DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL28513004M
Compliance #: HL28513004M

Date Concluded: October 4, 2022

Name, Address, and County of Licensee Investigated:
Oak Terrace Housing of Jordan
622 Aberdeen Avenue
Jordan, MN 55352
Scott County

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

Evaluator's Name: Michele R. Larson, 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.

Allegation(s):
The alleged perpetrators (AP#1, AP#2) financially exploited the resident when the resident had 8.5 milliliters (mL) of morphine unaccounted for. The former director of nursing (AP#2) documented the missing morphine as spillage and waste without investigating the missing morphine. An unlicensed personnel, (AP#1), documented frequent administrations of morphine during the overnight shifts with discrepancies of documentation in the narcotic ledger compared to the electronic medication administration record (eMAR).

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation for drug diversion, was inconclusive. AP#1 had vast experience passing medications although she incorrectly transcribed the morphine dosage instructions in the narcotic logbook. AP#1 frequently signed out morphine than other direct care staff and signed out more doses of morphine than what the resident's electronic medication administration (eMAR) indicated the resident received. AP#2 signed off the 8.5 mL of missing morphine as spillage/waste yet never investigated the

incident. There was no documentation AP#2 talked to AP#1 to find out how the morphine went missing.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident's entire medical record, facility policies and procedures, and medication incident reports. While onsite at the facility, the investigator observed the process for counting narcotics and signing out and administering a narcotic to a resident.

Resident resided in a locked memory care unit inside the assisted living facility. The resident's diagnoses included dementia with behavioral disturbance and Alzheimer's disease. The resident's care plan indicated the resident received assistance for all personal cares, meals, medication management, transfers, and mobility.

The resident's progress note indicated the resident was placed under hospice care due to failure to thrive and her diagnoses of dementia and Alzheimer's disease. An outside hospice agency provided comfort cares to the resident while she resided at the facility. The resident's prescribing physician's order indicated the resident was prescribed morphine concentrate, 20 milligrams (mg)/milliliter (mL); take 0.5 mL (10 mg) by mouth, every six hours as needed (PRN) for pain and agitation for end of life, supportive care.

The resident's narcotic ledger indicated AP#1 signed out 11 doses of the resident's morphine and the resident's eMAR indicated only 9 doses were documented as administered. In addition, the times AP#1 signed the morphine out of the narcotic box were after the morphine was documented as administered to the resident, not before, which was the proper procedure for signing out narcotics. In addition, AP#1 transcribed the morphine dosage instructions incorrectly on a new page, and entered an illegible date, not completing time of removal, and scratching out entries on the ledger.

The resident's two-page medication incident report indicated a facility nurse found a discrepancy in the resident's narcotic ledger on the remaining amount of morphine. On page one the nurse indicated there should have been 21.5 mL of morphine left, not 13 mL that was documented left in the bottle. The second page of the incident report included information for AP#2 to complete, such as details of the incident, if pharmacy was notified, if the resident was assessed, summary of the incident, resident's status, and an action plan. The second page of the incident report was blank except for AP#2's signature.

AP#2 stopped working at the facility three months prior to the investigation and never told the facility about the medication error. An MDH complaint survey found the discrepancy, alerted management staff and AP#1 was removed from the medication cart and reassigned pending an investigation. AP#1 however, resigned from the facility and did not provided any information about the missing morphine.

During an interview, an administrative person stated they immediately removed AP#1 from passing medications once they learned about the missing morphine. The administrative staff person stated AP#1 was a good employee when she was first hired, but started behaving differently, calling off work and yelling at co-workers. administrative staff person stated AP#2 became less thorough with her job role as an administrative nurse, stating, “she did not follow through with incidents and training, stating other supervisors were frustrated with AP#2.

During an interview, a facility registered nurse (RN) stated AP#1 mainly worked the overnight and evening shifts in the memory care unit. The facility nurse stated previously, overnight medication passers did not require another staff person to witness when they removed a narcotic from the narcotic box. The RN stated the facility changed their policy so that two staff were required to sign out and witness the removal of a narcotic. The RN stated medication passers first sign out a narcotic in the ledger, administer the narcotic to the resident, then electronically document the administration in a resident’s eMAR. The RN stated the entire process took only a couple of minutes. The RN stated AP#1 was less interested and moody overtime. The RN stated, “I always felt there was something going on with her; something seemed off.” The RN stated AP#2 was knowledgeable but not very motivated and tried to do as minimal work as possible.

During an interview, a facility nurse stated AP#2 never reached out to them after they wrote the medication incident report on the missing morphine. The nurse stated they placed the medication incident form in AP#2’s file on her desk. The nurse stated AP#1 worked in the facility for a while and was familiar with the process of signing out narcotics, transcribing, and documenting. The nurse stated they thought it would be difficult to spill that much morphine and stated sometimes they would find drops of a liquid on the narcotic medication cards, but not 8.5 mL of morphine that was missing. The nurse stated the resident never appeared to be in pain.

During an interview, AP#1 stated she had many years of experience as a medication passer and stated she did not require as much training as other medication passers due to her experience. AP#1 stated she had performed the same job role for over 20 years. AP#1 stated she was familiar with the steps and process for signing out and documenting narcotics and stated the correct order during her interview with the investigator. AP#1 stated she was never talked to about the missing morphine. AP#1 stated administrative staff never told her why she was reassigned from passing medications other than administration wanted to talk to her about a medication error. AP#1 stated, “I wondered this entire time why they wanted to have a meeting with me.” AP#1 stated the meeting never happened, stating her husband injured his back and required “imminent” back surgery which caused her to immediately resign from her position at the facility.

During an interview, AP#2 stated she did not recall the missing morphine or signing the medication incident form.

In conclusion, financial exploitation was inconclusive.

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

Financial exploitation: Minnesota Statutes, section 626.5572, subdivision 9
"Financial exploitation" means:
(b) In the absence of legal authority a person:
(1) willfully uses, withholds, or disposes of funds or property of a vulnerable adult;

Vulnerable Adult interviewed: No. Deceased.
Family/Responsible Party interviewed: Not applicable.
Alleged Perpetrator interviewed: Yes, both AP#1 and AP#2 were interviewed.

Action taken by facility:
The facility changed their process on how narcotics were signed out from the narcotic box. Two direct care staff persons need to verify and witness the removal of a narcotic from the locked narcotic box. AP#1 and AP#2 are no longer employed at the facility.

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.

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
	28513	A. BUILDING: _____ B. WING _____	C 08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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: #HL28513005C/#HL28513004M On August 31, 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 84 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL28513005C/#HL28513004M, tag identification 620, 1430, 1500, 1540, 1760, 1920, 3000.	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.	
0 620 SS=D	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma	0 620		

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0 620	Continued From page 1 144G.42 Subd. 6. Compliance with requirements for reporting maltreatment of vulnerable adults; abuse prevention plan. (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to comply with the requirements for reporting suspected maltreatment within 24 hours for one of one residents (R1) with records reviewed. R1's liquid oral morphine went unaccounted for during unlicensed personnel (ULP)-I's overnight shift. The former director of nursing (DON)-G signed off R1's 8.5 mL missing morphine as spillage and waste yet never investigated the missing morphine and never alerted other administrative staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). Findings Include: R1's medical record was reviewed. R1 admitted to the facility on September 10, 2020 and resided there until April 28, 2022. R1 resided in a locked memory care unit in the facility. R1's diagnoses included unspecified dementia with behavioral	0 620		

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0 620	Continued From page 2 disturbance and Alzheimer's disease. R1's Individual Abuse Prevention Plan (IAPP) dated July 15, 2021, indicated R1 was susceptible to being abused due to her diagnoses of dementia and Alzheimer's disease. R1's care plan updated December 15, 2021, indicated R1 received assistance with personal cares, mobility, toileting, transfers, eating, and medication management. On October 1, 2021, R1 started receiving hospice care at the assisted living facility. R1 used a Hoyer (total body mechanical) lift for all transfers. R1's progress note dated October 4, 2021, at 11:38 a.m., indicated R1 was discharged back to the facility after a brief stay at a hospital for a urinary tract infection (UTI) and fever. R1's physician prescribed morphine concentrate 20 milligrams (mg)/mL; take 0.5 milliliters (mL) (10 mg) by mouth, every six hours as needed (PRN) for pain and agitation for end of life, supportive care. R1's narcotic ledger dated October and November of 2021, on pages 32 and 61, indicated ULP-I signed out and removed from the narcotic box, 0.5 mL of oral morphine to administer to R1 on the following dates and times: October 15, 2021, at 4:45 a.m. October 15, 2021, at 3:30 p.m. October 17, 2021, at 3:00 a.m. October 20, 2021, at 11:56 p.m. October 21, 2021, at 3:00 a.m. October 23, 2021, at 1:00 a.m. October 23, 2021, at 3:00 a.m. October 24, 2021, at 3:34 a.m.	0 620		

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0 620	Continued From page 3 November 1, 2021, at 12:09 a.m. November 13, 2021, at 7:40 p.m. November 18, 2021, at 5:00 a.m. ULP-I's 11 removals of 0.5 mL of morphine from R1's narcotic box were all signed by ULP-I but lacked witness/verifed signatures. R1's narcotic ledger indicated on October 15, 2021, at 4:45 a.m., and October 17, 2021, at 3:00 a.m., ULP-I signed out two 0.5 mL doses of morphine but never documented in R1's electronic medication administration record (eMAR) they were administered. R1's eMAR dated October and November 2021, indicated ULP-I documented she administered 0.5 mL of morphine to R1 on the following dates and times: October 15, 2021, at 4:23 p.m. (Signed out morphine at 3:30 p.m. but documented administered at 4:23 p.m.) October 20, 2021, at 11:33 p.m. (Signed out morphine at 11:56 p.m. but documented administered at 11:33 p.m.) October 21, 2021, at 3:00 a.m. October 23, 2021, at 12:00 a.m. (Signed out morphine at 1:00 a.m. but documented administered at 12:00 a.m.) October 23, 2021, at 6:16 a.m. (Signed out morphine at 3:00 a.m. but documented administered at 6:16 a.m.) October 24, 2021, at 1:27 a.m. (Signed out morphine at 3:34 a.m. but documented administered at 1:27 a.m.) November 1, 2021, at 12:09 a.m. November 13, 2021, at 7:40 p.m. November 18, 2021, at 4:35 a.m. (Signed out morphine at 5:00 a.m. but documented	0 620		

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0 620	Continued From page 4 administered at 4:35 a.m.) R1's eMARs indicated ULP-I documented she administered a total of 9 doses of 0.5 mL oral morphine to R1. R1's medication incident form dated November 18, 2021; written by licensed practical nurse (LPN)-H, indicated on November 18, 2021, at 4:00 a.m., he found a discrepancy in R1's narcotic ledger. LPN-H indicated R1's remaining morphine should have been 21.5 mL, not 13 mL that was documented. LPN-H wrote, "ULP-I has been administering PRN morphine during the overnight shifts, transposed to page 61 and wrote incorrect directions." LPN-H indicated he did not administer any morphine to R1 during their shift. LPN-H indicated nursing administration could call him if they had any questions. LPN-H completed and signed the first page of the document. The second page contained areas for DON-G to complete with details of the medication incident; if pharmacy was notified, resident assessment, summary of the incident, resident's current status, and an action plan. At the bottom of the second page was a place for DON-G to sign. The second page was blank except for DON-G's signature. On November 19, 2021, at 2:57 p.m., DON-G documented the remaining amount of R1's liquid morphine was 13 mL. DON-G wrote in the notes column, "amount adjusted due to spillage/waste." R1's medication incident report lacked evidence DON-G conducted an investigation to determine why 8.5 mL of of liquid morphine was missing. A MDH undated document indicated on April 5-6, 2022, an MDH investigator discovered the medication error in R1's narcotic ledger while	0 620		

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0 620	Continued From page 5 conducting a complaint investigation. The MDH investigator spoke to licensed assisted living director (LALD)-C, who indicated she was unaware of the medication error and would look into it. Two weeks later, the investigator contacted LALD-C, who indicated she attempted to contact ULP-I, but ULP-I did not return to work after the error was found, and did not wish to discuss the medication discrepancy with LALD-C. On April 27, 2022, LALD-C finally completed a MAARC report after being instructed to do so by the MDH investigator. On April 14, 2022, LALD-C and RN-D scheduled a meeting with ULP-I to discuss the medication error. On April 14, 2022, at 10:44 a.m., ULP-I emailed LALD-C, informing her she was resigning effective immediately. ULP-I wrote, "Unfortunately, I will not be putting in a two-week notice due to personal, life circumstances." On April 14, 2022, at 12:10 p.m., LALD-C emailed ULP-I. LALD-C indicated she and register nurse (RN)-D wanted to discuss R1's morphine medication error that took place on November 18, 2021. LALD-C indicated specifics of LPN-H's medication incident report. Facility records indicated ULP-I never reached out to LALD-C or offerred an explanation as to what happened to the missing morphine. On September 19, 2022, at 10:00 a.m., DON-G stated she did not recall the November 18, 2021, medication error or the incident. DON-G stated ULP-I was an excellent employee when she was first hired but changed over time and became unreliable, not showing up for shifts, not charting	0 620		

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0 620	Continued From page 6 or administering medications. On September 21, 2022, at 9:00 a.m., LALD-C stated the medication incident needed to immediately be addressed with ULP-I was they discovered the incident on April 6, 2022. LALD-C stated she and RN-D attempted to schedule meetings with ULP-I after the incident was discovered, but were unsuccessful. On October 3, 2022, at 8:20 a.m., LALD-C stated she was unsure why the facility waited three weeks to file a MAARC report after they found out about the narcotic ledger discrepency and missing morphine. The licensee policy titled, Vulerable Adult Maltreatment-Prevention & Reporting, dated August 1, 2021, indicated all staff would be trained on the identification of incidents of maltreatment including abuse, financial exploitation, and neglect. If the LALD or clinical nurse supervisor (CNS) confirmed the suspicion of maltreatment, they would contact MAARC. MAARC reports must be made no later than 24 hours after the maltreatment was first suspected. TIME PERIOD TO CORRECT: Seven (7) days.	0 620		
01430 SS=D	144G.62 Subd. 3 Supervision of staff (a) Staff who only provide assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), must be supervised periodically where the services are being provided to verify that the work is being performed competently and to identify problems and solutions to address issues relating to the staff's ability to provide the services. The supervision of the unlicensed	01430		

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01430	Continued From page 7 personnel must be done by staff of the facility having the authority, skills, and ability to provide the supervision of unlicensed personnel and who can implement changes as needed, and train staff. (b) Supervision includes direct observation of unlicensed personnel while the unlicensed personnel are providing the services and may also include indirect methods of gaining input such as gathering feedback from the resident. Supervisory review of staff must be provided at a frequency based on the staff person's competency and performance. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure periodic, direct supervision and documentation were performed for one of two unlicensed personnel (ULP-I) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings include: ULP-I's employee record was reviewed. ULP-I was hired October 10, 2019 and worked at the facility until April 14, 2022. ULP-I's document titled, "Direct Supervision of Staff Performing Delegated Tasks Within 30 Days	01430		

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01430	Continued From page 8 of Beginning Work, indicated on December 11, 2019, registered nurse (RN)-D provided direct supervision of ULP-I performing catheter care. ULP-I's employee record lacked evidence ULP-I received periodic direct supervision after December 11, 2019. ULP-I's employee record lacked documentation of direct supervision to verify she performed competently and to identify problems and solutions to address issues relating to the staff's ability to provide the services. On September 26, 2022, at 11:00 a.m., RN-D stated she was in charge of competencies, orientation, and skill sign-off for all staff. The licensee policy titled, Supervision of Staff, dated August 1, 2021, indicated staff who provided delegated nursing or therapy tasks to residents would be supervised by an RN or appropriate licensed health professional (LHP) where services were provided to verify work was being performed competently and to identify problems and solutions related to the staff person's ability to perform tasks. Supervision would include observation of staff administering medications or treatments and the interactions with residents. TIME PERIOD TO CORRECT: Twenty-one (21) days.	01430		
01500 SS=E	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training	01500		

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01500	Continued From page 9 for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following	01500		

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01500	Continued From page 10 topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received at least eight hours of annul training for each 12 months of employment for two of three employees, unlicensed personnel (ULP)-E and ULP-I, with training records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). Findings Include: The Minnesota Department of Health (MDH) surveyor entered the facility on August 31, 2022, at 10:00 a.m.	01500		

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01500	Continued From page 11 ULP-E ULP-E was hired November 10, 2017. ULP-E's training transcripts indicated ULP-E's most recent annual training was dated June 25, 2021. ULP-E's employee record lacked evidence of up-to-date annual training to include: *Reporting of maltreatment of vulnerable adults under section 626.557 *Review of the assisted living (AL) bill of rights (BOR) *Review of infection control techniques *Effective approaches to use to problem solve when working with a resident's challenging behaviors *Review of the facility's policies and procedures *Principles of person-centered planning and service delivery ULP-I ULP-I was hired October 10, 2019, and worked at the facility until April 14, 2022. ULP-I's training transcripts indicated ULP-I's most recent annual training was dated July 21, 2021. ULP-I's most recent training record did not include ULP-I completed all required annual training. ULP-I's employee record lacked evidence of up-to-date annual training to include: *Review of infection control techniques *Effective approaches to use to problem solve when working with a resident's challenging behaviors *Review of the facility's policies and procedures	01500		

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01500	Continued From page 12 *Principles of person-centered planning and service delivery On September 26, 2022, at 11:00 a.m., registered nurse (RN)-D stated she was in charge of training staff. The licensee policy titled Annual Required Training, dated August 1, 2021 indicated all staff who performed direct care services at the licensee's building would complete at least eight (8) hours of annual training for each 12 months of employment. TIME PERIOD TO CORRECT: Twenty-one (21) days.	01500		
01540 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter;	01540		

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01540	Continued From page 13 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff received the required amount of dementia care training in the required time frame for one of three unlicensed personnel ((ULP)-E) personnel 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: The licensee provided services under an Assisted Living with Dementia Care license. ULP-E ULP-E was hired on November 10, 2017. ULP-E's employee record lacked evidence she completed at least two hours of dementia care training On September 26, 2022, at 11:00 a.m., registered nurse (RN)-D stated she was in charge of training staff. The license policy titled, Assisted Living Facility Notice of Dementia Training, dated August 1, 2021, indicated direct care staff would receive two hours of training on topics related to dementia care for each 12 months of employment thereafter.	01540		

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01540	Continued From page 14 TIME PERIOD TO CORRECT: Twenty-one (21) days.	01540		
01760 SS=G	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an unlicensed personnel (ULP)-I correctly transcribed a narcotic in the narcotic ledger for one of one resident (R1) with records reviewed. ULP-I removed two doses of morphine from R1's narcotic box yet never documented the morphine was administered in R1's electronic medication administration record (eMAR). In addition, the licensee failed to ensure ULP-I performed in proper order the steps for signing out R1's narcotics, administering the narcotic, then documenting its administration. This practice resulted in a level three violation (a	01760		

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01760	Continued From page 15 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 medical record was reviewed. R1 admitted to the facility on September 10, 2020 and resided there until April 28, 2022. R1 resided in a locked memory care unit in the facility. R1's diagnoses included unspecified dementia with behavioral disturbance and Alzheimer's disease. R1 used a Hoyer lift for all transfers. R1's care plan updated December 15, 2021, indicated R1 received assistance with medication management. R1's progress note dated October 4, 2021, at 11:38 a.m., indicated R1 was discharged back to the facility after a brief stay at a hospital for a urinary tract infection (UTI) and fever. R1's physician prescribed morphine concentrate, 20 milligrams (mg)/milliliter (mL); take 0.5 mL (10 mg) by mouth, every six hours as needed (PRN) for pain and agitation for end of life, supportive care. R1's narcotic ledger dated October and November of 2021, on pages 32 and 61, indicated ULP-I signed out and removed from the narcotic box, 0.5 mL of oral morphine to administer to R1 on the following dates and times:	01760		

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01760	Continued From page 16 October 15, 2021, at 4:45 a.m. October 15, 2021, at 3:30 p.m. October 17, 2021, at 3:00 a.m. October 20, 2021, at 11:56 p.m. October 21, 2021, at 3:00 a.m. October 23, 2021, at 1:00 a.m. October 23, 2021, at 3:00 a.m. October 24, 2021, at 3:34 a.m. November 1, 2021, at 12:09 a.m. November 13, 2021, at 7:40 p.m. November 18, 2021, at 5:00 a.m. ULP-I's 11 removals of 0.5 mL morphine from R1's narcotic box were all signed by ULP-I but lacked witness/verified signatures. R1's narcotic ledger indicated on October 15, 2021, at 4:45 a.m., and October 17, 2021, at 3:00 a.m., ULP-I signed out two 0.5 mL doses of morphine but never documented in R1's eMAR they were administered. R1's narcotic ledger indicated ULP-I signed out and removed a total of 11 doses of 0.5 mL of oral morphine. R1's electronic medication administration record (eMAR) dated October and November 2021, indicated ULP-I documented she administered a total of 9 doses of 0.5 mL oral morphine to R1. On November 24, 2021, the facility sent a telephone order to R1's prescribing physician requesting R1's liquid, oral morphine be changed to morphine solutabs, sublingual. On November 24, 2021, at 3:26 p.m., R1's prescribing physician ordered the following Schedule II narcotic: morphine solutab, 5 milligrams (mg). Give two capsules, a total of 10	01760		

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01760	Continued From page 17 mg, by mouth, every six hours PRN for pain or dyspnea. The new morphine order was signed and electronically faxed to the facility on November 25, 2021, at 9:31 a.m. R1's morphine solutab narcotic ledger dated November 25, 2021, indicated ULP-I signed out two 5 mg tablets (10 mg) on the following lines and dates: *Line 1-November 25, 2021, at 6:58 p.m. *Line 2-November 26, 2021, at 3:42 a.m. *Line 3-November 28, 2021, at 2:00 a.m. R1's eMAR dated November 2021, indicated ULP-I administered two 5 mg tablets (10 mg) of morphine solutab to R1 on the following dates: *November 25, 2021, at 6:38 p.m. *November 28, 2021, at 12:30 a.m. R1's record indicated ULP-I signed out one additional dose of morphine solutab that was not electronically documented as administered in R1's November 2021 eMAR. In addition, R1's November 2021 eMAR indicated ULP-I documented she signed out R1's morphine solutabs from R1's narcotic box after she administered the morphine to R1. On September 26, 2022, at 11:00 a.m. registered nurse (RN)-D stated removing a narcotic from the narcotic box involved opening the narcotic box from the locked drawer in the medication cart; signing out the narcotic after ensuring the correct amount was remaining, administering the narcotic to the resident, then electronically signing the eMAR after the narcotic was administered. RN-D stated it should only be "a minute or two" between signing out the narcotic and administering it. On September 27, 2022, at 3:30 p.m., ULP-I	01760		

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01760	Continued From page 18 stated she had over 20 years' experience working as a ULP and medication passer and did not require as much medication pass training when she was hired due to her past experience. ULP-I stated removing a narcotic from a resident's narcotic box involved ensuring it was the right resident, dose, and drug. ULP-I stated a narcotic was removed only after everything looked correct and was signed out. ULP-I stated the resident's eMAR was electronically signed after the medication was administered to the resident. ULP-I confirmed the entire process only took a few minutes. On September 30, 2022, at 8:55 a.m., RN-D stated she did not perform random narcotic checks to verify narcotic counts, and was unsure if the former director of nursing performed them, even though the facility had a policy on controlled substances and could perform random narcotic count checks at anytime. RN-D stated random narcotic count checks should be performed after the surveyor informed her additonal medication errors were found in the narcotic ledger and eMAR. The licensee policy titled Medication Error, dated August 1, 2021, indicated the licensee had a goal of zero medication errors. In the event an error occurred, staff would document, track, and resolve medication administration errors for quality improvement. Staff would be retrained if necessary. TIME PERIOD TO CORRECT: Seven (7) days.	01760		
01920 SS=G	144G.71 Subd. 23 Loss or spillage (a) Assisted living facilities providing medication	01920		

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01920	Continued From page 19 management must develop and implement procedures for loss or spillage of all controlled substances defined in Minnesota Rules, part 6800.4220. These procedures must require that when a spillage of a controlled substance occurs, a notation must be made in the resident's record explaining the spillage and the actions taken. The notation must be signed by the person responsible for the spillage and include verification that any contaminated substance was disposed of according to state or federal regulations. (b) The procedures must require that the facility providing medication management investigate any known loss or unaccounted for prescription drugs and take appropriate action required under state or federal regulations and document the investigation in required records. This MN Requirement is not met as evidenced by: Based on observation and record review, the licensee failed to follow procedure for loss and spillage of a controlled substance for one of one resident (R1) with records reviewed. R1 was prescribed a controlled substance that was managed by the licensee's facility. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at 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:	01920		

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01920	Continued From page 20 R1's medical record was reviewed. R1 admitted to the facility on September 10, 2020 and resided there until April 28, 2022. R1 resided in a locked memory care unit in the facility. R1's diagnoses included unspecified dementia with behavioral disturbance and Alzheimer's disease. R1's care plan updated December 15, 2021, indicated R1 received assistance with medication management. On October 1, 2021, R1 started receiving hospice care at the assisted living facility. R1's written, prescriber orders dated October 4, 2021, indicated an order for oral, liquid morphine concentrate (a moderate to severe Schedule II controlled substance), 20 milligrams (mg)/milliliter (mL) oral liquid. The order read, "Give 0.5 mL by mouth every six hours as needed (PRN) for pain/agitation. 0.5 mL = 10 mg." R1's new order for morphine was entered on page 32 in the narcotic ledger. The top of page 32 contained R1's first/last name, name of medication, prescription number, prescribing physician, route, date/ initial quantity received, dosage and directions,and pharmacy. Initial quantity received was entered as 30 mL on October 4, 2021. Dosage and directions were documented as prescribed. Line 16 (last line on page 32), had a listed date of November 13, 2022, at 7:40 p.m., completed by ULP-I. On November 13, 2021, (no time listed), R1's narcotic ledger indicated ULP-I transferred the information from page 32 to the top of page 61. ULP-I indicated 22.0 mL of morphine remained. ULP-I transcribed the following dosage and directions inaccurately at the top of page 61: "100 mg per 5 mg (20 mg)", every six hours PRN.	01920		

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01920	Continued From page 21 Line 1 lacked a signature or the remaining amount of morphine. On November 18, 2021, (date was changed), at 5:00 a.m., ULP-I entered the following information on R1's morphine narcotic ledger, Line 2: on-hand amount -22.0 (no weighted measurement); given-0.5 (no weighted measurement); remaining-21.5 (no weighted measurement). Nurse signature- ULP-I's initials followed by letters "TMA," acronym for trained medication aide. On November 19, 2021, at 2:57 p.m., Line 4 (Line 3 blank), R1's morphine narcotic ledger indicated the following: On-hand (blank); given (blank); remaining-13 mL. Nurse signature-former director of nursing (DON)-G; verified signature- a licensed practical nurse (LPN); note section-"amount adjusted due to spillage/waste." R1's medication incident form two pages long, dated November 18, 2021; written by LPN-H, indicated on November 18, 2021, at 4:00 a.m., LPN-H found a discrepancy in the narcotic ledger book for the remaining amount of R1's liquid oral morphine. LPN-H indicated R1 should have had 21.5 mL or liquid oral morphine remaining, but the bottle had 13 mL. LPN-H wrote, "ULP-I has been administering PRN morphine during the overnight shifts, transcribed to page 61 and wrote incorrect directions." LPN-H indicated he did not administer any morphine to R1 during their shift. LPN-H indicated nursing administration could call him if they had any questions. LPN-H completed and signed the first page of the document. The second page contained areas for DON-G to complete with details of the medication incident; if pharmacy was notified, resident assessment, summary of the incident, resident's current status,	01920		

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01920	Continued From page 22 and an action plan. At the bottom of the second page was a place for DON-G to sign. The second page was blank except for DON-G's signature A MDH undated document indicated on April 5-6, 2022, an MDH investigator discovered the medication error in R1's narcotic ledger while conducting a complaint investigation. The MDH investigator spoke to licensed assisted living director (LALD)-C, who indicated she was unaware of the medication error and would look into it. Two weeks later, the investigator contacted LALD-C, who indicated she attempted to contact ULP-I, but ULP-I did not return to work after the error was found, and did not wish to discuss the medication discrepancy with LALD-C. On September 19, 2022, at 10:00 a.m., DON-G stated she did not recall the November 18, 2021, medication error or the incident. On September 20, 2022, at 4:30 p.m., LPN-H stated DON-G never reached out to him after he completed the medication incident report. LPN-H stated ULP-I "had been around" for a while and was familiar with transcribing and removing narcotics from the narcotic box. LPN-H stated R1 was not very verbal at the end of her life and did not appear to be in pain. LPN-H stated he thought it would be difficult to spill much liquid morphine (8.5 mL). LPN-H stated sometimes he found drops of liquid narcotics on the blister pack medication cards but stated it did not equate to the amount of morphine that was missing. On September 27, 2022, at 3:30 p.m., ULP-I stated she had over 20 years' experience working as a ULP and medication passer. ULP-I stated most of the time there were only two ULP's in the building during the overnight shift; one in memory	01920		

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01920	Continued From page 23 care and one in assisted living. ULP-I stated, "sometimes you were the only med passer in the building so you don't have another person to ask (co-sign)." The licensee policy titled Controlled Substance, dated August 1, 2021, indicated the licensed nurse would verify the count of controlled medications each time the nurse sets up the resident's medications and may conduct random checks at other times. When a loss or spillage of a Schedule II drug occurs, an explanatory notation must be made in the resident's record. The notation must be signed by the person responsible for the loss or spillage, and by one witness who must also observe the destruction of any remaining contaminated drug by placing in the drug buster container or wiping up the spill. A facility nurse would log Schedule II narcotics into the narcotic book with complete resident information, including resident's name, apartment number, prescription number, directions for use, date received, quantity received, and prescribing health professional's name. A completed or discontinued controlled substance had an end date on the last line with a yellow line drawn across the page. If the medication was not finished, the remaining quantity, information, and new transferred page number was entered at the top of the new page. Staff persons coming on duty and staff persons going off duty would count and document controlled substances together. Any discrepancies with the narcotic ledger and count were to be immediately reported to the RN. If controlled drugs were missing, the RN and LALD would investigate to determine when the narcotics went missing and who may have been involved. Depending on the circumstances and result of the investigation, the RN and LALD would decide whether law enforcement and/or	01920		

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01920	Continued From page 24 Common Entry Point (CEP) were contacted. TIME PERIOD TO CORRECT: Seven (7) days.	01920		
03000 SS=D	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause	03000		

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03000	Continued From page 25 (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to comply with the requirements for reporting suspected maltreatment within 24 hours for one of one residents (R1) with records reviewed. R1's liquid oral morphine went unaccounted for during unlicensed personnel (ULP)-I's overnight shift. The former director of nursing (DON)-G signed off R1's 8.5 mL missing morphine as spillage and waste yet never investigated the missing morphine and never alerted other administrative staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). Findings Include:	03000		

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03000	Continued From page 26 R1's medical record was reviewed. R1 admitted to the facility on September 10, 2020 and resided there until April 28, 2022. R1 resided in a locked memory care unit in the facility. R1's diagnoses included unspecified dementia with behavioral disturbance and Alzheimer's disease. R1's Individual Abuse Prevention Plan (IAPP) dated July 15, 2021, indicated R1 was susceptible to being abused due to her diagnoses of dementia and Alzheimer's disease. R1's care plan updated December 15, 2021, indicated R1 received assistance with personal cares, mobility, toileting, transfers, eating, and medication management. On October 1, 2021, R1 started receiving hospice care at the assisted living facility. R1 used a Hoyer (total body mechanical) lift for all transfers. R1's progress note dated October 4, 2021, at 11:38 a.m., indicated R1 was discharged back to the facility after a brief stay at a hospital for a urinary tract infection (UTI) and fever. R1's physician prescribed morphine concentrate 20 milligrams (mg)/mL; take 0.5 milliliters (mL) (10 mg) by mouth, every six hours as needed (PRN) for pain and agitation for end of life, supportive care. R1's narcotic ledger dated October and November of 2021, on pages 32 and 61, indicated ULP-I signed out and removed from the narcotic box, 0.5 mL of oral morphine to administer to R1 on the following dates and times: October 15, 2021, at 4:45 a.m. October 15, 2021, at 3:30 p.m.	03000		

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03000	Continued From page 27 October 17, 2021, at 3:00 a.m. October 20, 2021, at 11:56 p.m. October 21, 2021, at 3:00 a.m. October 23, 2021, at 1:00 a.m. October 23, 2021, at 3:00 a.m. October 24, 2021, at 3:34 a.m. November 1, 2021, at 12:09 a.m. November 13, 2021, at 7:40 p.m. November 18, 2021, at 5:00 a.m. ULP-I's 11 removals of 0.5 mL of morphine from R1's narcotic box were all signed by ULP-I but lacked witness/verifed signatures. R1's narcotic ledger indicated on October 15, 2021, at 4:45 a.m., and October 17, 2021, at 3:00 a.m., ULP-I signed out two 0.5 mL doses of morphine but never documented in R1's electronic medication administration record (eMAR) they were administered. R1's eMAR dated October and November 2021, indicated ULP-I documented she administered 0.5 mL of morphine to R1 on the following dates and times: October 15, 2021, at 4:23 p.m. (Signed out morphine at 3:30 p.m. but documented administered at 4:23 p.m.) October 20, 2021, at 11:33 p.m. (Signed out morphine at 11:56 p.m. but documented administered at 11:33 p.m.) October 21, 2021, at 3:00 a.m. October 23, 2021, at 12:00 a.m. (Signed out morphine at 1:00 a.m. but documented administered at 12:00 a.m.) October 23, 2021, at 6:16 a.m. (Signed out morphine at 3:00 a.m. but documented administered at 6:16 a.m.) October 24, 2021, at 1:27 a.m. (Signed out	03000		

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03000	Continued From page 28 morphine at 3:34 a.m. but documented administered at 1:27 a.m.) November 1, 2021, at 12:09 a.m. November 13, 2021, at 7:40 p.m. November 18, 2021, at 4:35 a.m. (Signed out morphine at 5:00 a.m. but documented administered at 4:35 a.m.) R1's eMARs indicated ULP-I documented she administered a total of 9 doses of 0.5 mL oral morphine to R1. R1's medication incident form dated November 18, 2021; written by licensed practical nurse (LPN)-H, indicated on November 18, 2021, at 4:00 a.m., he found a discrepancy in R1's narcotic ledger. LPN-H indicated R1's remaining morphine should have been 21.5 mL, not 13 mL that was documented. LPN-H wrote, "ULP-I has been administering PRN morphine during the overnight shifts, transposed to page 61 and wrote incorrect directions." LPN-H indicated he did not administer any morphine to R1 during their shift. LPN-H indicated nursing administration could call him if they had any questions. LPN-H completed and signed the first page of the document. The second page contained areas for DON-G to complete with details of the medication incident; if pharmacy was notified, resident assessment, summary of the incident, resident's current status, and an action plan. At the bottom of the second page was a place for DON-G to sign. The second page was blank except for DON-G's signature. On November 19, 2021, at 2:57 p.m., DON-G documented the remaining amount of R1's liquid morphine was 13 mL. DON-G wrote in the notes column, "amount adjusted due to spillage/waste." R1's medication incident report lacked evidence	03000		

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03000	Continued From page 29 DON-G conducted an investigation to determine why 8.5 mL of of liquid morphine was missing. A MDH undated document indicated on April 5-6, 2022, an MDH investigator discovered the medication error in R1's narcotic ledger while conducting a complaint investigation. The MDH investigator spoke to licensed assisted living director (LALD)-C, who indicated she was unaware of the medication error and would look into it. Two weeks later, the investigator contacted LALD-C, who indicated she attempted to contact ULP-I, but ULP-I did not return to work after the error was found, and did not wish to discuss the medication discrepancy with LALD-C. On April 27, 2022, LALD-C finally completed a MAARC report after being instructed to do so by the MDH investigator. On April 14, 2022, LALD-C and RN-D scheduled a meeting with ULP-I to discuss the medication error. On April 14, 2022, at 10:44 a.m., ULP-I emailed LALD-C, informing her she was resigning effective immediately. ULP-I wrote, "Unfortunately, I will not be putting in a two-week notice due to personal, life circumstances." On April 14, 2022, at 12:10 p.m., LALD-C emailed ULP-I. LALD-C indicated she and register nurse (RN)-D wanted to discuss R1's morphine medication error that took place on November 18, 2021. LALD-C indicated specifics of LPN-H's medication incident report. Facility records indicated ULP-I never reached out to LALD-C or offerred an explanation as to what happened to the missing morphine.	03000		

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03000	Continued From page 30 On September 19, 2022, at 10:00 a.m., DON-G stated she did not recall the November 18, 2021, medication error or the incident. DON-G stated ULP-I was an excellent employee when she was first hired but changed over time and became unreliable, not showing up for shifts, not charting or administering medications. On September 21, 2022, at 9:00 a.m., LALD-C stated the medication incident needed to immediately be addressed with ULP-I was they discovered the incident on April 6, 2022. LALD-C stated she and RN-D attempted to schedule meetings with ULP-I after the incident was discovered, but were unsuccessful. On October 3, 2022, at 8:20 a.m., LALD-C stated she was unsure why the facility waited three weeks to file a MAARC report after they found out about the narcotic ledger discrepency and missing morphine. The licensee policy titled, Vulerable Adult Maltreatment-Prevention & Reporting, dated August 1, 2021, indicated all staff would be trained on the identification of incidents of maltreatment including abuse, financial exploitation, and neglect. If the LALD or clinical nurse supervisor (CNS) confirmed the suspicion of maltreatment, they would contact MAARC. MAARC reports must be made no later than 24 hours after the maltreatment was first suspected. TIME PERIOD TO CORRECT: Seven (7) days.	03000		