Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL312214883M
Compliance Report #: HL312218355C

Date Concluded: October 26, 2023

Name, Address, and County of Licensee Investigated:
Carefree Cottages MPLD Chateau
1801 Gervais Ave
Maplewood MN, 55109
Ramsey County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Lori Pokela, 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):
A facility staff member/alleged perpetrator (AP) abused a resident when the AP told the resident to stop pressing the call pendant, then raised her hand as if to strike the resident and told the resident: "I ought to smack you."

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. It is unable to be determined if abuse occurred as there was no direct witness to the incident and conflicting accounts of the incident were provided by the resident, the witness, and the AP.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted the resident's family. The investigation included review of the resident's medical records, facility internal investigation documentation, policies and procedures, and facility training. At the time of the onsite visit, the

investigator observed staff's interaction with residents, and medication and treatment administration.

The resident resided in an assisted living facility. The resident's diagnoses included Parkinson's disease, diabetes mellitus, and chronic kidney disease. The resident's service plan included assistance with daily medication management, daily blood sugar level checks, monthly vital signs, light housekeeping, and laundry.

Review of the resident's medical record indicated that one day prior to the incident, the resident reported to nursing staff feeling "zapped of energy because of one of her medications." Nursing staff reached out to the resident's primary care provider regarding the resident's report of low energy. The primary care provider responded and informed staff they would review the resident's lab results and acknowledged the resident's increased need for reassurance.

Facility documentation identified an incident was reported to nursing staff involving the resident and an unlicesned staff member/alleged perpetrator (AP). It was reported that the resident pushed her call pendant to inquire about medication, as she thought her medications were over an hour late. The resident's spouse was visiting at the time and left the resident's room to find staff to assist the resident. The AP and the spouse were witnessed walking down the hallway exchanging frustrated words. The AP went in the resident's apartment, walked over to the couch where the resident was lying, and told the resident to stop pressing the call pendant. The AP turned off the call pendant and said, "I ought to smack you" and held a hand in the air as if going to strike the resident. The resident reported that the AP appeared mad as the AP's face was red.

Upon administration learning of the allegation, the AP was removed from the schedule and facility management determined the AP would no longer care for the resident.

Nursing administration interviewed the AP, who denied the incident occurred. The AP acknowledged an interaction with the resident, but reported she told the resident to speak with a nurse, as the AP could not help the resident with her medications. The AP stated she offered to walk with the resident down to the nursing office, however, the resident declined by saying: "yeah, yeah, yeah."

The AP declined requests for interview.

During an interview, the resident stated she pushed her call light to inquire about her medications that were an hour and a half late. The AP came into the resident's apartment and started cussing and yelling at the resident. The resident stated the incident made her cry and she was unable to sleep that night.

During an interview, the resident's spouse stated he overheard the AP say: "If you press that call light one more time, I am going to slap you." The spouse stated he did not witness the AP raise her hand as if she was going to strike the resident. Later, in the same interview, the spouse stated the AP used the word "damn light" and "bitch, slap the hell out of you."

During an interview, the resident's family member stated the resident reported the incident to him soon after it occurred. The family member stated the resident reported that the AP had a bad attitude. The resident told him that the AP said "I should slap you for turning on your pendant so many times a day". The family member stated the resident told him she felt vulnerable at the time of the incident and if she were younger, she would have dealt with the AP herself. The resident told the family member she dealt with the issue by staying an arm's length away from the AP.

In conclusion, the Minnesota Department of Health determined abuse 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.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: No. AP declined to be interviewed.

Action taken by facility:
An incident report and facility investigation were completed. The AP was removed from the schedule pending a facility investigation.

Action taken by the Minnesota Department of Health:
No further action taken at this time.

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
	31221	A. BUILDING: _____ B. WING _____	C 06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREFREE COTTAGES OF MAPLEWOOD CHATEAU	1801 GERVAIS AVENUE LITTLE CANADA, MN 55109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL312215029C/#HL312213007M #HL312218355C/#HL312214883M On June 27, 2023, 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 80 residents receiving services under the provider's Assisted Living license. The following correction order is issued/orders are issued for #HL312215029C/ #HL312213007M, tag identification 0730.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31221	A. BUILDING: _____ B. WING _____	C 06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREFREE COTTAGES OF MAPLEWOOD CHA	1801 GERVAIS AVENUE LITTLE CANADA, MN 55109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Continued From page 1	0 000	ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 730 SS=E	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional;	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31221	A. BUILDING: _____ B. WING _____	C 06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREFREE COTTAGES OF MAPLEWOOD CHA	1801 GERVAIS AVENUE LITTLE CANADA, MN 55109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 730	Continued From page 2 (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the license failed to ensure documentation of an incident and actions taken to follow-up in response to an incident for one of one resident (R1) and failed to ensure R1's record contained all required content for one of six residents (R1) when there was a resident fall, report of a suspected medication error, and a discovered medication error. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a 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). The findings include: DOCUMENTATION OF SIGNIFICANT CHANGES IN STATUS, ACTION TAKEN, AND FOLLOW-UP:	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31221	A. BUILDING: _____ B. WING _____	C 06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREFREE COTTAGES OF MAPLEWOOD CHA	1801 GERVAIS AVENUE LITTLE CANADA, MN 55109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 730	Continued From page 3 R1's medical records were reviewed. R1's diagnoses included diabetes mellitus, osteoarthritis, history of arthroscopy for sepsis in left (L) ankle and deep vein thrombosis (a condition in which blood clots form in veins deep under the tissue). R1's service plan dated September 6, 2022, indicated R1 was to receive staff assistance with medication administration and obtaining blood glucose (sugar) level readings daily, along with staff assistance with dressing, grooming and showering. R1's daily blood sugar levels recorded for the month of September 2022, were between 291 mg/dL to 600 mg/dL and averaged approximately 328 mg/dL. R1's nurse's notes dated September 1, 2022, at 11:05 a.m., signed by registered nurse (RN)-D, indicated R1's physician would be notified of high blood sugar levels. R1's notes lacked documentation of the indicated update to the physician and lacked follow-up regarding the physician's response to the notification. R1's Medication Administration Record, (MAR) dated September 1, 2022 through September 19, 2022, indicated R1's insulin orders included the following: -Lantus 8 units given subcutaneously daily at bedtime. -Humalog 2 units given subcutaneously three times per day (TID). R1's physician provided a physician visit document dated September 15, 2023 at 11:10	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31221	A. BUILDING: _____ B. WING _____	C 06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREFREE COTTAGES OF MAPLEWOOD CHA	1801 GERVAIS AVENUE LITTLE CANADA, MN 55109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 730	Continued From page 4 a.m., which indicated R1 visited her physician's office regarding high blood sugar levels, dysuria (difficulty urinating) and bilateral leg edema. These same records indicated R1 was diagnosed with a urinary tract infection to which an antibiotic was ordered. The visit notes further indicated the physician would reach out to R1's pharmacy to obtain a history of the resident's blood sugar levels for review. R1's facility medical record lacked documentation, as well as follow-up, regarding R1's physician visit on September 15, 2022 at 11:10 a.m. R1's medication administration records (MAR) dated September 16, 2022, indicated R1 started an antibiotic, but did not identify why the antibiotic was prescribed. The licensee's pharmacy fax log dated September 19, 2022, indicated one of two of R1's insulin orders were increased: -Humalog insulin was increased from 2 units to 5 units three times per day, (TID). The September 19, 2022, pharmacy fax log also indicated registered nurse, (RN)-D, transcribed the insulin order but did not discontinue the existing insulin order on R1's MAR of: -Humalog 2 units subcutaneously TID. R1's MAR for September 21, 2022, indicated both Humalog 2 units and 5 units were given at 12:00 p.m. and 4:00 p.m. R1's MAR for September 22, 2022, indicated both Humalog 2 units and 5 units were given at 12:00 p.m. and 4:00 p.m.	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31221	A. BUILDING: _____ B. WING _____	C 06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREFREE COTTAGES OF MAPLEWOOD CHA	1801 GERVAIS AVENUE LITTLE CANADA, MN 55109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 730	Continued From page 5 R1's nurses notes dated September 23, 2022 at 8:55 a.m. indicated R1 was sent to the hospital and had a blood sugar level over 600. R1's medical records lacked documentation R1 fell, lacked evidence of an assessment of R1's condition, and failed to include the time of the incident and time that R1 was transported to the hospital or if R1's family was notified of the incident. R1's hospital medical records dated September 23, 2022, at 12:15 a.m., indicated R1 reported lowering herself to the floor after feeling weak at the facility. R1 also reported to hospital staff she had pain in her lower extremities, a sore throat, and a cough. R1's hospital medical records dated September 23, 2022, at 3:41 a.m., indicated R1 had an CT Scan which revealed R1 had pneumonia, and an x-ray revealed a fractured left ankle from the fall and labs revealed R1 continued to have a UTI. R1's facility nursing notes dated September 23, 2022 at 8:55 a.m., indicated registered nurse; (RN)-C complained to the R1's physician as to why R1's insulin orders were not increased prior to R1's hospitalization. R1's hospital medical records dated September 23, 2022 at 8:50 p.m. and signed by R1's primary care physician, indicated the physician verified to RN-C, R1's medications were both increased and sent to R1's pharmacy on September 19, 2022: -Lantus insulin was increased from 8 units to 12 units subcutaneously to be given daily at bedtime.	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31221	A. BUILDING: _____ B. WING _____	C 06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREFREE COTTAGES OF MAPLEWOOD CHA	1801 GERVAIS AVENUE LITTLE CANADA, MN 55109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 730	Continued From page 6 -Humalog insulin was increased from 2 units to 5 units subcutaneously to be given at mealtime, three times per day, (TID). R1's medical records lacked documentation of an incident report, medication errors, or facility investigation of the incidents. R1's medical records also lacked documentation of R1's surgery or discharge from the hospital to a transitional care unit (TCU). An email provided by registered nurse, (RN)-B on August 14, 2023 at 11:01 a.m., indicated after RN-B reviewed R1's September 21, 2022 and September 22, 2022 MAR, and clarified both staff signed off R1's MAR as giving two additional units of Humalog at 12:00 p.m. and 4:00 p.m. on both dates. RN-B indicated the nurses were not using the part of the licensee's MAR system that records the nurses check of medications against R1's MAR. The email further indicated RN-B tried to check pharmacy receipts, however, pharmacy receipts were only kept for a 6 month period and were then discarded. An email provided by RN-B on August 14, 2023 at 4:32 p.m., indicated RN-B reviewed licensee documents that indicated RN-D imported one of the two insulin orders and forgot to discontinue one of the two previous insulin orders which resulted in R1 receiving additional units of insulin on September 21, 2022 and September 22, 2022 at both 12:00 p.m. and 4:00 p.m. During an interview on August 8, 2023 at 2:06 p.m., the licensed assisted living director, (LALD)-A, stated all of R1's incidents were reported to him, including medication errors.	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31221	A. BUILDING: _____ B. WING _____	C 06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREFREE COTTAGES OF MAPLEWOOD CHA	1801 GERVAIS AVENUE LITTLE CANADA, MN 55109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 730	Continued From page 7 During this same interview, the LALD-A indicated they were aware R1 was hospitalized in September 2022, but could not recall if an incident report was made and stated he would send one if it could be found. No incident report was sent to the MDH investigator. During an interview on August 8, 2023 at 2:03 p.m., nursing administration/registered nurse, (RN)-B, stated in reference to R1's insulin's orders prior to the hospitalization on September 23, 2022: " The problem I am finding is, there should be an incident report and I cannot find one." RN-B also stated in reference to RN-C reviewing R1's insulin orders after R1's hospitalization: " I have no documentation of a medication error, so I do not know what had happened to R1's insulin orders." "There was also no documentation by RN-C or RN-D in R1's notes." RN-B stated R1 was transported to the hospital on September 23, 2023, and returned to the licensee in February 2023 after ankle surgery and a stay at a TCU to convalesce after the sugery. During an interview on August 10, 2023 at 1:48 p.m., registered nurse, (RN)-C, was asked if she completed an incident or fall report after R1 was sent to the hospital on September 23, 2022, RN-C stated: "the aides are supposed to do that." During an interview on August 14, 2023 at 2:47 p.m., with the licensee's contracted pharmacist (ADM)-I stated R1's physician orders included increases in insulin for the following on September 19, 2022: Lantus increased from 8 units to 12 units	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31221	A. BUILDING: _____ B. WING _____	C 06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREFREE COTTAGES OF MAPLEWOOD CHA	1801 GERVAIS AVENUE LITTLE CANADA, MN 55109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 730	Continued From page 8 subcutaneously daily at bedtime. Humalog increased from 2 units to 5 units subcutaneously TID. ADM-I stated the updated Humalog order was successfully sent electronically to the licensee on September 19, 2022. ADM-I stated the updated Lantus order was successfully sent electronically to the licensee at a later date due to a software issue. The software recognized the Lantus order as a refill because the pharmacy's system showed R1 to have Lantus in stock at the licensee. The licensee provided Incident Report Policy dated: August 1, 2021 indicated any incident involving a resident should be completed by utilizing an incident report and turned into the licensed assisted living director and supervisor. All incident reports will be kept in the resident's records. The licensee provided Falls Policy dated August 21, 2021, indicated the following: If a resident fall is suspected, the staff were to: 1. obtain vital signs 2. complete an incident report 3. incident reports will have follow-up by a registered nurse No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		