Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL294436904M
Compliance #: HL294433183C

Date Concluded: August 15, 2023

Name, Address, and County of Licensee Investigated:
Arbor Oaks Senior Living
1640 155th Lane NW
Andover, MN 55304
Anoka County

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

Evaluator's Name: Deb Schillinger, RN
Christine Bluhm, RN
Special Investigators

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:
The facility neglected the resident when new insulin orders were not followed and resulted in the resident's hospitalization for sepsis.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. While a medication error did occur and the resident did not receive her long-acting insulin (a medication which regulates sugar in the blood) for four days, the facility continued to monitor her blood sugar and administer short-acting insulin. Additionally, when the resident developed symptoms of illness, the facility assessed the resident and provided updates to the medical provider.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted the resident's pharmacy and primary care provider. The investigation included a review of facility medical records, hospital

records, staff training and education, and facility policies and procedures. The investigator conducted an onsite visit, toured the facility, and observed staff interactions with residents.

The resident resided in an assisted living facility with dementia care. The resident's diagnoses included diabetes and dementia. The resident received assistance with medication management including blood sugar monitoring and insulin administration. The resident also received assistance with toileting and transferring.

The progress notes indicated the resident received a change in her long-acting insulin, but an error occurred and instead her long-acting insulin was discontinued. The same documents indicated two days later the resident developed back pain, so the facility checked her vital signs, which were normal, and gave her a pain reliever. On the third day the resident developed intermittent abdominal pain and the facility checked her vital signs and updated the medical provider who ordered a urinalysis to screen for infection.

On the fourth day the facility observed the resident's increased weakness and continued back pain, so the facility sent the resident to the hospital. Meanwhile, the facility also discovered the resident's long-acting insulin had been discontinued in error and the resident had not received her long-acting insulin as prescribed. The facility updated the medical provider, the hospital, and the resident's family.

The hospital records indicated the resident was treated for high blood sugars and sepsis (a systemic infection). The same records indicated the resident could only describe back pain and the source of the infection remained unknown at the time of admission to the hospital.

During an interview, the licensed practical nurse (LPN) stated the medication order transcription process was to fax the physician order to the pharmacy where they entered the medication order electronically on the medication administration record (MAR). An alert would then be sent back to the facility for the nurse to review the order, edit with administration times, "acknowledge" the order, and send on via the MAR to the unlicensed staff to administer to the residents. The LPN stated she remembered receiving the order but did not know how the order was discontinued. The LPN stated that when acknowledging the order, she did customize the order and could have inadvertently clicked the wrong box which could have discontinued the order.

During an interview with pharmacy staff, they verified the same medication transcription process as the LPN and stated they had not received an order to discontinue the medication.

During an interview with the registered nurse, there was no process in place to double check for accuracy at the time of the insulin transcription error, but a checklist was instituted after the incident which included a second and third check of the order.

During an interview, the resident's medical provider stated the missed doses of long-acting insulin did not help the resident's health situation but could not say if the missed doses caused the hospitalization since she also developed sepsis.

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.

(c) For purposes of this section, a vulnerable adult is not neglected for the sole reason that:
(5) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult that results in injury or harm, which reasonably requires the care of a physician, and:
(i) the necessary care is provided in a timely fashion as dictated by the condition of the vulnerable adult;
(ii) if after receiving care, the health status of the vulnerable adult can be reasonably expected, as determined by the attending physician, to be restored to the vulnerable adult's preexisting condition;
(iii) the error is not part of a pattern of errors by the individual;
(iv) if in a facility, the error is immediately reported as required under section 626.557, and recorded internally in the facility;
(v) if in a facility, the facility identifies and takes corrective action and implements measures designed to reduce the risk of further occurrence of this error and similar errors; and
(vi) if in a facility, the actions required under items (iv) and (v) are sufficiently documented for review and evaluation by the facility and any applicable licensing, certification, and ombudsman agency.

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

Action taken by facility:

The facility informed the hospital the resident did not receive long-acting insulin for four days. The facility reviewed the policies and procedures in place regarding processing medication orders and implemented a checklist for medication orders with ongoing audits.

Action taken by the Minnesota Department of Health:
No action taken at this time.

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
	29443	A. BUILDING: _____ B. WING _____	C 07/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR OAKS SENIOR LIVING	1640 155TH LANE NW ANDOVER, MN 55304

(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 On July 17, 2023, the Minnesota Department of Health initiated an investigation of complaint #H294436904M/#H294433183C. No correction orders are issued.	0 000		