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 #: HL308192908M
Date Concluded: February 16, 2023
Compliance #: HL308194912C

Name, Address, and County of Licensee Investigated:
South Grove Lodge
1701 22nd Avenue SW
Austin, MN, 55912
Mower County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Christine Bluhm, RN
Special Investigator

Finding: Substantiated, facility responsibility

Nature of Visit:
The Minnesota Department of Health investigated allegations 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 Allegations:

Allegation #1: The facility financially exploited the resident when some of the resident's morphine was discovered missing.

Allegation #2: The facility neglected the resident when medication supplies ran out, medications were not filled in a timely manner and the resident went without medications. One time the resident had to wait five hours for her pain medication while on another occasion the resident was given too much morphine.

Allegation #3: The facility abused the resident when an unexplained bruise was found on the resident's ear. The bruise had an appearance of a metal clip used to secure a bed control remote.

Investigative Findings and Conclusion:

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted law enforcement, outside hospice agencies, and multiple residents' family members. The investigation included review of resident records, incidents, and narcotic medication logs. Also, the investigator observed general daily activities, medication administration and documentation records, dining room services, housekeeping activities, and direct resident care during visits to the facility.

The resident resided in an assisted living facility. The resident's diagnoses included heart failure, chronic obstructive pulmonary disease (breathing problems), diabetes, and chronic pain. The resident's service plan included assistance with most activities of daily living and full assistance with medication administration. The resident's most recent assessment indicated the resident had intermittent confusion but able to make her needs known. The resident also received care under hospice services.

Allegation #1:

The Minnesota Department of Health determined financial exploitation was inconclusive. No specific alleged perpetrator could be identified as multiple facility staff members as well as an outside hospice agency had access to the resident's narcotics. A review of the documents available indicated there was no other reports of missing narcotics from other residents' supply. The facility failed to have an effective audit system (narcotics counts) in place to oversee and ensure narcotic medications were counted accurately at the time of the incident. Additionally, a review of the documentation indicated the facility and hospice used multiple ways of recording the narcotics, which may have contributed to a mathematical error in counting the resident's medication, which was attributed to being a missing medication.

A review of hospice agency records indicated the resident had a physician's order for morphine to be given for pain. Hospice nurses visited the resident at the facility and refilled oral syringes with morphine from the prescription bottle kept at the facility. The remaining amount in the bottle was documented in the narcotic record.

In the fall of the year, just prior to the change in ownership, during one visit, a nurse noted the bottle amount did not match the amount remaining in the logbook, a difference of approximately 14 milliliters (mL). Hospice alerted the facility of the discrepancy.

A review of narcotic records indicated the documentation differed from page to page on how the filled syringes were added and subtracted to and from the log record. The same document indicated many pages did not contain verification signatures for the remaining amounts. The page where the suspected missing morphine occurred was reviewed and the documentation was not clear possibly indicative of an error in accounting for morphine stored in oral syringes versus morphine stored in the bottle.

A review of the police report and audio recording made available by law enforcement indicated the former corporate nurse made statements that the value of the unaccounted medication was around $10,000.

During an interview with a former corporate nurse, she stated the facility did not have a nurse, so she traveled from Michigan to assist in the missing morphine investigation. She stated she called police after she collected the information but denied saying the missing medication was worth $10,000. The former corporate nurse stated the resident did not go without the medication and did not believe the missing medications was not reported as a vulnerable adult report for this reason.

This investigator contacted the police department for a quote on the street value but did not receive a response.

The investigator contacted the pharmacist of the pharmacy, which filled the prescription for the morphine who stated the entire 30 mL bottle of morphine cost $28.00 and was paid by the resident's insurance.

The Minnesota Department of Health determined financial exploitation was inconclusive.

In the months following the events described in allegation #1, the facility changed ownership.

Allegation #2:

The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the neglect. While concerns arose regarding the facility's administration of the resident's morphine, there was insufficient evidence to show this resulted in neglect. However, the facility neglected the resident when it failed to provide her medications as prescribed on numerous occasions.

A few months after the new owner took over the facility, the resident's medication administration record (MAR) indicated the facility failed to administer multiple prescribed medications on multiple occasions for multiple sequential months. These same documents indicated these occasions included:

- The facility did not administer one of the resident's inhalers more than 15 times in one month
- The facility did not administer the same inhaler more than 25 times the next month
- The facility did not administer the same inhaler more than 20 times the third month

- The facility did not administer one of the resident's antidepressant medications more than 9 times in one month

- The facility did not administer the same antidepressant medication any days the next month
- The facility did not administer the same antidepressant medication any days the third month

- The facility did not administer the resident's insulin for three days in a row

A review of the resident's medical records indicated the facility either did not document a reason the medication was not administered most of the time, but occasionally listed the medication(s) as out of supply. The same documents did not indicate what efforts the facility took to obtain a supply of medications nor whether the prescriber had been contacted regarding the missed doses.

One evening about six months after the change in ownership, the resident's progress notes indicated the resident waited for pain medications for five hours after requesting them. The same document provided a detailed account relating the resident requested the pain medication at 8:50 p.m. and the facility staff members administered the medication at 9:15 p.m. The same document indicated the resident was having increased difficulty with memory. Additionally, the same note indicated the facility updated hospice and the family.

A review of the resident's medical records indicated the resident consistently received the pain medication at bedtime, around the same time every night.

About two weeks later a concern arose that the resident received too much morphine on one occasion. The facility nurse stated the resident had chronic pain and could not get comfortable, so a hospice visit was requested. The resident's hospice records indicated hospice did not make a visit but rather a caregiver instructed over the phone to give an increased dose of morphine 10 milligrams (mg) instead of the 5 mg. The resident's narcotic administration record indicated the facility administered three doses of 5mg, and three doses of 10 mg were given in an eight-hour period.   The next morning hospice visited, found the resident lethargic, and confused, unable bed to use the restroom, but comfortable and her vital signs were normal. The resident's medical record indicated no further interventions were required and she remained at the facility.

During an interview, the hospice nurse stated the orders came from triage because they could not get her phantom pain under control. She stated the orders were appropriate and not at an overdose level.

During an interview, an interim nurse who previously worked at the facility stated she was brought in to help get caught up on things because the facility was behind on many tasks. She stated she advocated for changes in the pharmacy systems used at the facility. The interim nurse stated when she arrived at the facility much of the staff had quit and the staff members which remained required retraining while new staff also required training and orientation. The

interim nurse stated she worked the floor alongside unlicensed staff and witnessed staff leaving the building before the next shift person came on duty, and therefore narcotic counts did not get done. In response, the nurse stated she taught eight-hour medication classes. If a staff person passed meds, they were required to come and if they did not show up, they were removed from medication pass duties.

The Minnesota Department of Health determined neglect was substantiated.

Allegation #3:

The Minnesota Department of Health determined abuse was inconclusive. The resident did have an injury which appeared suspicious on her ear, but no witnesses could be identified, and the resident did not explain how it occurred.

About nine months after the change in ownership a complaint submitted to the state agency indicated the resident had a dark purple bruise bordered with straight lines on her right ear that was observed during a visit outside the facility.

A review of the resident’s facility record did not identify an incident report or nursing note regarding an injury or bruise on the ear.

A review of a bath skin assessment signed and dated the following day by an unlicensed caregiver and the nurse did not include reference to an injury or bruise to the resident’s ear.

Approximately two days later, the resident discharged and admitted to a new facility.

Approximately two weeks later after the injury was first noticed, the resident's doctor visit note indicated the area, which initially presented as a one-centimeter blackened area, had expanded with surrounding erythema (redness) and cellulitis.

During an interview, a caregiver from the new facility who observed the resident’s ear wound stated it looked like it may have been caused by something like a metal clip used to secure a bed remote. The caregiver stated when the resident was asked how it happened, the resident looked down, avoided eye contact and stated she did not know.

During an interview, the facility nurse stated she had no knowledge of an injury. The nurse stated when the skin assessment was completed, there was nothing there. She stated the family took her out of the facility multiple times and it could have occurred at any time.

The investigator attempted to contact multiple facility staff members who worked around the time period the resident’s ear injury occurred, but these individuals did not respond to the requests for interview.

During an interview, family members stated they believe someone at the facility clipped the metal clasp to the resident's ear. They stated the resident did not remember anything and did not know if it happened after she received morphine. When the resident admitted to the new facility, staff asked the resident during bedtime cares, where she would like her remote clipped and she grabbed her ear and said not on my ear, that would hurt. The family members stated the facility had trouble staffing nurses for months. The family members stated the facility seemed to run out of the resident's medications and not reorder them and one time a facility caregiver told them the resident ran out of insulin. The family members stated there were several meetings with the facility and with hospice trying to get everyone to work together but things did not seem to improve so the resident moved to a different facility.

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.

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.

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;
(2) obtains for the actor or another the performance of services by a third person for the wrongful profit or advantage of the actor or another to the detriment of the vulnerable adult;
(3) acquires possession or control of, or an interest in, funds or property of a vulnerable adult through the use of undue influence, harassment, duress, deception, or fraud; or
(4) forces, compels, coerces, or entices a vulnerable adult against the vulnerable adult's will to perform services for the profit or advantage of another.

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.

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: No, the resident was deceased.
Family/Responsible Party interviewed: Yes. Multiple families were interviewed.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility hired nurses to direct the cares and provided retraining for unlicensed staff members.

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

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

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

You may also call 651-201-4200 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
Mower County Attorney
Austin City Attorney
Austin Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30819	A. BUILDING: ______ B. WING ______	C 11/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH GROVE LODGE SENIOR LIVING	**1701 22ND AVENUE SW AUSTIN, MN 55912**

(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 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: #HL308194912C/#HL308192908M On November 10, 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 68 residents receiving services under the provider ' s Assisted Living license. The following correction orders are issued for # HL308194912C/HL308192908M, tag identification 0620, 0690, 0720, 0730, 1310, 1760, 2360, and 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 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.	
0 620 SS=D	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma	0 620		

Minnesota Department of Health

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0 620	Continued From page 1	0 620		

(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 licensee failed to ensure an allegation of maltreatment was reported to Minnesota Adult Abuse Reporting Center (MARRC) timely for one of two residents (R1) with records reviewed. R1 's morphine supply was short by approximately 13.5 milliliters (mL) during a medication count.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

R1 was admitted on June 22, 2008. R1 had a diagnosis of chronic obstructive pulmonary disease (COPD), heart disease and below the knee amputation with chronic phantom limb pain. R1 ' s record indicated she was on hospice and had a physician 's order for liquid morphine concentrate.

R1's hospice note dated October 26, 2021, indicated a hospice nurse noted a discrepancy of

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0 620	Continued From page 2	0 620		

the morphine amount. A bottle of morphine was short 13.5 milliliters (mL) noted during medication reconciliation.

A police report dated November 2, 2021, indicated police the licensee called the police to report missing liquid morphine. The same document indicated the police interviewed multiple staff members.

During an interview on December 22, 2022, at 2:05 p.m., registered nurse (RN)-A stated she traveled from Michigan to the facility to investigate because the previous nurses had quit and there was not a nurse in the facility. RN-A stated she reported the incident to police. RN-A stated after the incident she spoke with licensee staff members and hospice and directed the staff members to perform a medication reconciliation every time the hospice nurse visited. RN-A stated there was not a lot of oversight from the previous lead nurse, although she quit on her own, it was strongly encouraged. RN-A stated she did not recall the resident experiencing unmanaged pain issues.

During an interview on January 5, 2023, at 3:00 p.m., RN-M stated she requested the switch to solu-tablets (soluble tablets generally used under the tongue) because tablets have less risk of diversion and were easier to count. RN-M stated there was something not right going on there and there were red flags. RN-M stated she spoke with a male administrator during the incident.

An internal investigation report by the licensee was requested but not provided. Although requested, the licensee did not provide the narcotic logbook with the morphine count records from 2021.

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0 620	Continued From page 3 The licensee ' s Controlled Substance policy, effective August 24, 2021, indicated the agency will take all reasonable precautions to eliminate theft, diversion or misuse of controlled substances and will comply with requirements regarding the safe storage of and disposal of these drugs. The same document indicated if controlled drugs are missing, the RN working with the licensed assisted living director (LALD) will investigate and try to determine when the medications went missing. Depending on the circumstances and the result of the investigation, the RN/LALD will decide whether it is appropriate to contact the police and/or the MAARC. The licensee 's Loss or Spillage policy, effective August 24, 2021, indicated when theft or diversion of prescribed medications is suspected, the loss will be investigated, and the appropriate authorities will be contacted. The licensee's Vulnerable Adults and Maltreatment policy dated August 24, 2021, indicated if the incident appears to be suspected abuse, neglect or financial exploitation, a facility designee will immediately make a report to the CEP. "Immediately" means as soon as possible, but no longer than 24 hours from the time knowledge was received an incident occurred. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 620		
0 690 SS=E	144G.43 Subdivision 1 Resident record (a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be	0 690		

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0 690	Continued From page 4 current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure entries in the resident's records were authenticated by the name and title of the person making the entry for four of four residents (R1, R2, R5, R6) with 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). The findings include: R1's medication administration records (MAR)s dated February through September 2022, were not consistently authenticated with the name and title of the person making the entry. R1's progress note dated August 4 & 5, 2022, were not authenticated with the name and title of the person making the entry. R2's progress note dated October 6, 2022, was not authenticated with the name and title of the person making the entry. R5's MARs for months dated February through July 2022, were not authenticated with the name and title of the person making the entry.	0 690		

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0 690	Continued From page 5 R6's progress note dated August 5, 2022, and September 13, 2022, were not authenticated with the name and title of the person making the entry. On November 29, 2022, at approximately 11:45 a.m., registered nurse (RN)-B confirmed that not all entries in the resident records were authenticated with the name and title of the person making the entry. The licensee's Documentation of Medication, Treatment and Therapy Management services dated May 20, 2022, indicated staff will document each task and authenticate with the name and title of person making the entry. When initials are used by persons making the entries in the resident record, the person will authenticate initials with full signature and title. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 690		
0 720 SS=F	144G.43 Subd. 2 Access to records The facility must ensure that the appropriate records are readily available to employees and contractors authorized to access the records. Resident records must be maintained in a manner that allows for timely access, printing, or transmission of the records. The records must be made readily available to the commissioner upon request. This MN Requirement is not met as evidenced by: Based on interview and record review, the	0 720		

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0 720	Continued From page 6 licensee failed to ensure resident records were maintained and MDH surveyor had access to the requested records. The licensee was unable to produce the requested facility records for five of five residents (R1, R2, R3, R4, R5) with 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 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). Findings include: On November 10, 2022, at 3:45 p.m., facility resident records were requested for review for R1, R2, R3, R4 since December 1, 2021. R1 was admitted on R1 was admitted to the facility on June 22, 2008. R1' s diagnoses included heart failure, chronic obstructive pulmonary disease (COPD), diabetes and above the knee amputation with chronic phantom limb pain. The earliest record provided for R1 was an assessment dated April 5, 2022. R1's medical record included a medication administration record (MAR) dated February 2022, which indicated the licensee was administering medications to R1, but no medication management plan was provided. R2 was initially admitted to the facility on April 18, 2018, and re-admitted on June 28, 2022, after a hospitalization and skilled nursing stay. R2' s	0 720		

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0 720	Continued From page 7 diagnosis included Alzheimer' s dementia, heart disease and debility. The earliest record provided was for June 28, 2022, when R2 was re-admitted from a skilled nursing facility. R3 was admitted on May 31, 2021. R3 had a diagnosis of diabetes, chronic kidney disease and depression. The earliest record provided for R3 was a pre-admission assessment dated July 22, 2022. R4 admitted on June 21, 2015. R4 had diagnosis of Alzheimer's, kidney disease and depression. The earliest record provided for R4 was an assessment dated March 10, 2022. On January 20, 2023 at 12:29 p.m.., records for R5 were requested. R5 admitted to the facility on November 19, 2021. R5 's diagnosis included stroke, COPD, respiratory failure, congestive heart failure and chronic kidney disease. The earliest record provided for R5 was an assessment dated February 21, 2022. During an interview on November 29, 2022, at 11:00 a.m., registered nurse (RN)-B stated the previous facility owner took all resident records with them prior to the change in ownership. RN-B stated records from December 2021 and January 2022 were missing under the new ownership.	0 720		

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0 720	Continued From page 8 RN-B stated she started with the licensee in June 2022 and performed chart audits with RN-C, which showed there were documents missing from residents' medical records. The investigation included correspondence dated December 8, 2022 from Licensed Assisted Living Director (LALD)-R stating the change of ownership from Primrose to South Grove Lodge was on December 1, 2021. A policy titled Resident Records, effective date August 24, 2021, indicated assisted living facilities must maintain records for each resident for whom it is providing services. The same documents indicated entries in the records must be current, legible, permanently recorded, dated and authenticated with the name and title of person making the entry. Resident records, written or electronic, must be protected against loss, tampering, or unauthorized disclosure. The community must ensure that the appropriate records are readily available to employees and contractors authorized to access the records. Policy titled Record Security effective date August 24, 2021 indicated resident records will be kept secure and protected against loss, tampering or unauthorized disclosure. TIME PERIOD TO CORRECT: Two (2) Days.	0 720		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident:	0 730		

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0 730	Continued From page 9 (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; (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	0 730		

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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 licensee failed to ensure the resident record included documentation of incidents involving the resident and actions taken in response to the needs of the resident for one of one resident (R1) with record 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 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 admitted to the facility on June 22, 2008. R1's diagnoses included heart failure, chronic obstructive pulmonary disease, diabetes and above the knee amputation with chronic phantom limb pain. R1's service agreement signed July 20, 2022, indicated staff members were to monitor skin daily for redness, bruising, skin tears, abrasions, open areas or any concerns and report immediately to the nurse. Staff members were to document if any concerns were found during the skin check.

A report to the state agency indicated R1 had a dark purple bruise with perfectly straight lines on

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0 730	Continued From page 11 her right ear which was noted on September 21, 2022. R1's medical record did not include an incident report or progress note regarding a bruise on the ear. R1's bath skin assessment signed and dated September 22, 2022, by an unlicensed staff member and signed by registered nurse (RN)-B on September 23, 2022, indicated no issues noted and did not include mention of a bruise on R1's ear. R1 discharged from the facility on September 24, 2022. During interview on November 29, 2022, at 11:45 a.m., RN-B stated she had no knowledge of an injury. RN-B stated when the skin assessment was completed, there was nothing there. RN-B stated family did take her out multiple times at the end all day long and only bring her back at night and it could have occurred at any time. Time period for correction: Twenty-one (21) days	0 730		
01310 SS=F	144G.60 Subd. 3 Licensed health professionals and nurses (a) Licensed health professionals and nurses providing services as employees of a licensed facility must possess a current Minnesota license or registration to practice. (b) Licensed health professionals and registered nurses must be competent in assessing resident needs, planning appropriate services to meet resident needs, implementing services, and supervising staff if assigned.	01310		

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01310	Continued From page 12 (c) Nothing in this section limits or expands the rights of nurses or licensed health professionals to provide services within the scope of their licenses or registrations, as provided by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a Minnesota licensed registered nurse (RN) was available to provide oversight to staff and residents. Also, the licensee failed to document RN-N's training and orientation. This had the potential to affect all residents, staff and families. 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). Findings include: Email correspondence dated January 12, 2023, licensed assisted living director (LALD)-R provided a list of RN 's in the building since the change of ownership on December 1, 2021. RN-N, 1/10/2022 - 4/17/2022 RN-C, 3/28/2022 - 6/9/2022 RN-B, 6/6/2022 - Present Email correspondence dated January 13, 2023, LALD-R indicated the facility lacked a clinical nurse supervisor at the time of the transition from the previous owner to the current owner, but there was 24/7 on-call nurse coverage from a	01310		

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regional nurse.

A review of the Minnesota Board of Nursing website on January 13, 2023, indicated the regional nurse did not hold a Minnesota nurse license.

Review of RN-N's employee file contained a one-page document titled Religious Accommodation Request form, signed, and dated by RN-N on March 17, 2022. The licensee provided no other documentation to validate RN-N had orientation or required training on hire.

During interview on January 11, 2023, at 10:00 a.m., RN-C stated she was asked to help out the facility. RN-C stated RN-N said she was drowning and did not know what to do.

During interview on January 11, 2023 at 1:15 p.m., unlicensed personnel (ULP)-S stated the facility nurse left in September 2021 and the previous owner of the facility did not find a new nurse. ULP-S stated new ownership took over and a new nurse started but this new nurse was inexperienced. ULP-S stated that nurse left and again the facility had no nurse.

During interview on January 16, 2023, at 3:27 p.m., ULP-K stated there was no nurse for a period of time employed at the facility. ULP-K stated employees felt "thrown under the bus" and family members of residents were concerned. ULP-K stated the director told staff to bring concerns to him because the facility had no nurse. ULP-K stated the employees tried to keep track of medications and provided cares to residents without proper training.

The licensee-provided policy titled Staffing

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01310	Continued From page 14 Requirements, Training and Competency Evaluations dated August 24, 2021, indicated it is required a clinical nurse supervisor who is a registered nurse licensed to practice in Minnesota to lead and provide oversight to the provision of direct care and clinical services. Licensed health professionals must possess a current Minnesota license or registration. The licensee's Uniform Disclosure of Assisted Living Services & Amenities (UDALSA) dated October 28, 2022, licensed staff are either in the building, an attached building or within the campus and available to respond to resident requests 24/7 is marked as applicable. The same document indicated a registered nurse on-site "full time". TIME PERIOD FOR CORRECTION: Seven (7) days.	01310		
01760 SS=H	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.	01760		

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This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure each medication administered by the facility was appropriately documented in the medication administration record (MAR), administered as prescribed, reordered timely to ensure availability, and when not administered as prescribed, documentation included the reason why and follow-up procedures that were provided to meet the resident's needs for three of four residents (R1, R2, R5) with records reviewed.

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 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:

R1

R1 was admitted to the facility on June 22, 2008. R1 's diagnoses included heart failure, chronic obstructive pulmonary disease (COPD), diabetes and above the knee amputation with chronic phantom limb pain. R1 service plan, dated April 5, 2022, indicated R1 had an order for the licensee to assist with medications and met a level 2: complex medication greater than three med passes. An individual medication management plan dated July 20, 2022, was provided and

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indicated R1 medication services were provided four times a day by a registered nurse (RN) and/or unlicensed person.

R1 ' s MAR dated February 2022 indicated the following medications were not administered:

Budesonide/Formoterol Aerosol 80-4.5 micrograms (mcg); inhale two puffs by mouth twice daily- not administered on February 1, 9, 11, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, and 28.
Lactulose solution 10 gram (gm)/15 milliliters (mL); take 7.5 mL by mouth once daily- not administered on February 5, 6, 13, and 14.

R1 's MAR dated March 2022 indicated the following medications were not administered:

Budesonide/Formoterol Aerosol 80-4.5 mcg; inhale two puffs by mouth twice daily- not administered on March 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 and 31.
Lactulose solution 10 gm/15mL; take 7.5 mL by mouth once daily- not administered on March 29 and 30.
Nadolol 20 mg tab; take one tab by mouth daily- not administered on March 6 and 9.
Sertraline 25 mg tab; take one tab by mouth daily- not administered on March 21, 22, 23, 24, 25, 26, 27, 28, 30, and 31.
Basaglar injection 100 unit; inject 15 units subcutaneously every morning and 13 units every night at bedtime- not administered on March 7, 8 and 9.

R1 's MAR dated April 2022 indicated the

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following medications were not administered.

Budesonide/Formoterol Aerosol 80-4.5 mcg; inhale two puffs by mouth twice daily- not administered on April 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21 and 22.
Sertraline 25 mg tab; take one tab by mouth daily- not administered all days of the month and the entry is crossed out and labeled discontinued. Under reason not given indicated "out of supply."

R1 's MAR dated May 2022 indicated the following medications were not administered:

Sertraline 25 mg tab; take one tab by mouth daily. Entries are blank for the entire month, without initials or reason why the med was not given.
Lactulose solution 10mg/15; take 7.5 mL by mouth once daily- not administered on May 24, 25, 26, 27, 28, 29 and 30.
R1 's MAR dated June 2022 indicated the Sertraline was documented out of supply and then discontinued by hospice on June 6, and the Budesonide-Formoterol 80-4.5 was documented out of supply and then discontinued on June 10.

All monthly MAR records lacked a signature and title of the person who documented under the medication and entries did not contain a reason why not given other than out of supply.

R2

R2 ' s medical record was reviewed. R2 was initially admitted to the facility on April 18, 2018 and re-admitted on June 28, 2022. R2 's diagnosis included Alzheimer 's dementia, heart disease, atrial fibrillation and debility. R2 's

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service plan, and individualized medication management plan dated July 14, 2022, indicated R2 required assistance with medication management.

Seven of R2 's MAR documents reviewed lacked the name of the month of administration on the document.

Review of R2 's MAR dated April 2022 indicated the following medications were not administered:

Lidocaine patch 5%; apply one patch topically once daily, on for 12 hours and off for 12 hours-not administered on April 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, and 30.
Gavilax mix 17 grams in 4-8 oz water or juice and drink daily- not administered on April 7, 8, 9, 10, 11, 12, 13, and 15.
Alendronate tab po 70 mg; take one tab on Thursday, on an empty stomach with a full glass of water, remain upright for 30 minutes-not administered on April 7, 14, 21, and 28.

R2's MAR dated May 2022 indicated the following medications were not administered:

Acetaminophen 500 mg caplets, take two caps by mouth every eight hours for pain - not administered on May 8, 12, 17, and 26.
Alendronate tab po 70 mg; take one tab on Thursday, on an empty stomach with a full glass of water, remain upright for 30 minutes-not administered on May 5, 12.
Buspirone 10 mg tab, take one tab by mouth twice daily- evening dose not administered on May 7, 8, 12, 17, and 26.

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Eliquis tab 2.5 mg, take one tablet twice daily - not administered on May 7, 8, 12, 17, 26, 27, and 28.
Lidocaine 5% patch; apply one patch topically once daily, on for 12 hours and off for 12 hours - not administered on May 24, 27 and 28.
Melatonin 3 mg tab, take one tab every night at bedtime - not administered May 7, 8, 12, 17, 26, 27, and 28.
Memantine tab 10 mg; take one tab by mouth twice daily - not administered May 7, 8, 12, 17, 26, 27, and 28.
Metoprolol Tartrate tab 25 mg, take ½ tab twice daily by mouth - not administered on evening May 7, 8, 12, 26, 27, and 28.
Prenatal vitamin; take 1 tab by mouth daily- not administered on May 7, 8, 10, 11, 12, 17, 20, 25, 26, 27, and 28.
Tramadol HCL 50mg tab, take ½ tab by mouth three times a day - not administered on evening May 7, 8, 9, 12, 17, 24, 26, 27, and 28.

R2 's MAR dated June indicated R2 was in the hospital.

R2's MAR dated July 2022 indicated the following medications were not administered:

Polyethylene glycol 3350; mix one capful in liquid and take by mouth daily - not administered on July 1, 2, 3, 4 (reason given "out of med"), 5, 6, 7, 8, 11, 20 (reason given "out of med"), 21 (reason given "out of med"), 22, 23, and 31.
Acetaminophen 500 mg, take two tabs by mouth every 8 hours - not administered on July 22, 23, 24, (reason given "out of med, need to reorder").

All MAR records reviewed lacked a signature and

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title of the person who documented under the medication.

R5

R5 was admitted to the facility on November 19, 2021. R2 's diagnosis included stroke, atrial fibrillation, COPD, resp failure, congestive heart failure and chronic kidney disease. R5 's service plan dated June 30,2022, indicated R5 had an order for the licensee to administer medications. R5 was assessed to be at a level two: medication pass greater than three times daily.

R5 ' s MAR dated February 2022 indicated the following medications were not administered:

Divalproex 250 mg tab ER; take five tabs by mouth at bedtime- not administered on February 27 and 28, reason given "out of supply/need reorder."
Metoprolol Tartrate 50 mg tab; take three tabs by mouth twice daily- not administered on February 13, 14, 15, 16, 17, 26, 27, and 28.

R5 ' s MAR dated June 2022 indicated the following medications were not administered:

Acetaminophen 500 mg, take two tabs by mouth two times a day - not administered on June 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, and 30. Entries under reason not given on June 20 and 30, indicated "no supply/reordered."
Diltiazem ER 120 mg take one capsule by mouth once daily - not administered on 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, and 30. Entres under reason not given on June 16 and 30, indicated "no supply/reordered."

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	30819	A. BUILDING: ____ B. WING ____	C 11/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH GROVE LODGE SENIOR LIVING	**1701 22ND AVENUE SW AUSTIN, MN 55912**

(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
01760	Continued From page 21 Eliquis 5 mg tab, take one tablet by mouth two times a day- not administered on June 16, 17, 18, 19, 20, and 21. Metoprolol tart 50 mg tab, take three tab by mouth once daily- not administered on 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, and 30. Rosuvastatin 20 mg tab, take one tablet by mouth once daily - not administered on 22, 23, 24, 25, 26, 27, 28, 29, and 30. One entry under reason not given on June 30, indicated "no supply/reordered." Sensi-Care moist apply to affected area on low back two times a day- not applied on June 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, and 30. Progress note dated July 16, 2022 by RN-B, indicated R5 was transferred via ambulance to the hospital after complaining of shortness of breath and decreased ability to complete ADLs. All MAR records lacked a signature and title of the person who documented under the medication. During an interview on November 29, 2022, at 11:00 a.m., RN-B confirmed that MARS from December 2021 and January 2022 could not be found. RN-B confirmed that MARS from February 2022 to June 2022 contained incomplete and/or circled entries. RN-B could not comment on why medications were out of supply or not given prior to her start in June. RN-B stated that a circled initialed entry may have meant either a resident refused a medication or went out with family and refused to take meds with them. RN-B stated staff are educated and were to document on the MAR as to why the medication was not given.	01760		

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RN-B stated there was corrective action for those who do not follow policy. RN-B stated a medication error could be any time there is a hole in the MAR indicating a missed medication, a med given by the wrong route or wrong time. RN-B confirmed that there was no record of medication errors or incidents that contained this information prior to the start of her role at the facility and she could not comment on if it was a pharmacy refill related issue.

A website review performed on February 9, 2023, at 1:10 p.m. https://www.eliquis.bmscustomerconnect.com/afib/faq indicated the following Some important safety information to know about ELIQUIS is: (1) Do not stop taking ELIQUIS without talking to the doctor who prescribed it for you. For patients taking ELIQUIS for atrial fibrillation: stopping ELIQUIS increases your risk of having a stroke.

The licensee's policy titled, Medication Errors, dated November 1, 2014, indicated medication administration or assistance will be provided to residents in a manner that is safe and consistently free of errors. Staff members who commit medication errors will receive appropriate re-training, and disciplinary action as indicated. A medication error will be defined as: A. The wrong medication given, B. Medication given to the wrong resident, C. The wrong dosage given, D. A missed dose of medication, E. Medication given at the wrong time, F. Medication given by the wrong route, G. Medication mixed or prepared incorrectly, H. Missed documentation.

TIME PERIOD TO CORRECT: Seven (7) days.

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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. 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	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	
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	03000		

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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 (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 licensee failed to ensure an allegation of maltreatment was reported to Minnesota Adult Abuse Reporting Center (MARRC) timely for one of two residents (R1) with records reviewed. R1 's morphine supply was short by approximately 13.5 milliliters (mL) during a medication count.

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This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

R1 was admitted on June 22, 2008. R1 had a diagnosis of chronic obstructive pulmonary disease (COPD), heart disease and below the knee amputation with chronic phantom limb pain. R1 ' s record indicated she was on hospice and had a physician 's order for liquid morphine concentrate.

R1's hospice note dated October 26, 2021, indicated a hospice nurse noted a discrepancy of the morphine amount. A bottle of morphine was short 13.5 milliliters (mL) noted during medication reconciliation.

A police report dated November 2, 2021, indicated police the licensee called the police to report missing liquid morphine. The same document indicated the police interviewed multiple staff members.

During an interview on December 22, 2022, at 2:05 p.m., registered nurse (RN)-A stated she traveled from Michigan to the facility to investigate because the previous nurses had quit and there was not a nurse in the facility. RN-A stated she reported the incident to police. RN-A stated after

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the incident she spoke with licensee staff members and hospice and directed the staff members to perform a medication reconciliation every time the hospice nurse visited. RN-A stated there was not a lot of oversight from the previous lead nurse, although she quit on her own, it was strongly encouraged. RN-A stated she did not recall the resident experiencing unmanaged pain issues.

During an interview on January 5, 2023, at 3:00 p.m., RN-M stated she requested the switch to solu-tablets (soluble tablets generally used under the tongue) because tablets have less risk of diversion and were easier to count. RN-M stated there was something not right going on there and there were red flags. RN-M stated she spoke with a male administrator during the incident.

An internal investigation report by the licensee was requested but not provided. Although requested, the licensee did not provide the narcotic logbook with the morphine count records from 2021.

The licensee ' s Controlled Substance policy, effective August 24, 2021, indicated the agency will take all reasonable precautions to eliminate theft, diversion or misuse of controlled substances and will comply with requirements regarding the safe storage of and disposal of these drugs. The same document indicated if controlled drugs are missing, the RN working with the licensed assisted living director (LALD) will investigate and try to determine when the medications went missing. Depending on the circumstances and the result of the investigation, the RN/LALD will decide whether it is appropriate to contact the police and/or the MAARC.

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03000	Continued From page 27 The licensee 's Loss or Spillage policy, effective August 24, 2021, indicated when theft or diversion of prescribed medications is suspected, the loss will be investigated, and the appropriate authorities will be contacted. The licensee's Vulnerable Adults and Maltreatment policy dated August 24, 2021, indicated if the incident appears to be suspected abuse, neglect or financial exploitation, a facility designee will immediately make a report to the CEP. "Immediately" means as soon as possible, but no longer than 24 hours from the time knowledge was received an incident occurred. TIME PERIOD FOR CORRECTION: Seven (7) days.	03000		