Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL352504642M
Compliance #: HL352506021C

Date Concluded: December 23, 2024

Name, Address, and County of Licensee Investigated:
First Choice Nursing Services
5500 81st Avenue North
Brooklyn Park, MN 55443
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Willette Shafer, RN
Special Investigator

Finding: Substantiated, facility responsibility

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

Initial Investigation Allegation(s):
The facility neglected the resident when the facility ran out of the resident's insulin and the resident admitted to the hospital for high blood sugars.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility reported to the hospital they ran out of the resident's insulin supply on a Friday, four days prior to hospitalization. The resident's endocrinologist ordered a 32-day supply of insulin one month prior to the resident running out of insulin, which was filled and had a remaining refill left. In addition, the resident's primary care provider also wrote a prescription for insulin ten days prior to the resident running out of insulin. The facility failed to order the insulin refill prior to running out of insulin supply and the resident was without insulin supply for three days. Once the insulin was received on Monday, the facility documented insulin was administered at noon. There was no further blood sugar

checks or insulin administration until 2:00 a.m., the next morning, when emergency medical services (EMS) arrived and transported the resident to the hospital for diabetic ketoacidosis (a life-threatening complication of diabetes when the body does not have enough insulin to use blood sugar for energy.)

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's primary care provider's nurse and pharmacy. The investigation included review of resident records, hospital records, pharmacy records, facility incident reports, personnel files, staff schedules, law enforcement report, and related facility policy and procedures. Also, the investigator toured the facility and observed medication storage and administration process.

The resident resided in an assisted living facility. The resident's diagnoses included diabetes type I, anxiety, and depression. The resident's service plan included assistance with medication administration and meals. The resident's assessment indicated the resident's injections were administer by staff with "set up/supervise" documented in the note's column. The medication management plan indicated the resident had a history of noncompliance with his insulin, choosing to administer a different amount than ordered. The plan directed staff to encourage compliance and update endocrinology (specialist for his diabetes). The medication management plan identified the nurses as responsible for monitoring medication supplies and ensuring timely refills. The medication management plan lacked instruction for unlicensed personnel (ULP) to monitor for signs/symptoms of hyper/hypoglycemia when he was not compliant with the insulin dose and actions to take.

The resident's physician orders indicated he had NovoLog Mix 70/30 (part rapid acting insulin and part intermediate acting) 28 units scheduled at 8:00 a.m. and 18 units scheduled at 5:00 p.m. The resident had blood sugar checks four times per day at 8:00 a.m., 12:00 p.m., 5:00 p.m., and 9:00 p.m.

The pharmacy's Prescription Fills report indicated a 32-day supply of Novolog Mix 70/30 100 units per milliliter pen was dispensed one month before the resident ran out of insulin, with an expected date to run out the same day the facility reported to the hospital the resident was without insulin supply (Friday). The prescription had one additional 32-day refill available, that the facility did not request to be filled until three days after the resident ran out of insulin (Sunday).

During an interview, the resident's endocrinologist said the facility had a phone visit with the resident's primary care provider (PCP) to clarify orders two weeks before the resident ran out of insulin. The PCP printed a hard copy prescription for the resident's insulin for the facility. This prescription could have been filled at any pharmacy. This order also had one 32-day refill available.

The resident's progress note lacked documented concerns of the resident's insulin supply or insulin prescription. The progress notes had no entries since a clinic visit days before the resident's insulin supply running out until the resident went to the hospital.

The resident's blood sugar and insulin administration log indicated for a month prior to the resident's hospitalization, the resident had been taking 30 units at the 8:00 a.m. insulin administration time, however, was more compliant with taking the 28 units as ordered 10 days prior to hospitalization. He consistently was compliant with receiving 18 units at the 5:00 p.m. insulin administration. The record showed documented blood sugar readings ranging between below 100 into the 400's. The record also documented insulin administration, for the days when the resident's supply ran out.

During interviews with licensed nurses, each had indicated they offered the resident another resident's supply of insulin, but he refused. A different facility resident had the same name insulin, NovoLog, however was only rapid acting insulin and not 70/30 like the resident's order.

It was unclear if the ULP's falsely documented on the resident's blood sugar and insulin administration log of receiving insulin on the Friday, Saturday, and Sunday when the resident was without supply or if the ULPs administered insulin, with another resident's insulin supply due to conflicting documentation and interviews.

The resident's blood sugar and insulin administration log indicated on Monday, the day of the pharmacy delivery of insulin, he received 30 units of insulin at 12:00 p.m. The record lacked any further documentation including required blood sugar check at 5:00 p.m., insulin administration at 5:00 p.m., and another blood sugar check at 9:00 p.m.

The resident's ULP progress notes lacked documentation of his blood sugar or that it was completed during the evening after receiving insulin at noon. The notes indicated the resident refused his 5:00 p.m. insulin. At 1:00 a.m., the resident began vomiting with abdominal pain. At 2:00 a.m., the resident's pain was "aggravating" and he was groaning. The ULP called 911 and EMS transported the resident to the hospital at 2:00 a.m.

The EMS report indicated the resident's blood sugars were last documented at noon the day before. EMS checked the resident's blood sugar and the glucometer read "HIGH." The resident was not responsive to intravenous (IV) insulin and transported to the hospital.

The resident's hospital record indicated the resident admitted for diabetic ketoacidosis. The resident complained staff failed to check his blood sugars. Upon hospital arrival, the resident was agitated, confused, and vomiting. Labs indicated his blood sugar was 737 and he admitted to the critical care unit. Hospital pharmacy notes indicated the facility's manager reported they ran out of the resident's insulin four days prior (on Friday). The resident received insulin the day before he was sent to the hospital, but the manager reported staff were unable to provide a time or dose the resident received. The facility's manager reported they offered another

resident's insulin supply over the weekend, but the resident declined. The resident received IV insulin and required heart monitoring. The resident recovered and discharged back to the facility after three days.

During an interview, the resident's PCP nurse said a prescription for the resident's insulin was sent to the pharmacy on Sunday, two days prior to hospitalization, per the request of the facility.

During an interview, the pharmacy staff said there was no documentation the facility spoke with the pharmacy about refilling the resident's medication, prior to running out of supply. The pharmacy staff confirmed the same date of receiving the prescription (Sunday), and the insulin was filled the next day, on Monday.

During an interview, the resident's endocrinologist said an order for Novolog Mix 70/30 100 units per milliliter was sent to the pharmacy one month prior to the resident running out of insulin. The order directed the resident to take 28 units before breakfast and 18 units before supper. The insulin order had one 32-day refill available. This order provided enough insulin to last at least 60 days. The resident was often noncompliant with insulin administration and would frequently administer 30 units instead of the ordered 28 units before breakfast. Regardless, this minor adjustment would not cause the resident to run out of insulin much earlier. The endocrinologist said ketoacidosis causes severe illness and can be fatal.

During an interview, the owner (who was also a licensed practical nurse and licensed assisted living director) said staff dialed the insulin pen, and the resident administered his dose. The resident often changed the dial and administered whatever dose he chose. Sometimes he administered more insulin than prescribed. The owner said the resident ran out of insulin because he often changed the dose of insulin he was prescribed, and the facility was unable to obtain more from the pharmacy. The resident's blood sugar ran high without insulin, and he admitted to the hospital. The owner said the resident was without insulin for a couple days. He said they offered the resident another resident's insulin, but the resident declined.

During an interview, the nurse said they were going back and forth between the physician and the pharmacy trying to get insulin refilled. The nurse said they thought they had enough insulin to get through the weekend but did not. The nurse also said the resident ran out of insulin on Sunday. She said they monitored the resident's blood sugars and contacted the pharmacy. She said the nurse was responsible for observing medication supplies every week and ordering more medication before the resident runs out.

After the nurse interview, the nurse followed up with an email indicating she confused the details of the incident with a previous emergency room (ER) visit. The nurse indicated his previous ER visit was due to the resident refusing to take insulin. The nurse gave a synopsis of the events documented in the resident's record. Additionally, the nurse provided the ULP notes not previously provided during the onsite visit, however the ULP notes were of only the day the

facility received the insulin prescription and not of the previous days, including when the insulin supply ran out.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
“Substantiated” means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
“Neglect” means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

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

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

The facility did not direct an erroneous order, direction, or care plan.

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

The facility failed to provide proper training and/or supervision of staff.

The facility provided adequate staffing levels.

The facility failed to follow the facility directive and/or policies and procedures.

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

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

The maltreatment was not a sudden or foreseen event.

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: No, family was not involved.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility sent the resident to the hospital.

Action taken by the Minnesota Department of Health:

The responsible party will be notified of their right to appeal the maltreatment finding.

The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Hennepin County Attorney
Brooklyn Park City Attorney
Brooklyn Park Police Department
Minnesota Board of Executives for Long Term Services and Supports
Minnesota Board of Nursing

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	35250	A. BUILDING: _____ B. WING _____	C 11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRST CHOICE NURSING SERVICES INC	5500 81ST AVENUE NORTH BROOKLYN PARK, MN 55443

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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: HL352506021C/HL352504642M On November 5, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were four (4) residents receiving services under the provider's Assisted Living license. The following correction orders are issued for HL352506021C/HL352504642M, tag identification 1730, 2320 and 2360.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
01730 SS=G	144G.71 Subd. 5 Individualized medication management plan	01730		

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01730	Continued From page 1 (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing	01730		

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01730	Continued From page 2 medication management. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to identify specific instructions to monitor and order insulin timely and monitor for possible complications for one of one resident (R1) reviewed. R1 had a known history and active noncompliance with insulin administration taking a different amount prescribed. The licensee failed to monitor insulin supply and ran out of insulin for a couple of days, requiring R1 to be hospitalized for high blood sugar. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses include diabetes type I, and depression. R1's service plan dated April 17, 2024, indicated R1 received services including medication administration. R1's service plan indicated R1 received insulin two times per day and unlicensed personnel (ULP) were listed under responsible person for the service. Apart of the service plan, included the medication management plan, dated April 17, 2024. R1 had a history of noncompliance with his insulin, choosing to administer a different amount than ordered. Staff encouraged compliance and updated endocrinology. The medication	01730		

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01730	Continued From page 3 management plan identified the registered nurse (RN) or licensed practical nurse (LPN) responsible for monitoring medication supplies and ensuring medications were refilled timely. Separately, written instructions for insulin administration to R1 dated, September 23, 2019, indicated the policy and procedure steps to administer insulin and not specific to R1. Reasons to notify the nurse listed bruising at the injection site. There was lack of instruction for ULP to monitor for signs/symptoms of hyper/hypoglycemia when R1 was not compliant with the insulin dose and actions to take. A pharmacy prescription fill report dated June 1, 2024 through July 31, 2024, indicated R1's NovoLog Mix 70/30 insulin was fill on June 3, 2024, a 32 day supply (expected to last approximately until July 5, 2024). The report indicated the NovoLog had one additional 32-day refill available. The 32-day insulin refill was not dispensed until July 8, 2024. R1's medication administration record dated July 2024, indicated R1 received NovoLog Mix 70/30 28 units at 8:00 a.m., and 18 units at 5:00 p.m. R1's progress notes dated July 1, 2024 through July 10, 2024, did not include any note regarding R1's insulin supply, medication orders or prescriptions. R1's insulin administration record indicated the following blood sugars and NovoLog insulin received between July 5, 2024 and July 8, 2024, prior to R1's hospitalization on July 9, 2024: July 5, 2024 at 8:00 a.m., R1 received 28 units, blood sugar was 242. July 5, 2024 at 5:00 p.m., R1 received 18 units,	01730		

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01730	Continued From page 4 blood sugar was 156. July 6, 2024 at 8:00 a.m., R1 received 30 units, blood sugar was 333. July 6, 2024, at 5:00 p.m., R1 received 18 units, blood sugar was 427. July 7, 2024, at 8:00 a.m., R1 refused insulin, blood sugar was 124. July 7, 2024, at 12:00 p.m., R1 received 5 units, blood sugar was 271. July 7, 2024, at 5:00 p.m., R1 received 5 units, blood sugar was 366. July 8, 2024, at 8:00 a.m., no insulin was administered, blood sugar was 31. July 8, 2024, at 12:00 p.m., R1 received 30 units, blood sugar was 327. R1's hospital record indicated R1 admitted July 9, 2024, for diabetic ketoacidosis. R1 complained staff failed to check his blood sugars. Emergency medical services (EMS) reported, R1's blood sugars were last documented at noon the day before and no insulin was administered. EMS checked R1's blood sugar and the glucometer read "HIGH." Upon hospital arrival, R1 was agitated, confused, and vomiting. R1's labs indicated R1's blood sugar was 737 gm/dl and R1 admitted to critical care. Pharmacy notes indicated the facility's manager reported they ran out of R1's insulin on July 5, 2024, and were unable to get it filled or provide doses until July 8, 2024. R1 received some insulin July 8, 2024, at an unknown time. The licensee's manager reported staff were unable to provide details on exact dose R1 had been receiving. The licensee's manager reported they offered another resident's insulin supply over the weekend but R1 declined. R1 recovered and was discharged July 12, 2024. R1's medication assessment dated July 12, 2024, indicated during insulin administration, ULP set	01730		

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01730	Continued From page 5 up his insulin, checks the dose, and supervise self injection. The assessment indicated R1 was not compliant with his insulin regimen and administered whatever an insulin dose he wanted, not what was ordered. R1's diabetes assessment dated July 15, 2024, indicated R1 was not compliant with his diabetic medication and took 30 units of insulin instead of the 28 units ordered. There had been no medication changes. Interventions included ongoing encouragement to take the correct amount and to update endocrinology as needed. Symptoms of elevated blood sugar was nausea. R1's medication management plan lacked an update after R1's hospitalization related to failing to order insulin timely and running out of supply. Additionally, no new instructions of medication management were included in records of instruction for ULP to monitor for signs/symptoms of hyper/hypoglycemia when R1 was not compliant with the insulin dose and actions to take. On November 6, 2024, at 2:05 p.m., owner (O)-A stated staff dialed the insulin pen, and R1 administers his dose. O-A stated R1 often changed the dial and administered whatever dose he chose. Sometimes R1 administered more insulin than prescribed. O-A stated because R1 changed the dose, he ran out of insulin and the licensee was unable to obtain more from the pharmacy. R1's blood sugar ran high without insulin, and he was admitted to the hospital. O-A said R1 was without insulin for a couple days. On December 13, 2024, at 3:00 p.m., R1's endocrinologist (END)-G stated she ordered Novolog Mix 70/30 100 units per milliliter, 28 units	01730		

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01730	Continued From page 6 before breakfast and 18 units before supper on May 24, 2024. This insulin had two refills available and should have lasted through July 24, 2024, roughly sixty (60) days. There was a note made in the R1's medical record that indicated O-A called R1's primary care provider and asked for clarification of medications. The following day, June 25, 2024, R1's primary care provider had a phone visit with the facility and wrote a prescription for the same insulin order on paper to be picked up by the facility and brought to any pharmacy. R1 was often noncompliant with his insulin regimen often taking 30 units instead of the prescribed 28 units before breakfast. END-G stated the minor dose adjustment would not cause R1 to run out of insulin this early. On November 8, 2024, 9:56 a.m., R1's primary care provider's licensed practical nurse (LPN)-E said a script for NovoLog Mix 70/30 was sent to the pharmacy on July 7, 2024, per the request of the licensee. On November 8, 2024, at 11:10 a.m., RN-B stated R1 was noncompliant with insulin and takes whatever dose he wants. She said because R1 was noncompliant he ran out of insulin. She said she observed medication supplies weekly and ordered medications before residents run out. She said after R1 ran out of insulin, they called the pharmacy and requested more. The licensee's Medication & Supplies Reordering policy dated February 1, 2023, indicated on a daily basis, medications will be reordered by faxing or calling to request the designated supplier dispatch a refill. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		

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02320 SS=F	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for two of two (R1, R2) when the licensee ran out of R1's insulin and offered to administer R2's insulin to R1. This deficient practice was described by two of two licensed staff and had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1's diagnoses include diabetes type I, and depression. R1's service plan dated April 17, 2024, indicated R1 received services including medication administration. R1's service plan indicated R1 received insulin two times per day and unlicensed personnel (ULP) were listed under responsible person for the service. Apart of	02320		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02320	Continued From page 8 the service plan, included the medication management plan, dated April 17, 2024. R1 had a history of noncompliance with his insulin, choosing to administer a different amount than ordered. Staff encouraged compliance and updated endocrinology. The medication management plan identified the registered nurse (RN) or licensed practical nurse (LPN) responsible for monitoring medication supplies and ensuring medications were refilled timely. R1's physician orders dated July 2024, indicated R1 was prescribed NovoLog Mix 70/30 28 units at 8:00 a.m., and 18 units at 5:00 p.m. R2's diagnoses include diabetes, and depression. R2's careplan dated January 5, 2024, and last reviewed and updated October 14, 2024, indicated require assistance with medication administration. R2's physician orders dated July 2024, indicated R2 was prescribed NovoLog 100 units/milliter (ml) FlexPen on a sliding scale and Basaglar 100 units/ml Kwikpen four units every morning and every evening. According to NovoLog manufacturer website, NovoLog 70/30 mix is a mix of rapid-acting and intermediate acting insulin. NovoLog FlexPen is rapid-acting insulin. R1's hospital record pharmacy notes, dated July 9, 2024, indicated the licensee's manager reported they ran out of R1's insulin on July 5, 2024, and were unable to get it filled or provide doses until July 8, 2024. The licensee's manager reported they offered another resident's insulin supply over the weekend but R1 declined.	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35250	A. BUILDING: _____ B. WING _____	C 11/05/2024

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02320	Continued From page 9 On November 8, 2024, R1's primary care provider's licensed practical nurse (LPN)-E said a script for NovoLog Mix 70/30 was sent to the pharmacy on July 7, 2024, per the request of the licensee. R1's record lacked progress notes between July 3, 2024 through July 9, 2024. R1's progress note dated July 10, 2024, indicated R1 was hospitalized for high blood sugar, but lacked information regarding R1's insulin supply. R1's insulin administration record indicated the following blood sugars and NovoLog insulin received between July 5, 2024 and July 8, 2024, prior to R1's hospitalization on July 9, 2024: July 5, 2024 at 8:00 a.m., R1 received 28 units, blood sugar was 242. July 5, 2024 at 5:00 p.m., R1 received 18 units, blood sugar was 156. July 6, 2024 at 8:00 a.m., R1 received 30 units, blood sugar was 333. July 6, 2024, at 5:00 p.m., R1 received 18 units, blood sugar was 427. July 7, 2024, at 8:00 a.m., R1 refused insulin, blood sugar was 124. July 7, 2024, at 12:00 p.m., R1 received 5 units, blood sugar was 271. July 7, 2024, at 5:00 p.m., R1 received 5 units, blood sugar was 366. July 8, 2024, at 8:00 a.m., no insulin was administered, blood sugar was 31. July 8, 2024, at 12:00 p.m., R1 received 30 units, blood sugar was 327. There was no further record of blood sugar readings or insulin administration until July 12, 2024, R1's return from the hospital. On November 6, 2024, at 2:05 p.m., owner (O)-A stated R1 was sent to the hospital for high blood	02320		

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02320	Continued From page 10 sugars after he ran out of insulin. R1 was without insulin for a couple day when the licensee offered to administer R2's insulin, stating he also received NovoLog. R1 declined R2's insulin. On November 8, 2024, at 11:10 a.m., registered nurse (RN)-B stated R1 was noncompliant with insulin and takes whatever dose he wants. She said because R1 was noncompliant he ran out of insulin. She said she observed medication supplies weekly and ordered medications before residents run out. She said after R1 ran out of insulin, they called the pharmacy and requested more. She said staff monitored R1's blood sugars and offered insulin that belonged to another resident (not R2) at a different home. She said R1 refused the other resident's insulin. She failed to remember the other resident's name but denied they offered R2's insulin citing, they are prescribed different insulin. On December 13, 2024, at 3:00 p.m., R1's endocrinologist (END)-G stated she ordered Novolog Mix 70/30 100 units per milliliter, 28 units before breakfast and 18 units before supper on May 24, 2024. This insulin had one refill available and should have lasted through July 24, 2024, roughly sixty (60) days. There was a note made in the resident's medical record that indicated O-A called R1's primary care provider and asked for clarification of medications. The following day, June 25, 2024, R1's primary care provider had a phone visit with the facility and wrote a prescription for the same insulin order on paper to be picked up by the facility and brought to any pharmacy. R1 was often noncompliant with his insulin regimen often taking 30 units instead of the prescribed 28 units before breakfast. END-G stated the minor dose adjustment would not cause R1 to run out of insulin this early.	02320		

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02320	Continued From page 11 The pharmacy's Prescription Fills Report dated June 1, 2024 through July 31, 2024, indicated a 32-day supply of Novolog Mix 70/30 100 units per milliliter pen was dispensed June 3, 2024. The prescription had one additional 32-day refill available. The 32-day insulin refill was not dispensed until July 8, 2024. The licensee was unable to provide a policy on medication administration and/or setup after requested. The licensee only provided policies on medication documentation and medication reordering. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	There is no plan of correction required for this tag.	