Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL202575321M
Compliance #: HL202577303C

Date Concluded: January 13, 2025

Name, Address, and County of Licensee Investigated:
Assisted Living at North Ridge
5500 Boone Avenue North
New Hope, MN 55428
Hennepin County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name: Brooke Anderson, RN
Special Investigator

Finding: Not Substantiated

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 failed to administer the resident's morphine (opioid pain medication) according to physician's orders.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although a medication error occurred, it could not be determined if the error had any adverse effect on the resident. The resident passed away shortly after the error occurred; however, medical providers indicated there was no evidence the error contributed to the resident's death.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted the hospice agency. The investigation included review of the resident record, death records, facility incident reports, personnel files, staff schedules, and related facility policies and procedures. Also, the investigator observed interactions between staff and residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia and atrial fibrillation. The resident's service plan included assistance with medication administration and activities of daily living. The assessment indicated the resident was enrolled in hospice care.

Hospice records from three days prior to the resident's death indicated the resident was agitated and had a weak heart rate. Facility staff administered as-needed medication per hospice instructions and the resident calmed down. While visiting the resident, the hospice nurse wrote orders to increase the resident's morphine dose for additional comfort measures. However, the order was transcribed incorrectly, and the morphine was scheduled for administration every hour and was administered to the resident every one hour.

Hospice records from the day prior to the resident's death, indicated the resident was in bed and comatose. The resident was not responsive to stimuli and passed away the next day.

The resident's death record indicated the resident passed from complications of dementia.

During an interview, the hospice nurse stated the resident was agitated and medication orders were changed. The hospice nurse did not know why the morphine order was crossed out. The hospice nurse stated the orders were handed to a facility nurse who entered them into the computer system for staff. The hospice nurse stated he did not know there was an error with transcription until after the resident passed away. The medical director was consulted about the error, and it was determined the dosing of morphine was not lethal for the resident.

During an interview, a facility nurse recalled the resident was more agitated and hospice wrote new orders. A facility nurse stated she thought she transcribed the order correctly but found out after the resident passed that she had made a mistake with transcription. The nurse stated facility management contacted the medical director who determined the mistake was not detrimental to the resident. After the incident, facility management educated the nurse to double check all transcribed orders.

During an interview a family member stated she was not notified of the medication error.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

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

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: No. Resident was deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility consulted with hospice and the medical provider after the incident.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20257	A. BUILDING: _____ B. WING _____	C 12/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSISTED LIVING AT NORTH RIDGE	5500 BOONE AVENUE NORTH NEW HOPE, MN 55428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL202577303C/#HL202575321M On December 2, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 130 residents receiving services under the provider ' s Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for #HL202577303C/#HL202575321M, tag identification 1760.	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.	

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01760	Continued From page 1	01760		
01760 SS=D	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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to transcribe provider's orders correctly for one of two residents (R1). R1 received morphine every one hour scheduled when the order indicated every hour as needed. R1 passed within 48 hours of the transcription error. In addition, the facility did not deem the transcription error a medication error and no follow up was completed after the error. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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).	01760		

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01760	Continued From page 2 The findings include: R1's diagnoses included dementia and atrial fibrillation. R1's undated service plan indicated R1 received assistance with medication administration and activities of daily living. R1's hospice notes dated August 15, 2024, indicated R1 was agitated. Facility staff had given as needed Haloperidol 0.5 milligrams(mg) 1 tab and Morphine 2.5 mg 1 tab by mouth every 6 hours. Facility staff were instructed to give an as needed dose of Morphine 10 mg and Haloperidol 1 mg. R1's hospice notes indicated R1 was transitional and new medication orders were written by the hospice nurse. R1's orders dated August 15, 2024, indicated 1). discontinue previous morphine. 2). Morphine 5mg solutabs 1 tab by mouth/sublingual every 4 hours which was crossed out. 2). Morphine 1 tab mouth/sublingual every 1 hour as needed. R1's August 2024 medication administration record (MAR) indicated Morphine place and dissolve 5 mg sublingual every hour for pain/shortness of breath/anxiety/restlessness starting on August 15. R1's MAR indicated R1 was given 5 mg Morphine every one hour. R1's MAR indicated the Morphine was scheduled and lacked evidence the order was transcribed as needed as ordered. R1's hospice notes dated August 16, 2024, indicated R1 was lying in bed and comatose. R1 was not responsive to stimuli. R1's hospice notes dated August 17, 2024, indicated R1 was found by family deceased.	01760		

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01760	Continued From page 3 The facility documentation lacked evidence a medication error occurred, lacked evidence of an internal investigation being completed, and that training or education was completed with staff following the incident. During an interview December 2, 2024, 12:54 p.m., unlicensed personnel (ULP)-A stated she had never seen an order to administer medications every hour. ULP-A stated when administering medications, they had an hour before the scheduled time and an hour after to administer the medication however when it was scheduled every hour it became hard to give every hour resulting having to administer two doses at one time. During an interview December 2, 2024, at 1:30 p.m., licensed assisted living director (LALD)-E stated registered nurse (RN)-D, RN-E, and hospice staff met and determined the medication error was not an error and an incident form was not filled out. During an interview December 3, 2024, at 12:48 p.m. registered nurse case manager (RNCM)-C stated on August 15, 2024, R1 had a change in status and RNCM-C wrote new medication orders and provided them to the director of nursing (DON)-D. RNCM-C stated the morning before R1 passed, facility staff called and requested additional Morphine, the need for more would have been inconsistent with the orders he wrote two days prior. When RNCM-C arrived at the facility, staff reported R1 was getting two doses at one time because it was hard to administer the medications every hour. RNCM-C stated when the staff member found R1 deceased she had 2 doses of morphine to give R1 at once. RNCM-C	01760		

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01760	Continued From page 4 looked at R1's MAR and verified the morphine orders were transcribed incorrectly. RNCM-C stated hospice staff discussed the medication error with the hospice medical director who did not feel the morphine given to R1 was a lethal dose. During an interview December 9, 2024, at 3:25 p.m. director of nursing (DON)-D stated she transcribed the order and thought the transcription was done correctly. DON-D stated she later found out it was not transcribed correctly. Facility management consulted with the medical director who indicated the medication error was not detrimental for R1. DON-D stated she thought a medication error form for R1 was completed. DON-D stated facility management verbally educated her to double check when she transcribes orders but denied any formal education was provided to her or other facility staff. DON-D's personnel file lacked evidence education or training was conducted after the incident. The licensee's Medication and Treatment Orders-Implementing policy dated August 2021, indicated upon receipt of a medication order, a licensed nurse must take action to implement the order within 24 hours. The licensee's Medication Error policy dated August 2021, indicated when a medication error occurs staff will document, track, and resolve medication errors. Staff will be retrained if necessary. No further information was provided.	01760		

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01760	Continued From page 5 TIME PERIOD FOR CORRECTION: Seven (7) days	01760		