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 #: HL296475282M
Compliance #: HL296477224C

Date Concluded: December 31, 2024

Name, Address, and County of Licensee Investigated:
The Waters of Edina
6300 Colonial Way
Edina, MN 55436
Hennepin County

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

Evaluator's Name:
Maerin Renee, 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 oral respiratory inhaler medication for 68 days. The resident developed audible wheezing, pallor, weakness, and increased difficulty in breathing. The resident required hospitalization to manage her symptoms.

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 review medications transcribed onto resident medical administration records (MARs). As a result, when the resident's scheduled daily inhaler (Breo Ellipta) was incorrectly transcribed and removed from the MAR, staff did not notice the error and the resident did not receive her inhaler for 65 days. The resident developed difficulty breathing and was sent to the hospital.

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

The resident resided in an assisted living facility. The resident's diagnoses included chronic obstructive pulmonary disease and Alzheimer's disease. The resident's services included assistance with meals, activities of daily living, and medication management. The resident's assessment indicated the resident experienced mild cognitive impairment and required assistance with medication management.

After a family member discovered the medication error regarding the resident's Breo Ellipta inhaler, the resident's progress notes indicated staff completed a focused respiratory and cardio assessment. The resident experience increased work of breathing described as labored with stupor, breathy voice, and gasping when talking. The resident was pale and unkempt, which was unusual for her. Staff contacted the resident's primary care provider (PCP) who recommended the resident go to urgent care to rule out pneumonia. A later note indicated the resident returned from the emergency room with no new diagnoses.

The resident's MARs indicated staff administered her daily scheduled inhaler, Breo Ellipta, until it was abruptly stopped after the start of one month. The Breo Ellipta was crossed out on the MAR for 65 days until staff began to initial the medication, indicating staff were again administering it to the resident.

A medication error document indicated the resident's PCP sent out a new order for the Breo Ellipta. Prior to the new order, the MAR indicated the inhaler was "Regular," meaning staff would administer the inhaler to the resident. After the facility received the new inhaler order, the nurse who transcribed the medication into the resident's MAR indicated the inhaler was "Self," indicating the resident would self-administer the Breo Ellipta. The inhaler was changed back to "Regular" nearly two months later and staff began to administer the inhaler to the resident again.

The resident's hospital record indicated she was seen in the emergency room for non-productive cough and wheezing. A family member discovered facility staff had not been administering the Breo Ellipta inhaler to the resident for several weeks. The family member noticed the resident was having coughing fits one to two times a day and wanted to make sure she did not have pneumonia. The resident's blood pressure and respiratory rate were slightly elevated, but her lungs were clear. The resident was instructed to resume her Breo Ellipta inhaler and see her PCP in one week if her symptoms persisted.

The facility’s internal investigation indicated a family member notified the facility that the resident had not received her Breo Ellipta inhaler for several weeks. Staff reviewed the resident’s chart and saw after her original order for the inhaler expired, her PCP sent a new prescription to the pharmacy. The pharmacy processed the order and then a staff member confirmed the order and changed the inhaler from “regular” to “self” in the resident’s MAR. Since the MAR indicated the resident would self-administer the Breo Ellipta inhaler, it no longer showed up on the MAR for staff to administer. When the family member was present, she noticed the resident was not given her inhaler during a medication pass. A nurse completed a focused assessment at which time the resident had audible wheezing, pallor, weakness, and increased effort in breathing. Staff notified the resident’s PCP, who was concerned about the development of pneumonia, and a family member took the resident to the hospital.

When interviewed, a facility nurse said upon receiving a new order for the resident’s Breo Ellipta inhaler, a nurse mistakenly transcribed it into the MAR as self-administer rather than administered by staff. Since the inhaler was transcribed as self-administer, it did not show up on the MAR so the medication passers would not have known to administer it. The facility nurse said a family member noticed with discrepancy and notified staff. At the time, the facility did not have a system in place to ensure the accuracy of medication transcriptions but had since developed on after the medication error.

When interviewed, family members said they noticed a pattern of medication errors that concerned them. Also concerning was the fact that the family members were finding the errors and not the staff.

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, declined.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility provided education to the nurse team regarding medication order processing and review to ensure the accuracy of orders. The facility established regular MAR audits to ensure accuracy of medication transcriptions and proper medication administration.

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29647	A. BUILDING: ____ B. WING ____	C 12/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERS OF EDINA	**6300 COLONIAL WAY EDINA, MN 55436**

(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: #HL296477224C/ #HL296475282M and #HL296477912C/ #HL296475643M On December 3, 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 132 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL296477224C/#HL296475282M, 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 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,	02360		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Minnesota Department of Health

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02360	Continued From page 1 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		