# STATE LICENSING COMPLIANCE REPORT

**Report #:** HL201875420C

**Date Concluded:** January 17, 2025

**Name, Address, and County of Facility Investigated:**
Brainerd Carefree Living
2723 Oak Street
Brainerd, MN  56401
Crow Wing County

**Facility Type:** Assisted Living Facility (ALF)

**Evaluator's Name:**
Katherine Barnhardt RN, Special Investigator

The Minnesota Department of Health conducted a complaint investigation to determine compliance with state laws and rules governing the provision of care under Minnesota Statutes, 144G (ALL). The purpose of this complaint investigation was to review if facility policies and practices comply with applicable laws and rules.  No maltreatment under Minnesota Statutes, Chapter 626 was alleged.

To view a copy of the correction orders, if any, please visit: https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html, or call 651-201-4201 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached state form.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 20187 | A. BUILDING: _____ B. WING _____ | C 01/15/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRAINERD CAREFREE LIVING LLC | 2723 OAK STREET BRAINERD, MN 56401 |

| (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 |
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| 0 000 | Initial Comments<br><br>ASSISTED LIVING LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.01 to 144G.95, these correction orders are issued pursuant to a complaint investigation.<br><br>Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.<br><br>INITIAL COMMENTS:<br><br>#HL201875420C<br><br>On January 15, 2025, 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 62 residents receiving services under the assisted living with dementia license.<br><br>The following immediate correction order is issued for #HL201875420C, tag identification 1750. | 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.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>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. | |
| 01750 SS=I | 144G.71 Subd. 7 Delegation of medication administration | 01750 | | |

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| 01750 | Continued From page 1<br><br>When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has:<br>(1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures;<br>(2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and<br>(3) communicated with the unlicensed personnel about the individual needs of the resident.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure prior to delegating the nursing task of medication administration, unlicensed personnel (ULP) were trained in the proper methods to perform the task or procedure for each resident and were able to demonstrate the ability to competently follow the procedure for four of four unlicensed personnel (ULP)-D, ULP-G, ULP-H, ULP-I) reviewed. This failure had the potential to affect the health and safety of all the residents that resided at the facility and led to numerous medication errors.<br><br>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).<br><br>The findings include: | 01750 | | |

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| 01750 | Continued From page 2<br><br>On January 15, 2025, at 2:30 p.m., the investigator observed unlicensed personnel (ULP)-D receive medication cart keys, verify and count narcotics in two medication carts with a second ULP and log into the electronic medication system to administer afternoon medications to the facility's 1st and 2nd floor residents.<br><br>ULP-D's temporary staffing agency was contracted on July 12, 2024, to provide direct care services to the licensee's residents.<br><br>ULP-G's temporary staffing agency was contracted on August 27, 2024, to provide direct care services to the licensee's residents.<br><br>ULP-H's temporary staffing agency was contracted on June 5, 2024, to provide direct care services to the licensee's residents.<br><br>ULP-I's temporary staffing agency was contracted on November 27, 2024, to provide direct care services to the licensee's residents.<br><br>ULP-D, ULP-G, ULP-H, and ULP-I's employee record lacked evidence ULP-D, ULP-G, ULP-H, ULP-I demonstrated competency to the registered nurse (RN) for medication administration.<br><br>R1's Electronic administration record (EMAR) dated November 2024, indicated temporary staff administered R1's medications on November 19, 21, 24, 26 and 27, 2024.<br><br>R1's EMAR dated December 2024, indicated temporary staff administered R1's medications on December 2, 3, 6, 16, 17, 18 and 19. | 01750 | | |

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| 01750 | Continued From page 3<br><br>During an interview on January 15, 2025, at 2:55 p.m., contracted ULP-D stated she had been contracted with the facility for a few months, picked up shifts and hours she chose and was trained by her contract agency. ULP-D stated she went to the facility when she had available time before her first shift at the licensee for 45 minutes to an hour of paperwork, was assigned a computer log-in, and toured the facility. ULP-D stated she had not completed any competency training with a RN at the facility, however, medication administration was one of the tasks she's assigned .<br><br>During interview on January 15, 2025, at 3:15 p.m., clinical nurse supervisor (CNS)-B stated temporary staff duties included medication administration to the facility's residents. CNS-B stated when staff were needed she called the contract agency and requested medication trained staff and would spend between 30 to 45 minutes with them before their first shift completing paperwork and touring the facility. CNS-B was unaware temporary staff were required to be medication trained or competency tested by a RN at the facility.<br><br>The licensee's Training Unlicensed Personnel for Medication Administration policy revised January 16, 2023, indicated after the unlicensed personnel have met the qualifications in MN Statute 144G.61 and 144G.62, and have been competency tested by an RN, they may be delegated the task of medication administration. The nurse would document the training and competency in the ULP's personnel record.<br><br>TIME PERIOD FOR CORRECTION: IMMEDIATE | 01750 | | |