call law enforcement when her behavior became physical. On September 19, 2024, at 11:34 a.m., case worker (CW)-C said R2 was on a court ordered commitment because of mental illness. R2 was previously hospitalized in November 2023, then discharged to an intensive residential treatment service (IRTS) facility, but she assaulted her peers, so they discharged her. She was homeless until she admitted into the licensee's facility. CW-C said R2 found placement to the licensee by herself. CW-C said R2 moved into the licensee before the county completed a MN Choice assessment (this is an assessment	0 630		

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0 630	Continued From page 8 completed to receive funding). CW-C said she did not have any communication with the licensee regarding R2's care, services, or medications. CW-C said law enforcement informed her of R2's multiple interactions with them. This resulted in R2 re-entering the hospital and court system. On September 24, 2024, at 10:08 a.m., registered nurse (RN)-B said R1 made no attempts to harm himself. R1 went to the hospital on March 9, 2024, and she assessed him upon his return to the licensee the same day. She did not make changes to his care plan. RN-B said she did not contact his physician, or psychiatrist after this hospital visit. RN-B said she assessed R1 on March 16, 2024, after he returned from another hospital stay for suicidal ideation. RN-B said she made no changes to R1's care plan and had no communication with R1's physician. RN-B said the direction given to staff how to provide care included ensuring he was safe, monitor him, and allow him to verbalize his thoughts. RN-B said staff also offered PRN medications. RN-B said after these suicidal ideations and hospital stays, she did not changed his care plan or services. RN-B said R1 was able to communicate to staff and advocate for himself. RN-B said R1 has PRN medications if he has anxious thoughts, and he knows his anxiety. R1 was competent in directing his own care. On September 25, 2024, at 9:02 a.m., social worker (SW)-D said she worked with R2 for many years. SW-D said she worked with R2 while she lived at the licensee. R2 had significant mental illness which included hallucinations and delusions. R2 used substances including methamphetamine, and told SW-D she used this drug while she lived at the licensee.	0 630		

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0 630	Continued From page 9 On September 16, 2024, at 4:41 p.m., the surveyor requested the licensee's IAPP policy. No policy was provided. The licensee's policy titled, Comprehensive Nursing Assessment, dated August 1, 2021, indicated the registered nurse would complete a comprehensive assessment for all residents to determine the services required and would develop an individualized care plan for staff to implement. The assessment would address the resident's physical, mental, and cognitive needs. The assessment would include a vulnerability assessment. Time period for correction: Seven (7) days.	0 630		
0 690 SS=F	144G.43 Subdivision 1 Resident record (a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure entries in resident progress notes were authenticated with the name and title of the person making the entry for two of two residents (R1, R2) 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, but was not likely to cause serious injury, impairment, or death), and	0 690		

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0 690	Continued From page 10 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 type one diabetes, depression, substance abuse disorder, anxiety, and schizophrenia. R1's service plan dated August 2, 2023, indicated he required home health aide services twenty-four hours each day. R2's diagnoses included bipolar disorder, hypothyroidism, and asthma. R2's service plan dated February 7, 2024, indicated she required home health aide services twenty-four hours each day. On September 12, 2024, at 10:28 a.m., the surveyor requested documentation for R1 and R2 and provided licensed assisted living director (LALD)-A a paper list with the date range for the documents. The list included R1 and R2's progress notes. On September 16, 2024, at 10:36 a.m., LALD-A sent the surveyor R1 and R2's progress notes. The licensee's progress notes for R1 and R2 contained a date on top of the note. The notes lacked a time when it was written, and a signature (electronic or handwritten) of the person competing the note. Each progress note included an accout of the entire day. On September 24, 2024, at 2:09 p.m. registered nurse (RN)-B said each staff member tells the other staff member what happened at the end of their shift, so they write it down. When asked which staff member writes the note, RN-B said	0 690		

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0 690	Continued From page 11 who ever is working. RN-B said it was not only one staff member documenting but acknowledged the paragraph for the progress note included information from all shifts. RN-B acknowledged the progress notes should contain signatures of the person completing the documentation. Time period for correction: Fourteen (14) Days	0 690		
01290 SS=F	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 and interview, the licensee allowed unlicensed personnel (ULP) direct resident contact, access to resident health information and property without a cleared background study for one of one employee (ULP-E) with records reviewed. This affected all residents.	01290		

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01290	Continued From page 12 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). The findings include: On September 12, 2024, at 8:28 a.m., the surveyor entered the licensee. ULP-E greeted the surveyor and said he was the staff member working for the morning. ULP-E said there was one resident residing at the licensee currently (R1) who was sleeping. ULP-E told the surveyor about the care and services provided to R1. ULP-E called licensed assisted living director (LALD)-A and informed her of the surveyor's arrival. ULP-E called registered nurse (RN)-B. ULP-E unlocked the medication closet and removed medications for the surveyor. ULP-E showed the surveyor the medicaion administration records (MARs) for R1. ULP-E toured the facility with the surveyor and opened resident rooms. ULP-E said room "B" was empty because the resident discharged approximately one month prior. On September 12, 2024, at 9:00 a.m., LALD-A arrived and the surveyor informed her about the investigation process. The surveyor asked LALD-A if employee files were on site. LALD-A said employee files were kept on site and there would be no difficulty providing employee files for the surveyor to review. The surveyor requested ULP-E's employee file. On September 12, 2024, at 11:53 a.m., LALD-A	01290		

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01290	Continued From page 13 brought the surveyor her own employee file, not ULP-E's employee file. The surveyor asked about ULP-E's file and LALD-A said ULP-E was only filling in. No employee file provided. The surveyor observed ULP-E left the facility. On September 16, 2024, at 4:41 p.m., the surveyor sent LALD-A an email and requested the completed background study for ULP-E. On September 12, 2024, at 2:04 p.m., LALD-A said while the surveyor was at the licensee, another staff member was in the locked office, in the lower area of the building, so ULP-E was not working alone. On September 17, 2024, at 1:49 p.m., LALD-A sent the surveyor an email indicating ULP-E was a caregiver in-training working under the house manager learning how the workplace works, and was still in training. The email indicated ULP-E worked as "IT" and wanted to work as a caregiver, but had not completed his training. The licensee failed to provide a completed clear background study for ULP-E. Time period for correction: Two (2) days	01290		
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	01760		

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01760	Continued From page 14 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 document medication administration accurately and failed to transcribe medication orders/prescriptions accurately, resulting in medication errors for one of two residents (R1) with records reviewed. As a result, R1 required hospitalization because the licensee failed to administer insulin injections. R1 went to the hospital for suicidal ideation and the licensee had several mediation dosing errors with R1's psychiatric 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 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 admitted to the licensee August 2, 2023. R1's diagnoses included diabetes, depression, substance abuse disorder, and schizophrenia. R1's service plan dated August 2, 2023, indicated he required medication management.	01760		

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01760	Continued From page 15 R1's service plan dated August 2, 2023, included a medication management plan. The medication management plan lacked identification of the medications R1 required. R1's medication profile dated September 13, 2023, contained a list of R1's medications written by a registered nurse (RN). The medication list was dated forty two days after R1 admitted into the licensee's facility. On September 12, 2024, the surveyor spoke to licensed assisted living director (LALD)-A and requested R1's physician orders for medications. The surveyor again requested this information via email on September 16, 2024, at 4:41 p.m. On September 17, 2024 at 1:49 p.m., the surveyor received R1's "physician orders." The licensee provided a copy of a document titled, Physician Standing Orders. This document contained as needed, over the counter medication orders for the facility to administer. The document was dated by a physician on October 10, 2023. This was two months after R1 admitted to the licensee. The licensee did not provide R1's individual medications R1 required the licensee to administer. The licensee failed to have signed prescription orders for R1 in his medical record. The surveyor requested clinic records from R1's providers. R1's psychiatry clinic records dated October 10, 2023, indicated R1's visit was to establish psychiatric care. R1 had polysubstance use disorder in early remission and alcohol use disorder. had multiple psychiatric hospitalizations. R1 was on mental incapacitation commitment	01760		

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01760	Continued From page 16 and Jarvis through February 23, 2024. Signed physician orders were not included, however R1 required psychiatric medications and the record indicated R1's current psychiatric medications at the start of the visit included: gabapentin 600 milligrams (mg) three times per day as needed Seroquel (quetiapine) 50 mg (anti-psychotic fro schizophrenia) daily at bedtime (HS) Zyprexa (olanzapine) 20 mg (anti-psychotic fro schizophrenia) daily at bedtime citalopram 20 mg (anti-depressant) daily As a result of the visit, R1's medication changes included increasing Seroquel to 100 mg at bedtime, scheduled gabapentin (used for generalized anxiety disorder) 600 mg three times per day and added Vistaril (hydroxyzine) (used for anxiety) 25-50 mg three times per day as needed. The clinic record also noted for polysubstance use disorder, R1 was on Naltrexone (anti-substance abuse medication) 50 mg. R1's physician visit records dated October 11, 2023, indicated he was at the clinic to establish primary care with a physician. The visit records indicated R1 was at the appointment with a "group home worker" and they requested a medication list review form to be filled out. Signed physician orders were not included, however, the visit note indicated R1's current medications included: citalopram 20 mg daily gabapentin 600 mg three times per day hydroxyzine 25 mg, take 1-2 tablets every 8 hours as needed for anxiety melatonin (sleep aid) 3 mg daily at bedtime Zyprexa (olanzapine) 20 mg daily at bedtime Seroquel (quetiapine) 100 mg daily at bedtime naltrexone 50 mg daily	01760		

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01760	Continued From page 17 pantoprazole 40 mg (for acid reflux) daily Seroquel 50 mg remained on the medication list in error from the change made by psychiatry. ammonium lactate 12% cream, apply to feet twice per day Lantus (long-acting insulin) 100 units/milliliter (mL), inject 18 units daily in the evening lisinopril 40 mg daily for hypertension Novolog (short-acting insulin) 100 units/mL, inject 10 units with each meal, plus sliding scale. Novolog sliding scale indicated blood sugar of 150 and below, no additional insulin, 151-200: 1 extra units, 201-250: 2 extra units, 251-300: 3 extra units, 301-350: 4 extra units, 351 and higher: 5 extra units. In addition, inject 5 units with snacks every one hour as needed, maximum of 60 units per day. lisinopril 40 mg (for high blood pressure) daily rosuvastatin 5 mg (for high cholesterol) daily amlodipine (for high blood pressure) 2.5 mg blood glucose four times per day The licensee's medication profile dated September 13, 2023, matched the medication list from R1's clinic visit notes date October 11, 2023, except for the dose increase of Seroquel from 50 mg to 100 mg and hydroxyzine from 25 mg to 25 mg-50 mg every 8 hours as needed identified by R1's psychiatry visit notes date October 10, 2023. MARCH 2024 TRANSCRIPTION/MEDICATION ERRORS: R1's progress notes dated March 9, 2024, indicated R1 said he was feeling unwell and suicidal. R1 wanted to visit his psychiatrist in the hospital. Law enforcement took R1 to the hospital, and he returned to the licensee that afternoon. R1's incident report dated March 9, 2024,	01760		

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01760	Continued From page 18 indicated R1 was feeling suicidal. R1 requested an ambulance to go to the hospital to see his psychiatrist. After returning to the facility, R1 said he felt better. R1's hospital discharge record dated March 9, 2024, indicated R1 presented to the emergency room with suicidal ideation. R1 reported a suicide gesture of tying something around his neck. R1 discharged back to the licensee. There were no medication changes during the emergency room visit. R1's progress notes included R1's hospital discharged paperwork dated March 9, 2024. There was medications listed to "ask your doctor about," which included the following medication discrepancies: olanzapine 20 mg daily at bedtime, olanzapine 5 mg daily at bedtime, hydroxyzine 25-50 mg scheduled three times daily, Lantus insulin, inject 20 units every evening, and nicotine polacrilex 2 mg gum, 1 (2 mg) gum every hour as needed for nicotine craving. R1's incident report dated March 16, 2024, indicated R1 was feeling suicidal. R1 requested an ambulance to go to the hospital to see his psychiatrist. After returning to the facility, R1 said he felt better and was in a good mood. R1's progress note dated March 16, 2024, indicated staff picked up R1 from the hospital at 9:30 p.m., and returned him to the facility. There was no documentation for the reason of the hospitalization. The staff person documented they talked to R1 about his substance abuse and recommended outside help for his mental health like an "ARMS" program. R1's medication administration record (MAR)	01760		

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01760	Continued From page 19 dated March 1, 2024, through March 31, 2024, included the following medication transcription errors resulting in administration of the wrong dose: -The licensee transcribed Zyprexa (olanzapine) 5 mg daily at bedtime from the discharge paperwork, given in addition to Zyprexa 20 mg that was ordered. R1 received an additional 5 mg of Zyprexa 31 out of 31 days. The licensee failed to do a medication reconciliation upon R1's return to the facility. -Ammonium lactate 12% cream, was transcribed with only one administration per day at 8:00 a.m. The licensee failed to apply ammonium lactate cream a second time each day for 31 out of 31 days. -Lantus (long-acting insulin) 100 units/mL, inject 25 units daily before bed. R1 received 7 additional units of Lantus insulin in error from the 18 units ordered 31 out of 31 days. -Prilosec 20 mg (acid reflux medication) daily was transcribed on the MAR, the wrong medication and not ordered. R1 received in error Prilosec 20 mg 31 out of 31 days. Not transcribed on the MAR was R1's order for pantoprazole 40 mg (for acid reflux) daily. -Hydroxyzine 25-50 mg three times per day as needed for anxiety was not transcribed on the MAR for staff to administer. -Blood glucose four times per day was not transcribed on the MAR to staff to take R1's blood glucose readings. -Novolog (short-acting insulin) 100 units/mL,	01760		

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01760	Continued From page 20 inject 10 units with each meal, plus sliding scale, inject 6 units was transcribed incorrectly from R1's order for Novolog sliding scale which indicated blood sugar of 150 and below, no additional insulin, 151-200: 1 extra units, 201-250: 2 extra units, 251-300: 3 extra units, 301-350: 4 extra units, 351 and higher: 5 extra units. In addition, inject 5 units with snacks every one hour as needed, maximum of 60 units per day. R1 received the wrong dose, a standard 6 units instead of the sliding scale 31 out of 31 days, three times a day. -Insulin aspart (ASP) 100 mg/mL, which is the generic drug for Novolog insulin was a duplicate insulin transcription on the MAR with directions to inject 8 units three times daily before meals. R1 received an additional 8 units 31 out of 31 days, three times a day. -Nicotine polacrilex 2 mg gum, 1 gum (2 mg) every 1 hour as needed while awake for nicotine craving, which was not ordered. The nicotine gum remained a transcription error due to no administrations provided during the month of March 2024. AUGUST 2024 TRANSCRIPTION/MEDICATION ERRORS: The surveyor requested clinic records (not maintained by the licensee) included a note indicating "low insulin output." R1 was prone to ketosis and to manage his Type 2 diabetes as Type 1 per endocrine, dated September 5, 2023. The clinic records also included a list a medication prescriptions, authorized by R1's primary physician. The medication orders, with annual prescription renewal dates included: -Blood glucose testing four times daily, yearly prescription dated August 12, 2023.	01760		

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01760	Continued From page 21 -rosuvastatin 5 mg daily, yearly prescription dated November 24, 2023. -nicotine polacrilex 2 mg gum, 1 gum (2 mg) every 2 hours as needed for nicotine craving up to 6 times per day, yearly prescription dated June 18, 2024. -vitamin D3 1000 unit daily, yearly prescription dated June 18, 2024. -amlodipine 2.5 mg daily, yearly prescription dated August 5, 2024. -melatonin 3 mg daily at bedtime, yearly prescription dated August 15, 2024. -lisinopril 40 mg (for high blood pressure) daily, yearly prescription dated August 15, 2024. -quetiapine 200 mg daily at bedtime, yearly prescription dated August 28, 2024. -olanzapine 15 mg daily at bedtime, yearly prescription dated August 28, 2024. -citalopram 20 mg, take 1.5 tabs (30 mg total) daily, yearly prescription dated August 28, 2024. -hydroxyzine 25 mg take 1-2 tablets three times per day as needed for anxiety, yearly prescription dated August 28, 2024. The following medications included in the clinic records were an incomplete order, but listed as medication orders: -Novolog insulin, no dose and no frequency included, yearly prescription dated December 3, 2023. -Lantus insulin, no dose and no frequency included, yearly prescription dated December 3, 2023. -pantoprazole 40 mg, no frequency, yearly prescription dated November 24, 2023. -ammonium lactate 12% cream, no location of application and frequency, yearly prescription dated November 24, 2023. -gabapentin 600 mg, no instruction on frequency, yearly prescription dated August 28, 2024.	01760		

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01760	Continued From page 22 R1's MAR dated August 1, 2024, through August 31, 2024, included the following medication transcription errors resulting in administration of the wrong dose: -Zyprexa (olanzapine) 20 mg daily at bedtime failed to stop on August 28, 2024, when the prescription order changed decrease the dose to 15 mg daily at bedtime. R1 received the wrong dose 4 out of 31 days. -Seroquel (quetiapine) 100 mg, take 1 and 1/2 tablet (150 mg) daily at bedtime was transcribed in error from R1's medication orders of 100 mg daily. In addition, the licensee failed to transcribe R1's order dated August 28, 2024, increasing Seroquel to 200 mg daily. R1 received 50 mg more than prescribed 27 out 31 days and received 50 mg less than what was prescribed 4 out of 31 days. -Prilosec 20 mg (acid reflux medication) daily was transcribed on the MAR, the wrong medication and not ordered. R1 received in error Prilosec 20 mg 31 out of 31 days. Not transcribed on the MAR was R1's order for pantoprazole 40 mg (for acid reflux) daily. -Amlodipine (Norvasc) 2.5 mg daily was transcribed as "D/C" (discontinued), "new dosage" and transcribed as amlodipine 5 mg daily, although the prescription dated August 5, 2024, indicated the dose had not changed and remained 2.5 mg. R1 received the wrong dose of 5 mg daily 30 out 31 days. R1's MAR lacked documentation of administration on August 31, 2024. -Lisinopril 40 mg daily was stopped and last dose	01760		

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01760	Continued From page 23 provided on August 13, 2024, and transcribed as "D/C," "new dosage." The licensee transcribed Lisinopril 2.5 mg daily, started on August 14, 2024, although the renewed prescription order dated August 15, 2024, indicated to continue 40 mg. R1 received 37.5 mg less than what was prescribed 18 out of 31 days. -Lantus (long-acting insulin) 100 units/mL, inject 25 units daily before bed. R1 received 7 additional units of Lantus insulin in error from the 18 units ordered 31 out of 31 days. -Novolog (short-acting insulin) 100 units/mL, inject 10 units with each meal, plus sliding scale, inject 6 units was transcribed incorrectly from R1's order for Novolog sliding scale which indicated blood sugar of 150 and below, no additional insulin, 151-200: 1 extra units, 201-250: 2 extra units, 251-300: 3 extra units, 301-350: 4 extra units, 351 and higher: 5 extra units. In addition, inject 5 units with snacks every one hour as needed, maximum of 60 units per day. R1 received the wrong dose, a standard 6 units instead of the sliding scale 31 out of 31 days, one time per day. R1's MAR lacked documentation Novolog was administered during the morning and bedtime scheduled administrations 31 out 31 days. -Insulin aspart (ASP) 100 mg/mL, which is the generic drug for Novolog insulin was a duplicate insulin transcription on the MAR with directions to inject 8 units three times daily before meals. R1 received an additional 8 units 31 out of 31 days, one time a day. R1 received the wrong dose of Insulin aspart (Novolog) 31 out of 31 days, twice a day when due staff documented administration for the morning and bedtime scheduled administration.	01760		

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01760	Continued From page 24 -Blood glucose four times per day was not transcribed on the MAR to staff to take R1's blood glucose readings. -The licensee failed to transcribed nicotine polacrilex 2 mg gum, 1 gum (2 mg) every 2 hours as needed for nicotine craving up to 6 times per day from the prescription dated June 18, 2024. Clinic records did not indicate an order to stop naltrexone 50 mg daily, however a renewed prescription order was not included in the medication orders list. The licensee failed to transcribe naltrexone 50 mg daily on R1's August 2024 MAR and failed to conduct a medication reconciliation to determine if naltrexone should be stopped with R1's psychiatrist. SEPTEMBER 2024 TRANSCRIPTION/MEDICATION ERRORS: R1's MAR dated September 1, 2024, through September 30, 2024, included the following medication documentation, transcription and omission errors: -Lisinopril 40 mg daily had the dose crossed off and written "2.5 mg," although the renewed prescription order dated August 15, 2024, indicated to continue 40 mg. R1 received 37.5 mg less than what was prescribed 12 out of 30 days. -Hydroxyzine HCL 25 mg tablet was inaccurately transcribed as scheduled three times a day, in the morning, at noon and at bedtime. The MAR also included transcription of the correct prescription order dated August 28, 2024, indicating hydroxyzine 25 mg take 1-2 tablets three times per day as needed for anxiety. The MAR indicated R1 received the "scheduled" medication	01760		

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01760	Continued From page 25 September 1 through September 7, 2024, three times per day. The MAR lacked identification which dosage (how many tablets) R1 received on the days staff administered it to him. -Prilosec 20 mg (acid reflux medication) daily was transcribed on the MAR, the wrong medication and not ordered. R1 received in error Prilosec 20 mg 6 out of 30 days. Not transcribed on the MAR was R1's order for pantoprazole 40 mg (for acid reflux) daily. -Seroquel (quetiapine) 100 mg, take 1 and 1/2 tablet (150 mg) daily at bedtime was transcribed in error from R1's prescription order dated August 28, 2024, directing to increase Seroquel to 200 mg daily. R1 received 50 mg less than what was prescribed 9 out of 30 days. The MAR did include a transcribed order for Seroquel 200 mg daily at bedtime, however a line was drawn through the days with no administration time included in the transcription. The MAR lacked documentation of Seroquel administration on September 1 and 8, 2024. -Lantus (long-acting insulin) 100 units/mL, inject 25 units daily before bed. R1 received 7 additional units of Lantus insulin in error from the 18 units ordered 9 out of 30 days. The MAR lacked documentation R1 received the medication as prescribed on September 1 and 8, 2024. -Novolog (short-acting insulin) 100 units/mL, inject 10 units with each meal, plus sliding scale, inject 6 units was transcribed incorrectly from R1's order for Novolog sliding scale which indicated blood sugar of 150 and below, no additional insulin, 151-200: 1 extra units, 201-250: 2 extra units, 251-300: 3 extra units, 301-350: 4	01760		

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01760	Continued From page 26 extra units, 351 and higher: 5 extra units. In addition, inject 5 units with snacks every one hour as needed, maximum of 60 units per day. R1 received the wrong dose, a standard 6 units instead of the sliding scale 12 out of 30 days and 9 out of 30 days at bedtime. R1's MAR lacked documentation Novolog was administered during the noon scheduled administration 30 out 30 days. R1's MAR lacked documentation Novolog was administered at bedtime on September 1, 8 and 12, 2024. -Insulin aspart (ASP) 100 mg/mL, which is the generic drug for Novolog insulin was a duplicate insulin transcription on the MAR with directions to inject 8 units three times daily before meals. R1 received the wrong dose of Insulin aspart (Novolog) 8 out of 30 days, once a day at noon. R1 received an additional 8 units 10 out of 30 days, two times a day. The MAR lacked documentation R1 received Novolog or aspart insulin at bedtime on September 8 and 12, 2024. -Ammonium Lactate 12% cream, apply to affected area on feet twice a day. The MAR lacked documentation R1 received the treatment as prescribed on September 1, 8, 9, 10, 11, and 12, 2024. -Gabapentin 600 mg tablet three times daily. The MAR lacked documentation R1 received the medication as prescribed on September 1, 8, 9, 10, and 11, 2024. -Vitamin D3 25 micrograms (mcg) tablet (supplement): Take one tablet (1000 units) by mouth daily. The MAR lacked the scheduled time R1 required this medication. The MAR lacked documentation R1 received this medication September 1 through September 11, 2024.	01760		

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01760	Continued From page 27 -Melatonin 3 mg tablet daily at bedtime. The MAR lacked documentation R1 received the medication on September 1, and 8, 2024. -Olanzapine 15 mg tablet daily at bedtime. The MAR lacked documentation R1 received the medication on September 1, and 8, 2024. -Blood glucose four times per day was not transcribed on the MAR to staff to take R1's blood glucose readings. -Naltrexone 50 mg daily was not transcribed on R1's MAR. On September 16, 2024, at 2:39 p.m., RN-B said she was the only nurse for the facility. RN-B said she reviews the MAR and communicates with the pharmacy and physician to make sure its accurate. RN-B said she goes to the facility a couple of times a week and observes the MAR. RN-B said staff were directed to initial and "circle" medications if a resident refused to take them. On September 23, 2024, at 3:09 p.m., during a follow up interview, RN-B said she reiterated to staff members they need to document accurately on the MAR and the facility was transitioning to an electronic medication system to minimize medication documentation errors. On September 24, 2024, at 10:08 a.m., RN-B said the written orders on the MAR are generated by the pharmacy. The pharmacy places the orders on the MAR and sends the MAR's to the licensee. RN-B said the licensee did not notice the medication discrepancy and the pharmacy only supply insulin from the sliding scale and R1 was not receiving the sliding scale. The order the	01760		

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01760	Continued From page 28 hospital had was from a prior hospital stay and that is how the order ended up on the MAR. RN-B said she did not contact R1's physician after his hospital stay on March 9, 2024, or subsequent hospital stay on March 16, 2024. RN-B said R1's insulin orders were corrected after the surveyor questioned the orders. On September 24, 2024, at 1:41 p.m., during a follow up interview, LALD-A said the licensee admitted R1 but did not administer medications because they did not have orders to do so. LALD-A said R1 had his own medications from a prior hospital stay and the licensee could not do anything without him having a physician, so they could not administer medications. LALD-A said R1 only stayed at the licensee for a couple of days, then returned to the hospital because he did not have insulin. LALD-A said he almost passed out. LALD-A said R1 admitted to the licensee without physician orders because he was homeless and needed help. LALD-A was unclear about the dates R1 was hospitalized, but the dates occurred from August 2, 2023, through October 2023. LALD-A said she would clarify those dates and provide the surveyor documentation. On September 23, 2024, at 2:42 p.m. the surveyor requested the licensee's policy regarding documentation of medications. No policy was provided The licensee's policy titled, Medication Administration, dated August 1, 2024, indicated the licensee would provide safe administration of medications by qualified personnel according to a written medication management plan. Time period for correction: Seven (7) days.	01760		

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01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to obtain valid prescription orders for medicaion management and maintained prescription orders in the resident licensee medical record for one of two residents (R1) 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, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's admitted to the licensee August 2, 2023. R1's diagnoses included diabetes, depression, substance abuse disorder, and schizophrenia. R1's service plan dated August 2, 2023, indicated he required medication management. R1's service plan dated August 2, 2023, included a medication management plan. The medication management plan lacked identification of the medications R1 required.	01820		

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01820	Continued From page 30 R1's medication profile dated September 13, 2023, contained a list of R1's medications written by registered nurse (RN)-B. The list included the name of the pharmacy but failed to identify the prescribing physician and contact information. The medication list was dated forty two days after R1 admitted into the licensee's facility. The list of medications included: amlodipine 2.5 milligrams (mg) for high blood pressure daily ammonium lactate 12% cream, apply twice a day to feet for dry skin citalopram (antidepressant) 20 mg daily gabapentin 600 mg three times daily, documented purpose for alcohol abuse hydroxyzine 25 mg three times per day as needed for anxiety Lantus (long-acting insulin) 100 units/milliliter (mL), inject 18 units daily in the evening lisinopril 40 mg daily for hypertension Novolog (short-acting insulin) 100 units/mL, inject 10 units with each meal, plus sliding scale. Novolog sliding scale indicated blood sugar of 150 and below, no additional insulin, 151-200: 1 "extra", 201-250: 2 "extra", 251-300: 3 "extra", 301-350: 4 "extra", 351 and higher: 5 "extra". In addition, inject 5 units with snacks every one hour as needed, maximum of 60 units per day. melatonin (sleep-aid) 3 mg daily at bedtime naltrexone 50 mg daily for alcohol abuse olanzapine (anti-psychotic) 20 mg daily at bedtime pantoprazole 40 mg daily for acid reflux quetiapine (anti-psychotic) 50 mg daily at bedtime rosuvastatin 5 mg daily for high cholesterol blood glucose four times per day On September 12, 2024, the surveyor spoke to licensed assisted living director (LALD)-A and requested R1's physician orders for medications.	01820		

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01820	Continued From page 31 The surveyor again requested this information via email on September 16, 2024, at 4:41 p.m. On September 17, 2024 at 1:49 p.m., the surveyor received R1's "physician orders." The licensee provided a copy of a document titled, Physician Standing Orders. This document contained as needed, over the counter medication orders for the facility to administer. The document was dated by a physician on October 10, 2023. This was two months after R1 admitted to the licensee. The licensee did not provide R1's individual medication orders. The licensee failed to have valid, signed prescription orders for R1 in his medical record. The surveyor requested clinic records from R1's providers. R1's psychiatry clinic records dated October 10, 2023, indicated R1's visit was to establish psychiatric care. R1 had polysubstance use disorder in early remission and alcohol use disorder. had multiple psychiatric hospitalizations. R1 was on mental incapacitation commitment and Jarvis through February 23, 2024. Signed physician orders were not included, however R1 required psychiatric medications and the record indicated R1's current psychiatric medications at the start of the visit included: gabapentin 600 mg three times per day as needed Seroquel (quetiapine) 50 mg daily at bedtime (HS) Zyprexa (olanzapine) 20 mg daily at bedtime citalopram 20 mg daily As a result of the visit, R1's medication changes included increasing Seroquel to 100 mg at bedtime, scheduled gabapentin (used for	01820		

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01820	Continued From page 32 generalized anxiety disorder) 600 mg three times per day and added Vistaril (hydroxyzine) (used for anxiety) 25-50 mg three times per day as needed. The clinic record also noted for polysubstance use disorder, R1 was on Naltrexone (anti-substance abuse medication) 50 mg. R1's physician visit records dated October 11, 2023, indicated he was at the clinic to establish primary care with a physician. The visit records indicated R1 was at the appointment with a "group home worker" and they requested a medication list review form to be filled out. Signed physician orders were not included, however, the visit note indicated R1's current medications included: citalopram 20 mg daily gabapentin 600 mg three times per day hydroxyzine 25 mg, take 1-2 tablets every 8 hours as needed for anxiety melatonin (sleep aid) 3 mg daily at bedtime Zyprexa (olanzapine) 20 mg daily at bedtime Seroquel (quetiapine) 100 mg daily at bedtime naltrexone 50 mg daily pantoprazole 40 mg daily Seroquel 50 mg remained on the medication list in error from the change made by psychiatry. ammonium lactate 12% cream, apply to feet twice per day Lantus (long-acting insulin) 100 units/milliliter (mL), inject 18 units daily in the evening lisinopril 40 mg daily for hypertension Novolog (short-acting insulin) 100 units/mL, inject 10 units with each meal, plus sliding scale. Novolog sliding scale indicated blood sugar of 150 and below, no additional insulin, 151-200: 1 extra units, 201-250: 2 extra units, 251-300: 3 extra units, 301-350: 4 extra units, 351 and higher: 5 extra units. In addition, inject 5 units with snacks every one hour as needed, maximum of	01820		

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01820	Continued From page 33 60 units per day. lisinopril 40 mg daily rosuvastatin 5 mg daily for high cholesterol amlodipine 2.5 mg blood glucose four times per day The licensee's medication profile dated September 13, 2023, matched the medication list from R1's clinic visit notes date October 11, 2023, except for the dose increase of Seroquel from 50 mg to 100 mg and hydroxyzine from 25 mg to 25 mg-50 mg every 8 hours as needed identified by R1's psychiatry visit notes date October 10, 2023. The requested clinic records (not maintained by the licensee) also included a list a medication prescriptions, however, the record indicated the report is for documentation purposes only, for accurate instructions regarding medications, the patient should contact their physician. The medication prescriptions, authorized by R1's primary physician, with annual prescription renewal dates included: Blood glucose testing four times daily, yearly prescription dated August 12, 2023. rosuvastatin 5 mg daily, yearly prescription dated November 24, 2023. nicotine polacrilex 2 mg gum, 1 gum (2 mg) every 2 hours as needed for nicotine craving up to 6 times per day, yearly prescription dated June 18, 2024. vitamin D3 1000 unit daily, yearly prescription dated June 18, 2024. amlodipine 2.5 mg daily, yearly prescription dated August 5, 2024. melatonin 3 mg daily at bedtime, yearly prescription dated August 15, 2024. quetiapine 200 mg daily at bedtime, yearly prescription dated August 28, 2024. olanzapine 15 mg daily at bedtime, yearly	01820		

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(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
01820	Continued From page 34 prescription dated August 28, 2024. citalopram 20 mg, take 1.5 tabs (30 mg total) daily, yearly prescription dated August 28, 2024. hydroxyzine 25 mg take 1-2 tablets three times per day as needed for anxiety, yearly prescription dated August 28, 2024. The following medications included in the clinic records were an incomplete prescription order: Novolog insulin, no dose and no frequency included, yearly prescription dated December 3, 2023. Lantus insulin, no dose and no frequency included, yearly prescription dated December 3, 2023. Protonix 40 mg, no frequency, yearly prescription dated November 24, 2023. ammonium lactate 12% cream, no location of application and frequency, yearly prescription dated November 24, 2023. gabapentin 600 mg, no instruction on frequency, yearly prescription dated August 28, 2024. R1's record lacked authenticated prescription orders. On September 16, 2024, at 2:39 p.m., RN-B said she was the only nurse for the facility. RN-B said she reviews the medication administration record (MAR) and communicates with the pharmacy and physician to make sure its accurate. RN-B said she goes to the facility a couple of times a week and observes the MAR. On September 24, 2024, at 10:08 a.m., RN-B said the written orders on the MAR are generated by the pharmacy. The pharmacy places the orders on the MAR and sends the MAR's to the licensee. RN-B said she did not contact R1's physician after his hospital stay on March 9,	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38087	A. BUILDING: _____ B. WING _____	C 09/12/2024

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01820	Continued From page 35 2024, or subsequent hospital stay on March 16, 2024. On September 24, 2024, at 1:41 p.m., LALD-A said the licensee admitted R1 but did not administer medications because they did not have orders to do so. LALD-A said R1 had his own medications from a prior hospital stay and the licensee could not do anything without him having a physician, so they could not administer medications. LALD-A said R1 admitted to the licensee without physician orders because he was homeless and needed help. TIME PERIOD OF CORRECTION: Seven (7) Days	01820		
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 two of two resident(s) reviewed (R1, R2) were free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No plan of correction is required for this tag.	