DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL295369806M
Compliance #: HL29536788C

Date Concluded: April 4, 2024

Name, Address, and County of Licensee Investigated:
Caring Meadows
7723 Brooklyn Boulevard
Brooklyn Park, MN 55443
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Peggy Boeck, 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 Alleged Perpetrator (AP) neglected a resident (#1) when the AP failed to follow medication administration procedure and gave resident #1 medications meant for resident #2. Resident #1 became unresponsive. Resident #1 was hospitalized in the intensive care unit (ICU) and required a ventilator to breathe.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The AP recognized the medication error and immediately notified the required persons. The nurse on site contacted the doctor, and staff monitored the resident overnight as ordered. When resident #1 became unresponsive the next morning, the staff immediately sent him to the hospital where he received treatment. The error was an isolated incident. Resident #1 returned to his baseline health condition and discharged back to the facility approximately one week later. The incident was documented and reported as required. The AP received retraining on medication administration and demonstrated competency.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family members and the resident's doctor. The investigation included review of the resident record, hospital records, facility internal investigation, facility incident reports, personnel files, staff schedules, related facility policy and procedures. Also, the investigator observed staff/resident interactions and staff administering medications.

Resident #1 lived in the assisted living facility due to diagnoses that included bipolar disorder, dementia, Parkinson's disease, and type 2 diabetes. Resident #1's service plan included assistance with bathing, grooming, dressing, meals, hygiene, turning, repositioning, transfers, toileting, housekeeping, laundry, and medication administration.

Resident #2 lived in the assisted living due to mental health diagnoses. Resident #2 services included medication administration.

An incident report indicated a staff called the nurse to the facility to set up bedtime medications for resident #2 who had none set up. The nurse arrived at the facility around 10:00 p.m., set up the medications in a medication planner, and handed bedtime medications to the AP to give to resident #2. The AP heard the nurse say to give the medications to resident #1 and she did. A few minutes later the nurse asked the AP how resident #2 was and they both realized the AP gave the medications to the wrong resident. The report indicated the nurse called the doctor and received orders to check vital signs every two hours.

During an interview, the nurse stated staff called her to the facility to set up bedtime medications for resident #2, which she normally did once per week. The nurse stated she was covering a shift at another house and went to the facility when the next shift came. The nurse stated she set up resident #2's medications in a planner for the week and gave the AP resident #2's bedtime medications to administer. The nurse stated when they realized the medication error, she immediately assessed resident #1, took vital signs, called the doctor, informed him of the medications resident #1 received in error, relayed resident #1's level of consciousness, and current vital signs. The nurse stated the doctor spoke with resident #1 on the phone and then told the nurse to check vital signs every two hours and call if there were any changes. The nurse stated she remained at the facility for several hours, monitored resident #1, and informed the AP to call her if resident #1 had any changes.

During an interview, the AP stated the nurse told her to give medications she had in a medication cup to resident #1, which she did because the nurse was her supervisor. The AP stated the nurse asked her how resident #2 was doing. The AP stated the nurse then asked the AP who she gave the medications to, and they realized the medication error. The AP stated the nurse called the doctor and told the AP to obtain resident #1's vital signs every two hours. The AP stated resident #1 woke each time she took vitals all through the night. The AP stated she

gave resident #1 a bed bath at 5:30 a.m. because he had a morning appointment, and noted he was responsive throughout the remainder of the night shift.

A facility investigative report indicated a day shift staff took resident #1's blood sugar at 7:15 a.m., noting resident #1 was alert and acted normally. The report indicated when staff went in to help resident #1 with dressing around 9:30 a.m., he appeared weak and did not respond to the staff. The report indicated resident #1 was breathing, but not arousable, so they immediately called 911.

Medical records indicated resident #1 was admitted to the hospital for monitoring due to a medication error. The records indicated during the evening at the hospital resident #1 demonstrated difficulty coughing/swallowing normal secretions and had low oxygen levels so required a breathing tube, sedation, and transfer to intensive care. Doctors successfully removed the breathing tube four days later. The records indicated resident #1 returned to baseline health condition and was discharged back to the facility.

During an interview, a family member stated they had concerns about the facility training of staff to ensure they were able to accurately read the medication administration record.

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: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility provided re-education on medication administration to AP, and initiated retraining for all facility staff.

Action taken by the Minnesota Department of Health:
No further 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
	29536	A. BUILDING: _____ B. WING _____	C 03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING NURSES LLC	**7723 BROOKLYN BOULEVARD BROOKLYN CENTER, MN 55443**

(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 March 28th, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL295367886C/#HL295369806M. No correction orders are issued.	0 000		