Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL286052401M
Compliance #: HL286054227C

Date Concluded: April 5, 2023

Name, Address, and County of Licensee Investigated:
Summit Hill Senior Living
1824 Old Hudson Road
St. Paul, MN 55119
Ramsey County

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

Evaluator's Name:
Maerin Renee. RN, Special Investigator
Juliet O'Martins, 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 staff failed to administer the resident's diuretic medication (furosemide) for two weeks. The resident was hospitalized with respiratory distress.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The resident did not receive furosemide (commonly known by the brand name Lasix) for sixteen days and was hospitalized with respiratory failure.

The investigators conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident's facility and hospital medical records, facility medication system, employee training, and facility's policies and procedures. In addition, the investigators observed resident/staff interactions and medication administration.

The resident resided in an assisted living facility. The resident's diagnoses included acute respiratory failure, heart failure, pleural effusion, type 2 diabetes, and high blood pressure. The resident's service plan included assistance with housekeeping, laundry, and medication management.

The facility's internal investigation of the incident indicated the resident was hospitalized for five days for treatment of pleural effusion (fluid buildup on the lungs). The resident returned to the facility with new orders to take one tablet daily of furosemide daily to prevent further fluid buildup in his lungs.

The facility investigation indicated when the resident returned from the hospital, a staff nurse processed the resident's readmission, however, the nurse failed to transcribe the furosemide onto the resident's medication administration record. The facility failed to administer furosemide to the resident for sixteen days. On the sixteenth day without furosemide, the resident was readmitted to the hospital for two days and diagnosed with acute respiratory failure related to diastolic heart failure exacerbation due to pleural effusion.

The resident's facility progress notes indicated several weeks after returning from the hospital the first time, the resident again began to complain of difficulty breathing. At that time, the resident stated he felt like he did before his first hospitalization. The notes indicated the resident was sent back to the hospital with complaints of difficulty breathing and oxygen saturations of 77-81% on room air.

The resident's hospital records indicated the resident was diagnosed with pleural effusion and respiratory failure, which might have been due to not receiving his prescribed furosemide at the facility. The resident was placed on 10 liters of oxygen and given furosemide. A right chest tube was placed, and 1.5 liters of fluid was removed from the resident's lungs. The resident was hospitalized for two days and returned to the facility.

When interviewed, a facility nurse stated when the resident returned from the hospital the first time, she transcribed and set up the resident's medication. The nurse stated she might have become distracted and forgotten to transcribe the furosemide onto the resident's medication administration record. The nurse stated she set up the furosemide for one week for staff to administer. However, staff did not notice the discrepancy in the resident's medication count from one week to the next, so the medication error was missed by all of the staff.

During interview, another facility nurse stated the nurse who set up the resident's medications after his first return from the hospital did not transcribe the furosemide onto the medication administration record. The resident received one week of the furosemide, which the staff nurse had set up per hospital instructions. However, because the nurse did not transcribe the furosemide onto the medication administration record, subsequent medication set-ups by other nurses did not include the furosemide. The nurse also stated staff who administered the

residents' medications did not identify the discrepancy between the resident's medication set-up and the resident's medication administration record. The nurse stated the error should have been caught sooner. Approximately 2-3 weeks later, the resident developed respiratory difficulties again and was readmitted to the hospital.

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, unable.
Family/Responsible Party interviewed: No, the resident is his own guardian.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The nurses were re-educated and the facility implemented new processes on transcribing and communicating new physician orders.

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
Ramsey County Attorney
St. Paul City Attorney
St. Paul Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28605	A. BUILDING: _____ B. WING _____	C 03/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT HILL SENIOR LIVING	1824 OLD HUDSON ROAD SAINT PAUL, MN 55119

(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 LICENSING 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: #HL316754309C/ #HL316752509M On March 7, 2023, 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 92 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL316754309C/#HL316752509M, tag identification 0510 and 2360.	0 000	Minnesota Department of Health is documenting the State Licensing 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 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.	
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and	0 510		

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0 510	Continued From page 1 nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure staff followed infection control standards including cleaning protocols during medication administration and blood glucose checks for two of two residents (R2 and R3), observed for blood sugar checks. This had the potential to affect all residents residing in the facility. 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). Findings Include: R2 resided in the memory care unit with diagnoses including type II diabetes mellitus, hepatic encephalopathy, liver cirrhosis and mild cognitive impairment. R2's service plan dated March 9, 2023, indicated R2 received assistance with medication	0 510		

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0 510	Continued From page 2 administration and management, showers, safety checks, escorts to meals, daily cares, and blood glucose monitoring. During observation on March 7, 2023, at 10:20 a.m., unlicensed personnel (ULP)-A checked R2's blood sugar using a multi-resident blood glucose monitor, then administered R2's eye drops. ULP-A did not remove gloves and perform hand hygiene between both tasks. ULP-A failed to sanitize the multi-resident blood glucose monitor before and after use. R3 resided in the memory care unit with diagnoses including chronic kidney disease, hyperlipidemia, diabetes, bipolar disorder, and hypertension. R3's service plan dated March 9, 2023, indicated R3 received assistance with medication administration and management, escorts to meals, safety checks, blood glucose monitoring, toileting, daily cares, and showers. During observation on March 7, 2023, at 10:28 a.m., ULP-B checked R3's blood sugar using a multi-resident blood glucose monitor. ULP-B failed to sanitize the multi-resident blood glucose monitor before and after use. During an interview on March 7, 2023, at 10:40am, ULP-C stated staff were trained to sanitize multi-resident blood glucose monitors before and after use. During an interview on March 7, 2023, at 2:00 p.m., registered nurse (RN)-D verified multi-resident blood glucose monitors were to be sanitized between each use.	0 510		

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0 510	Continued From page 3 Review of competency training indicated both ULP-A and ULP-B were trained and skill-checked in the task of cleaning and disinfecting blood glucose monitors after use. The facility's Blood Sugar Testing-Shared Equipment Use policy dated August 1, 2021, indicated blood glucose monitors were to be cleaned and disinfected after use. No further information was provided. TIME PERIOD TO CORRECTION: Seven (7) Days	0 510		
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 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 (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	