Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL20872001M
Compliance #: HL20872002C

Date Concluded: August 15, 2022

Name, Address, and County of Licensee Investigated:
Parmly on the Lake
28210 Old Towne Rd
Chisago City, MN 55013
Chisago County

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

Evaluator's Name:
Jana Wegener, RN, Special Investigator

Finding: Inconclusive

Nature of Visit:
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 administer prescribed medications according to physician orders. The resident had an episode of increased agitation and aggression and was transferred to the emergency department.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. The resident's Haldol medication was prescribed as needed (PRN) for agitation and aggression and was not scheduled at the time of the incident. Although the resident did not receive a dose the PRN Haldol the day of the incident, the resident had multiple other medications prescribed PRN for

behaviors and pain management. The resident did receive PRN Ativan, Depakote, and Morphine the day of the incident. Although, the resident had missed medications for Parkinson's disease, and depression on the day of admission, he did receive those medications as prescribed on the day of the incident. It could not be determined if a dose of PRN Haldol administered on the day of the incident would have stopped and/ or decreased the resident's behaviors and prevented the resident from needing to be transferred to the emergency department.

The investigator conducted interviews with facility staff members, including administrative and unlicensed staff. The investigation included review of the resident's medical record, medication administration records, progress notes, ambulance run report, emergency room record, hospice record, and inpatient geriatric psychiatric hospital records. The investigator also reviewed facility policies and procedures.

The resident was admitted to the facility from an inpatient geriatric psychiatric hospital with diagnoses including altered mental status, cognitive communication deficit, Parkinson's disease, major depressive disorder, and advanced dementia with behavioral disturbances including physical aggression.

The resident's admission service agreement indicated he required medication management services, physical assistance with mobility from two staff with transfers, dressing, bathing, grooming, toileting, and incontinence care. The service agreement indicated the resident required memory care and utilized hospice services for end-of-life care.

The resident's admission progress note indicated the resident was admitted to the facility from an inpatient geriatric psychiatric hospital where he was treated for physical aggression related to dementia. The resident was admitted with hospice services for dementia and Parkinson's syndrome and required medication administration four times daily and received multiple PRN medications for behavior management.

The day after admission a facility progress note indicated the resident was having increased agitation on the evening shift and was noted to be self-transferring, pushing, shoving, and punching at staff. The note indicated PRN Lorazepam (antianxiety) was administered but was not effective. The note indicated the resident had injured a staff member when he grabbed their arm and would not let go. 911 was called, hospice was notified of the incident, and law enforcement responded. The staff were instructed by hospice to give PRN gabapentin a few minutes after the PRN Ativan dose had been administered, and about an hour later PRN Morphine (pain medication) was also given. The progress note indicated interventions were not effective and law enforcement called the ambulance who transferred the resident to the emergency department.

A review of the resident's medication administration record (MAR) indicated the resident had multiple PRN medications prescribed for behavior management. The day the resident was

admitted to the facility he did not receive Carbidopa Levodopa (for Parkinson's syndrome), and Duloxetine (psychotropic for depression). The MAR indicated staff had documented the medication was not available for administration. However, the MAR indicated the resident received the scheduled doses of those medications as prescribed the following day when the incident occurred. In addition, the MAR indicated the resident had received a dose of PRN Haldol the day of admission, and received PRN Ativan, Depakote, and Morphine on the day of the incident.

The progress notes indicated the resident returned to the facility several hours after evaluation at the emergency department and required frequent ongoing medication adjustments by hospice for agitation, behaviors, and pain management until his death at the facility five days after admission.

The resident's record of death indicated the residents cause of death was dementia with Parkinson's disease.

When interviewed a facility staff stated the resident was so aggressive it was not safe to get close to the resident. The evening of the incident, the resident had pinned one staff member against the wall with the Hoyer (a mechanical lift), was banging into doors, hitting windows, aggressively lunging and grabbing at staff, and grabbed and pulled another staff's arm causing injury. Another staff stated because of the resident's behavior they could not protect the resident from harming himself or other residents so 911 was called. The staff stated when law enforcement arrived the resident remained aggressive and unsafe, so the resident was transferred by ambulance to the emergency department.

In conclusion, it was inconclusive whether neglect occurred.

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:
(a) 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.
(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or

maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Vulnerable Adult interviewed: No, resident was deceased
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: N/A

Action taken by facility:
The facility completed a medication reconciliation after the resident returned to the facility and continued to provide ongoing medication adjustments to help manage the resident's symptoms.

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 651-201-4890 to receive a copy via mail or email

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20872	A. BUILDING: _____ B. WING _____	C 07/20/2022

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PARMLY ON THE LAKE	28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013

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0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: HL20872001M/HL20872002C On July 20, 2022, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 48 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for HL20872001M/HL20872002C, tag identification 1760 and 2320.	0 000	Minnesota Department of Health is documenting the State Licensing 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.	
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication	01760		

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01760	Continued From page 1 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 facility failed to ensure accurate medication was administered as prescribed for one of one resident (R1) with records reviewed. R1 had multiple medication documentation errors including transcription, administration, and order implementation. 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 was admitted to the facility on August 27, 2021, from an inpatient geriatric psychiatric hospital with diagnoses including altered mental	01760		

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01760	Continued From page 2 status, cognitive communication deficit, Parkinson's Disease, Major Depressive Disorder, Advanced Dementia with behavioral disturbances, and Lewy Bodies Dementia. R1's face sheet indicated the resident required physical assistance with mobility using an EZ stand mechanical lift and two staff assistance for transfers and a rock n go wheelchair for mobility. R1's admission service agreement signed on August 27, 2021, indicated he required memory care, medication management services and administration, and utilized hospice services. R1's admission progress note dated August 27, 2021, at 3:31 p.m. indicated the resident was admitted to the facility from an inpatient geriatric psychiatric hospital at 11:00 a.m. where he was treated for physical aggression related to dementia. The note indicated R1 was admitted with hospice services for dementia and Parkinson's syndrome. R1 required medication administration four times daily and received multiple PRN (as needed) medications for behavior management. R1's August 2021, Medication Administration Record (MAR) identified multiple errors in order implementation as follows: - Carbidopa - Levodopa 25-100 milligram (mg) tablets with orders to give one tablet three times daily (TID) at 8:00 a.m., 12:00 p.m., and 4:00 p.m. for Parkinson's disease. On the day of admission August 27, 2021, the MAR indicated the resident did not receive the scheduled doses at 12:00 p.m., and 8:00 p.m. due to the medication not being available on admission.	01760		

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01760	Continued From page 3 - Duloxetine HCL 30 mg a psychotropic medication for depression with orders to give one tablet daily at 4:00 p.m. On day of admission August 27, 2021, the MAR indicated the resident did not receive the scheduled dose of medication due to it not being available on admission. - Midodrine HCL 10 mg tabs for orthostatic hypertension with orders to give one tablet BID at 8:00 a.m., and 4:00 p.m. On August 27, 2021, at 4:00 p.m. the MAR indicated R1 did not receive the medication because it was not available on admission. On August 28, 2021, at 10:54 p.m. a progress note indicated the registered nurse (RN) and a hospice RN reviewed R1's medications and identified multiple discrepancies including medication lists that did not match, with different instructions and medication frequency times. However, the MAR indicated R1 continued to have multiple medication errors including transcription, administration, timing, and frequency noted as follows: - Lorazepam 1 mg tabs (solutab) with orders to give TID at 8:00 a.m., 12:00 p.m., and 8:00 p.m. On August 29, 2022, the MAR indicated the resident did not receive the scheduled medication at 12:00 p.m. with no documented reason provided. - Lorazepam 1mg tabs (solutab) at 8:00 a.m. with orders to give one solutab every two hours, the MAR had four scheduled administration times at 4:00 p.m., 6:00 p.m., 8:00 p.m., and 10:00 p.m. The MAR lacked every two-hour scheduling as ordered, and only had four scheduled doses. - Lorazepam 1 mg (solutab) with orders to give	01760		

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01760	Continued From page 4 one solutab every hour as needed (PRN) for anxiety. The MAR indicated the medication was administered on August 31, 2021, at 3:55 p.m., in error within five minutes of the resident's scheduled dose at 4:00 p.m. The resident received other PRN doses the same day at 7:27 p.m., and 9:15 p.m. that were also administered in error less than one hour from the resident's scheduled doses. - Midodrine HCL 10 mg tabs for orthostatic hypertension with orders to give one tablet BID at 8:00 a.m., and 4:00 p.m. On August 31, 2021, at 4:00 p.m. the MAR was blank indicating the resident did not receive the medication as ordered, with no documented reason. - Morphine 5mg (solutab) with orders to take one solutab every two hours for moderate to severe pain and shortness of breath. The MAR lacked every two-hour scheduling as ordered, and only included four scheduled doses. On August 31, 2021, R1 received morphine at the scheduled times at 4:00 p.m., 6:00 p.m., 8:00 p.m., and 10:00 p.m. - Morphine 5mg Solutab with orders to take one solutab under the tongue every hour PRN for pain and shortness of breath. The MAR indicated R1 received a PRN dose of Morphine on August 31, 2021, at 3:55 p.m., in error within five minutes of the scheduled dose, and at 7:27 p.m., and 9:15 p.m. given in error less than one hour from scheduled administration times. - Olanzapine 5 mg solutab with orders to give one solutab every four hours for agitation and paranoia. The MAR failed to include every four-hour scheduling as ordered, and was only scheduled BID at 4:00 p.m. and 8:00 p.m. in	01760		

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01760	Continued From page 5 error. On August 31, 2021, at 8:00 p.m. the MAR indicated R1 did not receive the prescribed medication as ordered with no documented reason or refusal. In addition, on August 31, 2021, at 10:23 p.m. the resident required a PRN dose of Olanzapine 5 mg. - Haloperidol 2 mg solutab with orders to give a 2 mg solutab every two hours PRN for agitation. The order had a start date of August 29, 2021, and end date of August 31, 2021, at 3:25 p.m. The MAR indicated on August 31, 2021, at 4:02 p.m. R1 received the medication after the order was discontinued. - Acetaminophen 325 mg tablets with orders to give two tablets twice daily (BID) for pain. The MAR incorrectly had administration times scheduled three times daily (TID) in error and was scheduled at 8:00 a.m., 2:00 p.m., and 8:00 p.m. On August 29, 2021, and August 30, 2021, R1 received an extra dose of medication each day due to the error in scheduled administration times. A review of R1's September 2021, MAR indicated the following order implementation, transcription, and administration errors occurred: - Lorazepam 1mg Solutab with orders to give one tablet every two hours for anxiety and agitation. The MAR only included eight scheduled doses and failed to include every two hour scheduling as ordered. - Morphine 5mg solutab with orders to take one solutab every two hours for moderate to severe pain or shortness of breath. The MAR had eight scheduled times from 12:00 a.m. until 2:00 p.m. and failed to have every two hour scheduled	01760		

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01760	Continued From page 6 doses as ordered. - Olanzepine 5mg solutab with orders to give tablet every 4 hours. The MAR only included four scheduled times at 12:00 a.m., 8:00 a.m., and 12:00 p.m. and failed to schedule the medication every four hours as ordered. On August 8, 2022, at 2:45 p.m. during a phone interview Registered Nurse (RN)-A stated medication for Parkinson's syndrome, blood pressure medication, and antipsychotic medication prescribed for depression would be critical medications and stated they should have been available as ordered on admission. RN-A stated if medication was not available R1's admission should have been held because they did not have the proper medications for a safe admission to the facility. RN-A stated it was facility practice to verify orders using two staff to ensure orders are accurate, and correct. RN-A indicated the second staff review of orders was not documented anywhere. RN-A indicated there was nothing to alert staff if they were giving a PRN medication too early and indicated a PRN dose would be above and beyond a scheduled medication and could be given at any time. RN-A was provided the example of R1's PRN morphine dose being administered within five minutes of a scheduled dose and indicated that would be a medication error. RN-A indicated she was not aware of any medication errors identified by the investigator. The current facility policy and procedure titled "Medication and Treatment Orders Policy" dated December 2019, indicated the RN was responsible for assuring that current, authorized prescriber orders for medications or treatments administered by the staff are kept on file in the	01760		

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01760	Continued From page 7 residents records, communicated to the resident or responsible party, educate the resident or responsible party on all medication and treatment orders, and that changes in orders are addressed in the residents service plan and are communicated to the other staff. An order for medication or treatment must contain the name of the resident, a description of the medication, treatment or therapy to be provided and the frequency, duration, and other information needed to carry out the order. The licensed nurse would review all medication and treatment orders for progress, effectiveness and necessity on a regular basis and with resident change of condition. A residents MAR would be audited regularly by licensed nurse or designee for compliance. No additional information provided. TIME PERIOD FOR CORRECTION: Fourteen (14) Days	01760		
02320 SS=G	144G.91 Subd. 4 Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to ensure timely implementation of orders and accurate medication administration for 1 of 1 resident's (R1) with records reviewed. R1	02320		

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02320	Continued From page 8 had multiple medication errors in omission when the resident did not receive medications prescribed for Parkinson's disease, blood pressure medication, or antipsychotic medications for advanced dementia, and depression as ordered on admission. The resident had an episode of increased agitation and aggressive behavior and his safety was endangered requiring law enforcement assistance and transfer to the emergency department (ED). 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 was admitted to the facility on August 27, 2021, from an inpatient geriatric psychiatric hospital with diagnoses including altered mental status, cognitive communication deficit, Parkinson's Disease, Major Depressive Disorder, Advanced Dementia with behavioral disturbances, and Lewy Bodies Dementia. R1's face sheet indicated he required physical assistance with mobility using an EZ stand mechanical lift and two staff assistance for transfers and a rock n go wheelchair for mobility. R1's admission service agreement signed on August 27, 2021, indicated the resident required memory care, medication management services	02320		

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02320	Continued From page 9 and administration, and utilized hospice services. R1's admission progress note dated August 27, 2021, at 3:31 p.m. indicated the resident was admitted to the facility from an inpatient geriatric psychiatric hospital at 11:00 a.m. where he was treated for physical aggression related to dementia. The note indicated R1 was admitted with hospice services for dementia and Parkinson's syndrome. The note indicated R1 required medication administration four times daily and received multiple PRN (as needed) medications for behavior management. The following day after admission on August 28, 2021, at 10:54 p.m. a progress note indicated R1 was sent to the hospital, and the facility RN had instructed staff to not allow the resident back until medications were verified and at the facility. The progress note indicated the registered nurse (RN) and a hospice RN reviewed R1's medications and identified multiple discrepancies including medication lists that did not match, with different instructions and medication frequency times. On August 28, 2021, at 11:03 p.m. R1's progress note indicated the resident had increased behaviors including self-transferring, agitation, and aggression towards staff. The note indicated staff updated hospice. Lorazepam 0.5mg PRN was administered at 6:53 p.m. but was not effective. R1 became very angry and was not able to be redirected. R1's behaviors further escalated as the resident ran around the room, stumbling repeatedly, went into another resident room and pulled a mattress off the bed, pulled and pushed a Hoyer mechanical lift onto himself and staff, tried to pick up and throw his wheelchair, and grabbed a staff member causing injury. The note indicated staff were afraid for	02320		

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02320	Continued From page 10 resident safety and called hospice and 911. Staff were instructed by hospice to give Gabapentin 100 mg at 7:02 p.m. with no changes in the resident behavior. Law enforcement called the ambulance and R1 was taken to the hospital at 8:20 p.m. An incident report was requested, none was received. R1's prehospital ambulance run report dated August 28, 2021, at 7:13 p.m. indicated facility staff reported R1 was a new admission to the facility and was very aggressive. The report indicated staff had given PRN medication, but it was not effective, and police were present on scene. R1's emergency department (ED) after visit summary (AVS) dated August 28, 2021, at 8:43 p.m. indicated R1 was an emergent transfer for an episode of aggression where a staff member was injured. R1 had received lorazepam 0.5mg, morphine 5mg, and gabapentin 250 mg for sedative medications that day. The AVS plan and assessment indicated R1 presented to the emergency department with agitation and hallucinations. R1 was admitted to the facility the previous day following a stay in a geriatric psychiatric hospital, with medications ordered at discharge and not all medication were administered by the facility as ordered. The AVS indicated R1 received an injection of Zyprexa for agitation and hallucinations and was safe to be transferred back to the facility with recommendations of adhering to R1's medication orders. R1's August 2021, Medication Administration Record (MAR) identified multiple errors in order	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20872	A. BUILDING: _____ B. WING _____	C 07/20/2022

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02320	Continued From page 11 implementation when R1 did not receive Parkinson's medication, blood pressure medication, and antipsychotic medication for depression on the day of admission. - Carbidopa - Levodopa 25-100 milligram (mg) tablets with orders to give one tablet three times daily (TID) at 8:00 a.m., 12:00 p.m., and 4:00 p.m. for Parkinson's disease. On day of admission August 27, 2021, the MAR indicated the resident did not receive the scheduled doses at 12:00 p.m., and 8:00 p.m. due to the medication not being available on admission. - Duloxetine HCL 30 mg a psychotropic medication for depression with orders to give one tablet daily at 4:00 p.m. On day of admission August 27, 2021, the MAR indicated the resident did not receive the scheduled dose of medication due to it not being available on admission. - Midodrine HCL 10 mg tabs for orthostatic hypertension with orders to give one tablet BID at 8:00 a.m., and 4:00 p.m. On August 27, 2021, at 4:00 p.m. the MAR indicated R1 did not receive the medication because it was not available. On August 2, 2022, at 4:00 p.m. unlicensed personnel (ULP)-E stated on the day of admission R1 was not having behavior issues and indicated he started to become aggressive the day after admission in the afternoon. ULP-E recalled R1 tried to pick up the Hoyer and throw it to get out the door and was banging on windows and doors. ULP-E tried to gently walk with R1 to his wheelchair, but R1 reached down and grabbed ULP-E behind her knees, picked her up and tried to throw her. ULP-E stated she then called for ULP-D to assist, and another staff came to help who ended up getting hurt when R1	02320		

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02320	Continued From page 12 pulled her arm. ULP-E stated R1 became very aggressive, and the situation was not safe so 911 was called. ULP-E stated R1 remained unsafe and aggressive even with law enforcement present and ended up being transferred by ambulance. On August 2, 2022, at 3:32 p.m. ULP- D stated she was working at the time of the incident and was responsible for administering medications to R1. ULP-D stated on the day of admission R1 was calm but the following day he became aggressive. ULP-D stated she could not recall what medications R1 had received or if medications were available on admission. ULP-D stated the day after admission R1 was very aggressive, and she was afraid he would hurt himself. ULP-D stated R1's behaviors were so aggressive they could not protect R1 from harming himself or other residents so 911 was called. ULP-D stated when law enforcement arrived R1 remained aggressive and unsafe, so the ambulance came and transferred R1 to the emergency department. On August 8, 2022, at 2:45 p.m. during a phone interview Registered Nurse (RN)-A stated it was a standard of practice to ensure the facility knew of an admission in advance enough to have all prescribed medications available when a resident was admitted. RN-A indicated the reason some of R1's medications were not available was because they were waiting for pharmacy. RN-A indicated Carbidopa - Levodopa prescribed for Parkinson's syndrome, blood pressure medication, and Duloxetine antipsychotic medication prescribed for depression would be critical medications and stated they should have been available as ordered on admission. RN-A stated if medication was not available R1's admission should have	02320		

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02320	Continued From page 13 been held because they did not have the proper medications for a safe admission to the facility. RN-A stated she would have expected staff to communicate with the inpatient geriatric psychiatric hospital that proper medications were not in place for R1 to safely be admitted. RN-A indicated she did not think that was done for R1. RN-A verified R1's progress note had identified multiple medication discrepancies in medications and orders. RN-A stated no incident report had been completed, and no investigation of medication discrepancies identified by the facility was done after R1 was sent to the emergency department for behaviors. The most recent facility policy and procedure titled "Medication and Treatment Orders Policy" dated December 2019, indicated the RN was responsible for assuring that current, authorized prescriber orders for medications or treatments administered by the staff are kept on file in the residents records, communicated to the resident or responsible party, educate resident or responsible party on all medication and treatment orders, and that changes in orders are addressed in the residents service plan and are communicated to the other staff. An order for medication or treatment must contain the name of the resident, a description of the medication, treatment or therapy to be provided and the frequency, duration, and other information needed to carry out the order. The licensed nurse would review all medication and treatment orders for progress, effectiveness, and necessity on a regular basis and with resident change of condition. A residents MAR would be audited regularly by licensed nurse or designee for compliance. No additional information was provided.	02320		

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02320	Continued From page 14 TIME PERIOD FOR CORRECTION: Seven (7) Days	02320		