Protecting, Maintaining and Improving the Health of All Minnesotans

Ma

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL217877666M
Compliance #: HL217874405C

Date Concluded: March 7, 2024

Name, Address, and County of Licensee Investigated:
Sunrise of Edina
7128 France Avenue South
Edina, Minnesota 55435
Hennepin County

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

Evaluator's Name: Danyell Eccleston, 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 they failed to administer the resident's medications as ordered.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to obtain the residents three prescription, mood regulating medications for 16 days, and failed to obtain another mood regulating medication for 42 days. The resident experienced increased anxiety, agitation, and delusions during the time the resident did not receive the prescribed mood regulating medications.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of medical records, staffing

records, and policy. The investigator observed staff members providing care to residents at the facility.

The resident resided in an assisted living facility. The resident's diagnoses included dementia and glaucoma. The resident's service plan included assistance with decision making and medication management. The resident's assessment indicated the resident took psychotropic medications (drugs that affect a person's mental state) that required resident behavior monitoring.

Review of resident medication orders indicated an order for a medicated patch to treat dementia (rivastigmine) to be applied daily, an oral pill (escitalopram oxalate) to treat depression daily at bedtime, an oral pill (olanzapine) to treat agitation daily at bedtime, and eyedrops (latanoprost ophthalmic) to treat glaucoma (pressure that damages the eye nerve) in both eyes daily at bedtime.

Review of the resident's medication administration record indicated the resident did not receive the medicated patch to treat dementia for the first 42 days of admission. The medication administration record also indicated the resident did not receive the medications for depression, agitation, glaucoma 16 of the first 22 days of admission.

Progress notes from the 3rd day of admission indicated the facility contacted the pharmacy regarding the supply of the resident's eyedrops for glaucoma and patch for dementia and the pharmacy informed the facility it was awaiting approval from the resident's power of attorney due to high co-pay.

Progress notes from the 16th day of admission indicated the facility contacted the resident's spouse to inform him the facility was out of the resident's medications and the pharmacy was not sending the medication due to high co-pay. Progress notes the 37th day of admission indicated a family member reported to facility staff concern for the resident because she was experiencing paranoia and notes the 39th day of admission indicated the facility contacted the pharmacy to obtain medications for the resident as soon as possible.

During interview, an unlicensed staff stated during the time in question the resident's mental state changed, and she became highly anxious and delusional.

During interview, a second unlicensed staff stated she informed facility nurses the resident did not have a medication supply. The unlicensed staff stated there were process issues at the facility because staff were told to leave nurses notes regarding medication needs, but nurses would not always read the notes.

During interview, a leadership staff stated during the time of the incident the facility had a "clumsy" medication process between receiving orders and information being sent to pharmacy. The leadership staff stated because of this incident the facility implemented a

process where nurses review a daily report to ensure awareness around medications that were not given as ordered.

During interview, a family member stated the resident would deteriorate to the point of shaking and being severely paranoid and anxious when she didn't receive her prescribed medications. It was "very difficult" for family to witness the resident in such a state.

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: No, resident deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
Facility reviewed the incident and implemented additional processes, such as nurses reviewing daily reports of medications not given, to prevent future occurrences.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

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

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

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

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

cc:

The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Hennepin County Attorney
Edina City Attorney
Edina Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21787	A. BUILDING: _____ B. WING _____	C 01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF EDINA	7128 FRANCE AVENUE SOUTH EDINA, MN 55435

(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: #HL217874405C /#HL217877666M #HL217874542C/ #HL217877668M On January 9, 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 63 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL217874405C/#HL217877666M, and #HL217874542C/#HL217877668M, tag identification 2360.	0 000		
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	02360		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21787	A. BUILDING: _____ B. WING _____	C 01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF EDINA	7128 FRANCE AVENUE SOUTH EDINA, MN 55435

(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
02360	Continued From page 1 covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure two of two residents 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 reports for details.	02360		