

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL302826545M
Compliance #: HL302822284C

Date Concluded: February 12, 2024

Name, Address, and County of Licensee

Investigated:

The Waters on 50th
3500 West 50th Street
Minneapolis, MN 55114
Hennepin County

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

Evaluator's Name: Brooke Anderson, 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 facility neglected the resident when they failed to administer medications as prescribed by the provider resulting in worsening skin condition on the resident's buttocks.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was not substantiated. Although there was a delay in the initiation of a prescribed medication, the medication was administered as prescribed. Upon identification of the error, the physician was updated and made no changes to the resident's medication. There was not enough evidence available to support that the delay in the initiation of the medication resulted in a worsening of the resident's skin condition.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted the resident's medical provider. The investigation included review of the resident's medical record, personnel files,

and facility policies and procedures. At the time of the onsite visit, the investigator toured the facility and observed interactions between staff and residents.

The resident resided in an assisted living facility. The resident's diagnoses included Alzheimer's disease and atrial fibrillation (abnormal heart rhythm). The resident's service plan included assistance with medication management, toileting, transfers, dressing, and bathing.

The resident's medical record indicated the resident had a history of skin breakdown and staff were to monitor for changes in skin condition. Staff observed evidence of skin breakdown while assisting the resident with incontinent care. The resident's provider was contacted, and a barrier cream was ordered to be applied to the area. When the barrier cream was not effective, the provider was informed, and a wound paste was ordered. Due to issues with insurance coverage, the wound paste was not immediately filled by the pharmacy and not available to the facility.

While awaiting insurance authorization, the resident was seen by the provider who prescribed an oral Fluconazole (antifungal) medication. Facility documentation indicated the Fluconazole was not started due to a medication error by unlicensed facility staff. However, when staff noticed the error, the medication was administered as ordered by the physician.

Following the error, only licensed staff administered the resident's medications. The provider was updated on the error and advised the facility to continue with the medications as prescribed. The provider also ordered for skilled nursing to evaluate and treat the resident's wounds.

Skilled nursing notes indicated the medications utilized during the time of the medication error were not effective in the treatment of the wounds. Skilled nursing assumed management of the resident's wounds; new medications were ordered, and the wounds healed.

During an interview, the facility nurse and facility management acknowledged a medication error occurred and stated the orders were initiated as soon as the error was discovered. The nurse indicated the provider was immediately updated on the error. Following the error, all staff were re-educated on medication administration and the employees involved received disciplinary action and were required to complete a medication administration re-education course.

During an interview, the resident's family stated they had concerns with the administration of the wound creams and medications, but the facility addressed the concerns and improved their processes after the medication error occurred.

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: No; resident deceased.

Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: Not applicable

Action taken by facility:

The facility investigated the medication errors, educated staff, implemented a new process for the resident's medication administration, updated the family and the provider, and completed corrective actions for the staff involved.

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30282	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/08/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER THE WATERS ON 50TH	STREET ADDRESS, CITY, STATE, ZIP CODE 3500 50TH STREET WEST MINNEAPOLIS, MN 55410
---	---

(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	<p>Initial Comments</p> <p>On January 8, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL302822284C/#HL302826545M. No correction orders are issued.</p>	0 000		

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