Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL30661011M
Compliance #: HL30661012C

Date Concluded: December 15, 2021

Name, Address, and County of Licensee Investigated:
Kingsway Retirement Living
815 West Main Street
Belle Plaine, MN 56011
Scott County

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

Evaluator's Name: Erin Johnson-Crosby, RN
Rapid Response Evaluator

Finding: Substantiated, facility responsibility

Nature of Visit:
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.

Allegation(s): It is alleged: The facility neglected the resident when facility staff did not follow the resident's service plan and gave the resident her medications to administer independently due to being short staffed.

Investigative Findings and Conclusion:
Neglect was substantiated. The facility was responsible for the maltreatment. The facility gave the resident her medications to self-administer but did not perform an assessment to ensure the resident could safely administer the medications. Additionally, the facility did not notify the residents' representative the resident's service plan was going to change.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. In addition, the investigator reviewed the resident's medical record, employee files, and policies and procedures.

The resident's diagnoses include high blood pressure, history of blood clots, and history of a spinal infection. The resident's last assessment indicated the resident was independent with all activities of daily living (ADLs) but required assistance of one staff for bathing and medication administration. The resident's medical record indicated the most recent comprehensive assessment, which would include her cognitive assessment, was six years prior to the incident.

The resident's contract signed a week and a half before the incident indicated the family as the resident's designated representative.

The resident's individualized service plan indicated the resident required staff to administer and provide secure storage of all medications due to the large amount of medication the resident received.

The resident's medication assessment dated approximately three years before this incident indicated the client was unable to safely administer medications due to the complexity of the medication administration.

The resident's service plan signed approximately two years prior indicated the resident required full medication administration. The contingency plan for medication administration indicated other staff will be assigned or the client's responsible person will be notified to provide the service.

The resident's medication administration record (MAR) indicated the resident received 17 different medications at four different times throughout the day. The resident's medications included, but not limited to a blood thinner, an antibiotic, and blood pressure medications.

The resident's physician orders indicated medications should not be left for the resident to take independently and staff must watch the resident take the medication.

When interviewed, the resident said she did not feel comfortable administering her own medications since she has too many pills. The resident could not remember whether she had ever forgotten to take any pills or took too many during the time she had to self-administer and stated, "I don't know, I can't remember that good." The resident said she did not have a choice and said staff brought in the medication boxes with her medication in it and informed her she had to take the medication.

When interviewed, the family member (FM) said she has been the resident's representative for many years and the resident had not administered her own medication for several years. The FM said the facility did not notify her the service plan was going to change. The FM said if they

would have known they would have assisted the resident. The FM said the facility brought the medications to the resident approximately three days before the family discovered it. The FM took pictures because they were concerned about the resident administering her own medications. The FM said the first picture was of the medication boxes set up with some days taped shut, the second picture was of a green pill found on the floor, which was the resident's antibiotic, and the last picture was a picture of a spoon with medication in it. The FM said the resident had taken out the pills an hour earlier and put them in the spoon so she could remember to take the medication.

The investigator reviewed pictures provided by the RM. The first picture showed four medication boxes set up and labeled on top when medications should be taken with the medication box labeled am (morning) and taped shut with medications bulging out the top. The second picture showed a green pill on the floor of the resident's room. The last picture showed a spoon with a medication in the spoon.

When interviewed, a registered nurse (RN) said she did not usually work in assisted living but was directed to set up medications for five to ten residents in the assisted living as part of a facility contingency plan due to short staffing. The RN said she did not complete a medication assessment for the residents because it was an emergency. The RN said did now know the resident's medication assessment indicated the resident should not administer her own medications, nor was she aware of the resident's physician order to not leave medications in the resident's room and staff must watch the resident take the medications.

When interviewed, the Regional Director (RD) said the staff followed the contingency plan due to the staffing emergency. The RD said she did not know the resident had a representative. The RD said she did not know the resident's medication assessment indicated the resident should not administer her own medications, nor was she aware of the resident's physician order to not leave medications in the resident's room and staff must watch the resident take the medications.

In conclusion, 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:
(a) 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.
(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility re-initiated the resident's medication services.

Action taken by the Minnesota Department of Health:
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

Or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

The responsible party will be notified of their right to appeal the maltreatment finding.

cc:
The Office of Ombudsman for Long-Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
County Attorney Scott County
City Attorney for Belle Plaine, MN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30661	A. BUILDING: _____ B. WING _____	C 09/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWAY RETIREMENT LIVING	815 WEST MAIN STREET BELLE PLAINE, MN 56011

(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 Initial comments *****ATTENTION****** ASSISTED LIVING LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.01 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: On September 21, 2021 , the Minnesota Department of Health initiated an investigation of complaint #'s: HL30661002M/HL30661003C, HL30661005M/HL30661006C, HL30661007M/HL30661008C, HL30661009M/HL30661010C, HL30661011M/HL30661012C. At the time of the investigation, there were 74 residents receiving services under the assisted living license. The following correction order was issued for HL30661011M/HL30661012C tag identification 2360.	0 000	The Minnesota Department of Health documents 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 state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors ' findings is the Time Period for Correction. Per Minnesota Statute §144G.30, Subd. 5 (c), the home care provider must document any action taken to comply with the correction order. A copy of the provider ' s records documenting those actions may be requested for follow-up surveys. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider ' s Plan of Correction." The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144G.31, Subd. 2 and 3.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

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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: Based on observations, interviews, and document review, the facility failed to ensure one of five residents reviewed (R4) was free from maltreatment. R4 was neglected. Findings include: On December 15, 2021, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	