Protecting, Maintaining and Improving the Health of All Minnesotans

Health Regulation Division
Investigative Public Report

Maltreatment Report #: H5024023M

Date Concluded: July 1, 2020

Name, Address, and County of Facility Investigated:
Interfaith Care Center
811 3rd Street
Carlton, MN 55718
Carlton County

Facility Type: Nursing Home

Investigator Name: Jill Hagen, RN, PHN, Special Investigator

Finding: Not Substantiated

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

Allegation(s):
It is alleged: The facility neglected a resident when licensed staff administered insulin prior to the resident's meal and failed to ensure the resident ate the meal. As a result, the resident experienced a low blood sugar and required treatment at a hospital.

Investigative Findings and Conclusion:
Neglect was not substantiated. Although staff administered the insulin, the resident left the facility prior to eating without notifying facility staff. At the time of the incident, staff were following the resident's care planned needs, medication orders, and the facility policies and procedures for the administration of insulin. Following the incident, the resident returned to the facility at the same level of functioning.

The investigation included interviews with facility staff members, including administrative staff and nursing staff. In addition, the investigation included a review of the resident's record, emergency room visit, and review of the facilities policies and procedures.

The resident's diagnoses included insulin dependent diabetes. The resident was capable of making his needs known to staff but required others for decision making. The resident was able to independently walk and frequently spent time on a separate unit visiting his spouse. The resident received Novolog or short acting insulin, eight units three times a day at 8:00 a.m., 12:00 p.m., and 6:00 p.m.

Around noon one day, licensed staff gave the resident his dose of insulin. About one-half hour later, unlicensed staff delivered the resident's meal tray to his room. That day, the resident left the facility with family prior to his meal delivery however, staff were unaware the resident left the facility. While out of the facility, the resident experienced light headedness and dizziness. Emergency services provided the resident with intravenous (IV) glucose or sugar and lemonade. The residents symptoms improved and he returned to the facility the same day at baseline.

When interviewed, management said the resident ate his meals in his room. Staff administered the resident's noon insulin about one-half hour prior to his meal and according to the facility policy. Because the resident spent most of his day on another floor, staff were not aware the resident left the building prior to eating his meal. It was the facility policy for residents and/or family to sign out when leaving the facility. Since that time, the facility revised their policy for the administration of insulin. Staff must ensure the resident received and eating his meal prior to his insulin administration.

In conclusion, neglect was not substantiated. At the time of the incident, staff provided the resident with his assessed and care planned needs and followed the facilities policies and procedures.

"Not Substantiated" means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

Action taken by facility:
The facility revised their policies and procedures to ensure residents that receive insulin have their meal and eating prior to the administration. The facility developed a system to ensure that staff delivering resident meals communicated to licensed staff concerns with meal intake. The facility provided staff education on the policy revisions. The facility completed audits to ensure staff compliance.

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, or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

cc: The Office of Ombudsman for Long-Term Care