Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL373629342M
Compliance #: HL373628201C

Date Concluded: May 13, 2025

Name, Address, and County of Licensee Investigated:
Brooklyn Park Assisted Living
7711 Humboldt Avenue North
Brooklyn Park, MN 55444
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Peggy Boeck, 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 gave the resident more morphine than the doctor prescribed which resulted in respiratory depression and decreased level of consciousness. The resident required Narcan to reverse the morphine effects and hospitalization for several months.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility received both liquid morphine and quick dissolving tablets of morphine. The facility failed to monitor the liquid morphine and had inaccurate documentation of the tablet morphine. The facility provided undocumented doses of morphine, and the resident became unresponsive. Hospital records indicated (based on lab work) the doctors suspected the resident had poor intake in the three days she was at the facility, developed an acute kidney injury, and when received morphine led to respiratory depression. The hospital also concluded via imaging that the resident may have had a stroke

sometime since 2018 but could not determine when it happened. The facility had no record of the resident's intake, and at least one unaccounted dose of a morphine tablet and no accounting of the resident's liquid morphine.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family, hospice, and a case worker. The investigation included review of the resident records, hospital records, facility incident reports, staff schedules, related facility policy and procedures. Also, the investigator observed the facility and staff/resident interactions.

The resident lived in an assisted living facility due to diagnoses that included respiratory failure, obstructive sleep apnea, and heart failure. The resident's service plan included assistance with medication administration four times per day, vital signs three times per day, toileting six times per day, and assistance of two staff for repositioning 12 times per day. The resident also received hospice services from an outside agency. The resident's assessment indicated she required staff assistance with taking all forms of medications due to physical and medical needs.

A progress note indicated the resident admitted to the facility from the hospital. The note indicated the resident was admitted to hospice the same day. The note indicated hospice provided comfort medications (including morphine quick dissolve tablets, lorazepam for anxiety, and Haldol for agitation/nausea).

Medication orders indicated hospice ordered morphine 5 mg quick dissolve tablets, give one every hour as needed for pain and/or air hunger.

Narcotic documentation indicated the facility received 30 quick dissolve tablets and the resident received one tablet within 15 minutes of receipt of the tablets.

A progress note indicated a nurse received an order later that evening to give the resident a dose of liquid morphine (5mg/0.25 ml) for pain as the quick dissolve tablets were not present (the nurse could not find them).

The facility had no narcotic documentation of facility receipt of, or how many doses of the liquid morphine were given to the resident.

Progress notes indicated the resident received one 5 mg dose of the quick dissolve tablets on each of the next two mornings.

Narcotic documentation indicated the facility used four of the quick dissolve tablets of morphine for the resident (not three as noted in progress notes.)

A progress note indicated the next evening the resident appeared tired, was not responding to verbal commands, had no interest in food, and had difficulty swallowing so they notified hospice.

Hospice records indicated the arriving nurse found the resident in respiratory distress, with decreased level of consciousness, and only responded to pain so the nurse called 911.

Ambulance records indicated the resident received 10 mg of morphine per documentation and had a respiratory rate of 8 breaths per minute (normal rate is 12-20 breaths per minute). The paramedics gave the resident a dose of Narcan (a medication that reverses morphine overdose) and the resident showed improvement. The paramedics gave the resident a second dose of Narcan and transported her to the hospital.

Hospital records indicated the resident had expressed desire for full resuscitative care and was placed on a ventilator for a week. The resident remained in the hospital for two months and remained there at the time of the investigation.

During an interview, an administrative staff stated he believed another resident received one dose of the resident's morphine tabs, but the facility did not investigate. The administrative staff stated documentation indicated the resident received at least one dose of the liquid morphine, but the facility had no documentation of monitoring of the liquid morphine upon receipt, as it was given, or how/if/or when the facility destroyed the liquid morphine.

During an interview, a hospice nurse stated she arrived at the facility to find the resident in her bed, unresponsive with diminishing vital signs. The nurse stated the staff present were unable to determine what medication the resident received so the nurse counted the quick dissolve morphine, and two tablets had been removed that day.

During an interview a hospice case manager stated the liquid morphine came with the resident from the hospital when she admitted to the facility. The case manager said a facility nurse could not find the quick dissolve tablets, so asked for an order to use the liquid morphine which came with the resident from the hospital.

The resident and her family member were interviewed. The family member stated the resident could talk the first day at the facility, but after they kept giving her medication, she just slept. The family member stated staff told him the resident would receive morphine every six hours. The family member stated on the third day, "she [resident] was out," so hospice called an ambulance. The family member stated he and the resident had talked about resuscitation, so he was glad he was there to make sure they brought her back. The resident stated she did not remember anything.

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.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility looked into the morphine counts and changed their process to documenting on paper moving forward.

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
Hennepin County Attorney
Brooklyn Park City Attorney
Brooklyn Park Police Department
Board of Executives for long-Term Services and Supports

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37362	A. BUILDING: _____ B. WING _____	C 04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKLYN PARK ASSISTED LIVING	7711 HUMBOLDT AVENUE NORTH BROOKLYN PARK, MN 55444

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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: #HL373628201C/ #HL373629342M; #HL373629062C/ #HL373629683M On April 3,2025, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 26 residents receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL373628201C/#HL373629342M; #HL373629062C/HL373629683M, tag identification 0495, 1690, 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.	
0 495 SS=G	144G.41 Subdivision. 1 (13) Minimum Requirements	0 495		

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0 495	Continued From page 1 (13) provide staff access to an on-call registered nurse 24 hours per day, seven days per week. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure a registered nurse (RN) was available for consult for one of one residents (R2) reviewed for maltreatment when the facility assigned the lead licensed practical nurse (LPN-A) to provide independent on-call duties and complete change in condition and self-administration of medications assessments. 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). Findings include: R2 admitted to the facility on May 6, 2024, due to diagnoses that included stroke with paralysis of left side, complete below the knee amputations of both legs, insulin dependent diabetes, acute renal failure (undergoing dialysis three times per week). R2's Individualized Medication Management Plan dated January 21, 2025, indicated "Med self-admin is not applicable" and answered "no" to question "In summary, may self-administer medication safely?". The plan indicated the facility securely stored all R2's controlled substances in two separate keyed locks in the medication cart.	0 495		

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0 495	Continued From page 2 R2 required full help with bathing/showering, dressing, toileting, transferred with a full mechanical lift, and was dependent on a wheelchair for mobility. R2's progress note dated March 14, 2025, at 6:34 a.m. indicated R2 blood glucose level was 500 (normal level 70-110). The note indicated R2 told the staff he had a new order for Lantus 15 units, so would not take Lantus 10 units. The note indicated the staff could not reach the director of nursing. R2's progress note dated March 21, 2025, at 11:20 a.m. written by LPN-A indicated "Writer asked resident [R1] to call DON [director of nursing] phone if anything arises over the weekend and not to call [assisted living director in residence/acting director of nursing (DIR/DON) -K)]." R2's progress note dated March 26, 2025, at 12:38 p.m. written by LPN-A indicated "resident was evaluated by nurse in reference to having meds and insulin in his possession, he is very aware of his orders and how to give med, he demonstrated to this nurse with [DIR/DON-K] approval that he is able to maintain these meds himself, nurse gave resident his Lantus, NovoLog, Ventolin inhaler and nitro[glycerine] tabs to keep on his person. Nurse will monitor his use and follow progress. New Dexcom7 sensor placed." The documentation failed to indicated the acting director of nursing was consulted. R2's progress note dated March 27, 2025, at 2:51 a.m. written by LPN-A indicated "Writer received call at 2am re[guarding] insomnia med, writer checked and med was on hold. According to	0 495		

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0 495	Continued From page 3 current d/c [discharge] papers from HCMC this med is no longer on hold. Pt[R2] was asking for med and med was authorized by this nurse to give, and hold was removed. Nurse on duty made aware of same" The documentation failed to indicate the acting director of nursing was consulted or contacted. R2's progress note dated April 2, 2025, at 3:29 p.m. indicated R1 complained of shortness of breath, requested oxygen. Staff informed R2 he had no order for oxygen, so needed an emergency department visit. When R2 refused, staff called "Nurse Manager" [LPN-A] and "she told writer to send [R2] to the ER". The documentation failed to indicate the acting director of nursing was consulted or contacted. During an interview on April 3, 2025, at 12:15 p.m. LPN-A stated the former director of nursing left the facility the day after LPN-A began to work at the facility. LPN-A stated DIR/DON-K assigned her responsibility for the DON phone and role of on-call nurse. LPN-A stated the facility did not have an on-call schedule, as staff call the "DON phone" which she was assigned to carry. During an interview on April 15, 2025, at 1:36 p.m. unlicensed personnel (ULP)-H stated LPN-A was the "head nurse" and was "always on call." During an interview on April 17, 2025, at 8:32 a.m. DIR/DON-K stated R2 returned from the hospital with controlled substances (Oxycontin and Xanax) that the facility did not count or monitor. DIR/DON-K stated he was aware LPN-A assessed R2's ability to self-administer medications as it was a change for R2, but did not document the assessment. DIR/DON-K stated he made a bad decision to assign LPN-A	0 495		

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0 495	Continued From page 4 to take responsibility for the DON on-call phone and conduct assessments without having a discussion about expectations and clarifying what were appropriate tasks for LPN-A within her scope of practice. During an interview on April 22, 2025, at 9:00 a.m. former director of nursing (DON)-N stated the facility hired LPN-A to cover supervisory duties until they could find a new director of nursing. DON-N stated LPN-A previously worked at the facility and knew the processes to guide the unlicensed personnel. The Licensed Practical Nurse 3-Lead position description (undated) indicated the position was responsible for leading and assisting with special projects outside of the normal scope as assigned by the Licensed Assisted Living Director/Operations Manager and Director of Nursing. The Medication and Treatment Orders - Implementing policy dated August 14, 2024, indicated "An RN is on call 24 hours per day, 7 days per week." The Staffing On-Call Rotation policy dated September 29, 2023, indicated the site DON would cover 24 hours per day or delegate to another registered nurse or another director of nursing. The Initial and On-going Assessment of Residents' policy dated August 13, 2024, indicated an RN would complete a comprehensive nursing assessment of a resident with a change in condition. TIME PERIOD FOR CORRECTION: 7 (Seven)	0 495		

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0 495	Continued From page 5 Days	0 495		
01690 SS=G	144G.71 Subdivision 1 Medication management services (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced	01690		

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01690	Continued From page 6 by: Based on interview and document review, the licensee failed to implement medication policies for two of two residents (R1 and R2) reviewed for medication errors. Harm occurred when R1 was found unresponsive and required Narcan (a medication that reverses opioid overdose) and hospitalization after receiving undocumented dose/doses of morphine. Potential for harm occurred when the facility failed to ensure documentation of R2's sliding scale insulin doses and when the facility allowed R2 to carry controlled substances unmonitored. 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). Findings include: R1 R1 admitted to the facility on February 10, 2025, due to diagnoses that included respiratory failure, pulmonary hypertension, heart failure, and obesity. R1's service plan indicated R1's services included medication administration and total assistance with eating five times per day. R1's record indicated she received services from an outside hospice agency.	01690		

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01690	Continued From page 7 R1's hospice admission medication orders dated February 10, 2025, included the following: Discontinue liquid morphine. Morphine 5 milligram (mg) solutab every one hour as needed for pain and/or air hunger. R1's Physician Order Form dated February 10, 2025, indicated "Okay to give dose of liquid morphine 20 mg/milliliter (ml) 5 mg (0.25 ml) to help with pain, as solutab not present." R1's medication administration record (MAR) dated February 2025, indicated R1 received the following: February 11, 2025, at 12:17 a.m.- 5 mg morphine solutab. February 11, 2025, at 1:32 p.m. - 0.25 ml of liquid Morphine. February 12, 2025, at 9:43 a.m.- 5 mg morphine solutab. February 13, 2025, at 9:50 a.m.- 5 mg morphine solutab. R1's Pill Count History document dated February 10, 2025, through April 8, 2025, indicated: The facility received 30 solutabs of morphine 5 mg on February 11, 2025, at 12:15 a.m. R1 received one solutab morphine 5 mg on February 11, 2025, at 12:17 a.m.: 29 solutabs remaining R1 received one solutab morphine 5 mg on February 12, 2025, at 9:43 a.m.: 28 solutabs remaining R1 received one solutab morphine 5 mg on February 13, 2025, at 9:50 a.m.: 27 solutabs remaining. The Pill Count document indicated the next time staff counted the morphine solutabs was on February 28, 2025, at 7:06 a.m. with 26 tabs remaining.	01690		

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01690	Continued From page 8 The facility provided photo of R1's morphine solutabs medication card showed four solutabs removed. The facility provided no documentation of the fourth morphine solutab or an investigation of the incident. The facility had no documentation of receipt of liquid morphine, counts of liquid morphine, or disposal of liquid morphine. R1's SBAR Hospital Handoff document dated February 13, 2025, indicated emergency medical services (EMS) staff found R1 lying supine on her bed with hospice nurse, and family members present. The document indicated assisted living facility staff were not present or able to be found. The note indicated the hospice nurse informed emergency medical services (EMS) staff that she arrived to find R1 with altered mental status and in respiratory distress, so called 911. The document indicated R1 received 10 mg of morphine at 9:50 a.m., and noted dose ordered was 5 mg. The document indicated R1 had pinpoint pupils and a respiratory rate of 8 breaths per minute (normal rate for adults is typically 12 to 20 breaths per minute) so they gave R1 Narcan. The document indicated R1 then became more alert, able to smile, but unable to follow directions. EMS transported R1 and transferred her care to hospital staff. R1's hospital records dated February 13, 2025, indicated R1 had expressed desire for full resuscitative care and was placed on a ventilator for a week, was weaned off and continued hospitalization. As of April 9, 2025, R1 remained hospitalized pending placement in a nursing	01690		

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01690	Continued From page 9 facility. During an interview on April 17, 2025, at 8:32 a.m. assisted living director in resident/acting director of nursing (DIR/DON)-K stated the former director of nursing looked at R1's medications and had no reason to believe R1 received too much morphine. DIR/DON-K viewed and verified the morphine solutab count was off and stated the facility should have done an incident report and investigation. DIR/DON-K stated he did not know where the other tab went or what happened with the liquid morphine. An e-mail received from DIR/DON-K on April 18, 2025, at 12:02 p.m. indicated the facility did not have documentation of liquid morphine being destroyed or an investigation. DIR/DON-K indicated he "found out the resident that received the missing med." DIR/DON-K referenced med count sheets, numbers, and dates (February 14, 2025, and February 18, 2025), but did not identify the resident who allegedly received the fourth dose of morphine or provide documentation. During an interview on April 21, 2025, at 3:10 p.m. hospice registered nurse (HRN)-L stated she was called to the facility by the hospice case manager, as R1 had a change in condition. R1 was full code at the time. She was unresponsive and would only arouse to painful stimuli. HRN-L stated "I was unsure of what medications the facility gave her, so I counted the morphine and compared it to the medication administration record. I saw that there were two tabs of morphine taken out of the bubble pack on that day. I could not get a blood pressure, so I called 911. The EMT's gave her Narcan, she came around a little, and they took her to the hospital."	01690		

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	37362	A. BUILDING: _____ B. WING _____	C 04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKLYN PARK ASSISTED LIVING	7711 HUMBOLDT AVENUE NORTH BROOKLYN PARK, MN 55444

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01690	Continued From page 10 During an interview on April 21, 2025, at 3:30 p.m. hospice case manager/registered nurse (CM/RN)-M stated R1 had enrolled in hospice services so they sent a packet of ordered medications called the comfort kit. CM/RN stated the facility called hospice for medications on the day of admission, as R1 was in a lot of pain. The facility registered nurse stated the facility had not received the morphine solutabs, but did have the liquid morphine that came with the resident from the hospital. CM/RN-M told the registered nurse that she could get an order to give a one-time dose of liquid morphine, which she did. R2 R2 admitted to the facility on May 6, 2024, due to diagnoses that included stroke with paralysis of left side, complete below the knee amputations of both legs, insulin dependent diabetes, acute renal failure (undergoing dialysis three times per week). R2's Individualized Medication Management Plan dated January 21, 2025, indicated "Med self-admin is not applicable" and answered "no" to question "In summary, may self-administer medication safely?". The plan indicated the facility securely stored all R2's controlled substances in two separate keyed locks in the medication cart. R2 required full help with bathing/showering, dressing, toileting, transferred with a full mechanical lift, and was dependent on a wheelchair for mobility. R2's medication administration record (MAR) dated February 2025, provided inconsistencies in charting insulin administration. The MAR indicated R2 self-administered Novolog Flex pen, indicated R2 received insulin Aspart Muv via insulin pump, and indicated staff provided	01690		

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01690	Continued From page 11 NovoLog insulin to R2 per a sliding scale (blood glucose 0-149=no insulin, blood glucose 150-200=give one unit, blood glucose 201-250=give two units, blood glucose 251-300=give three units, blood glucose 301-350=give four units, blood glucose 451-500=give five units, blood glucose greater than 400=give six units.) R2's February MAR did not indicate the amount of insulin given per the sliding scale but noted times and initials of staff providing the injection. R2's hospital record dated February 19, 2025, indicated R2 admitted to the hospital with a complaint of shortness of breath. The record noted R2 stated he did not receive his insulin, missed dialysis and noted his blood glucose level was 777 (normal level between 70 and 110). R2's progress note dated March 21, 2025, at 11:20 a.m. indicated licensed practical nurse (LPN)-A sent a message to R2's provider requesting "self-admin order for all meds and narcotics as well as insulin and blood sugar checks." R2's progress note dated March 28, 2025, at 9:35 a.m. written by LPN-A indicated "New order, OK to keep in room and self-administer insulin, albuterol inhaler, nitro[glycerin], Xanax, limited supply, Oxycodone limited supply added to emar."[Electronic Medication Administration Record] An e-mail dated April 3, 2025, from DIR/DON-K indicated the former director of nursing (DON) completed an investigation of R2's narcotics and concluded "All staff reported appropriately, Meds all matched MARs, Meds were not over given."	01690		

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01690	Continued From page 12 Included was a photo of R2's morphine bubble pack with four tablets of morphine removed. During an interview on April 3, 2025, at 12:15 p.m. licensed practical nurse (LPN)-A stated she assessed R2 as capable of self-administration of insulin, did not fill out an assessment, and informed assisted living director in residence/acting director of nursing (DIR/DON)-K. LPN-A stated R2 was not compliant with reporting his blood sugar (he recently received a continuous glucose monitoring device) or allow staff to observe his glucose level, and was not compliant with showing staff the sliding scale dosage of insulin he was injecting himself with. LPN-A stated when R2 returned from hospital after a stent was placed in his left arm (for dialysis access) he had a supply of Oxycontin (a schedule-II controlled substance narcotic pain medication) and Xanax (a schedule IV controlled substance prescribed for anxiety) he received from the hospital. LPN-A stated R2 would not let her count the number of Oxycontin or Xanax (required by facility policy) or lock them up (required by facility policy). LPN-A stated DIR/DON-F directed her to let R2 keep the Oxycontin and Xanax on his person and "not to worry" about counting them. LPN-A stated the facility did not monitor how and when the resident took the Oxycontin or Xanax. During an interview on April 17, 2025, at 8:32 a.m. DIR/DON-K stated R2 returned from the hospital with controlled substances (Oxycontin and Xanax) that facility did not monitor. DIR/DON-K stated LPN-A assessed R2's ability to self-administer medications and "we were trying to make [R2] happy". DIR/DON stated the facility did not document the "issue" of the scheduled medications in R2's assessment or address it in	01690		

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01690	Continued From page 13 his service plan. DIR/DON-K also stated he did not know where in R2's record staff documented the amount of insulin given per the sliding scale. An e-mail received on April 8, 2025, at 12:02 p.m. from DIR/DON-K indicated "there is no documentation of the number of units. The sliding scale was set up that way in the MAR." The Insulin policy dated September 23, 2020, indicated only properly trained staff may provide medication assistance or administration. The policy indicated staff must be trained by the registered nurse and competency tested by the registered nurse including verification and documentation of dosage. The policy indicated insulin must be administered according to the prescriber's orders. The Medications-Controlled Substances/Schedule II Drugs policy dated August 1, 2022, indicated the facility would take all reasonable precautions to eliminate the theft, diversion, or misuse of controlled substances and would comply with requirements regarding the safe storage and disposal of these drugs. The policy further indicated if the resident's medications were all stored in the resident's room, the registered nurse would develop a different system for verifying the count of controlled medications. The policy also indicated if controlled drugs were missing the clinical nurse supervisor/registered nurse working with the assisted living director would investigate and depending on the circumstances and result of the investigation, decide whether to contact police and/or make a report to the Minnesota adult abuse reporting center. TIME PERIOD FOR CORRECTION: 7(Seven)	01690		

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01690	Continued From page 14 Days	01690		
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 two of two resident(s) reviewed (R1, R2) were 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		