Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL257294561M
Compliance #: HL257295661C

Date Concluded: October 21, 2024

Name, Address, and County of Licensee Investigated:
Select Senior Apartment LLC
11350 Martin N Street NW
Coon Rapids, MN 55433
Anoka County

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

Evaluator's Name: Lori Pokela, 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 refill medication and the resident missed six weeks of his anti-psychotic medication. The resident experienced an increase in mental health behaviors and was transported to the hospital for evaluation.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility had no system in place to ensure medication was available to be administered as prescribed. The resident missed 54 doses of his anti-psychotic medication and experienced a mental health crisis.

The investigator conducted interviews with facility staff members, including administrative staff and nursing staff. The investigator contacted case managers, family members, pharmacy representatives, and the psychiatric provider. The investigation included review of the resident

record(s), hospital records, pharmacy records, facility incident reports, personnel files, staff schedules, and related facility policies and procedures.

The resident resided in an assisted living facility. The resident's diagnoses included schizophrenia and tardive dyskinesia (a chronic movement disorder that causes involuntary, repetitive movements in the body). The resident's service plan included assistance with medication management and behavior monitoring. The resident's assessment indicated the resident was alert and oriented to person, place, and time.

The resident was prescribed Risperdal (anti-psychotic medication) twice daily for treatment of Schizophrenia.

Review of the resident's medication administration record (MAR) indicated the resident missed a total of 54 doses over a one month period. Staff documented the medication was not administered as no supply was available.

A review of facility documentation indicated that two weeks prior to the Risperdal supply running out, the pharmacy contacted the facility indicating they needed an updated physician's order before they could refill the Risperdal medication.

There was documentation of action taken by facility staff to fulfill the pharmacy's request or obtain the medication.

After six doses of Risperdal were missed, a medication error form was completed. The medication error form indicated there was no supply of the medication available and a request for an updated order was sent to the resident's psychiatric provider and a voice message was left on the provider's nurse-line.

Despite staff's documented knowledge of the medication not being available, no additional action was taken to obtain the medication. No additional monitoring or assessment of the resident was completed.

Approximately two week later, the pharmacy sent a second request indicating an updated order was needed to refill the Risperdal medication.

There was no documentation available to support that nursing staff followed up on this request.

Approximately one month after the Risperdal medication ran out, facility nursing staff sent the resident to the hospital for a mental health evaluation due to auditory hallucinations and verbalizations of self-harm.

Hospital records indicated the resident experienced worsening psychosis due to not receiving prescribed Risperdal medication for several weeks.

During an interview, the psychiatric provider stated if an order was needed for the medication to be refilled, the facility nurse usually called to request the order. The psychiatric provider could not recall if a request for refill of the Risperdal was sent by the facility.

During an interview, a pharmacy representative stated a request for updated orders was sent to the facility and the psychiatric provider. The pharmacy had no documentation of the facility contacting them about the lack of supply of the medication and made no attempts to obtain a partial refill of the medication while awaiting a response from the provider.

During an interview, facility nursing staff stated they received a text from unlicensed staff three days after the resident's Risperdal was initially out-of-stock. The nursing staff stated a request was sent to the resident's pharmacy to refill the anti-psychotropic medication, but the facility had no documentation of this request.

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, did not respond to requests for interview.
Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
None.

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.

cc:

The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Coon Rapids City Attorney
Anoka County Attorney
Coon Rapids Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25729	A. BUILDING: _____ B. WING _____	C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SELECT SR LVG COON RAPIDS LLC	11350 MARTIN STREET NW COON RAPIDS, MN 55433

(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: #HL257295661C/#HL257294561M On August 14, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. The following correction order is issued/orders are issued for #HL257295661C/#HL257294561M tag identification __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	

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0 000	Continued From page 1	0 000	ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
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. 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	No plan of correction required.	