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 #: HL307795425M
Compliance #: HL307797543C

Date Concluded: December 23, 2024

Name, Address, and County of Licensee Investigated:
York Gardens Senior Living
3451 Parklawn Ave
Edina, MN 55435
Hennepin County

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

Evaluator's Name: Lisa Coil, RN, BSN
Special Investigator
Paul Spencer, RN, BSN
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 #1 when a medication error and the facility administered medications prescribed for resident #2. Resident #1 experienced a drop in blood pressure and was sent to the emergency room.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. While a medication error did occur, the unlicensed caregivers involved promptly informed the facility nurse. The facility provided appropriate care and monitoring following the error including sending him to the emergency room later the same day.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted resident #1's family member. The investigation included review of resident #1's record, death record, hospital records, facility internal investigation, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed medication administration.

Both resident #1 and #2 resided in an assisted living facility and the service plans of both included medication management.

Resident #1's diagnoses included Parkinson's disease, non-healing ulcers, and hypertension. Resident #1's assessment indicated he was oriented but could be forgetful at times.

The facility's internal investigation indicated unlicensed caregiver #1 administered medications intended for resident #2 to resident #1 in error. The same document indicated one morning at 8:30 AM unlicensed caregiver #1 and unlicensed caregiver #2 were working together. Caregiver #2 prepared a cup of medications and asked caregiver #1 to give them to resident #2. However, there was a miscommunication between the two caregivers and caregiver #1 gave the medications to the incorrect resident: resident #1.

The same document indicated the caregivers realized the error and alerted the nurse by 9 AM. The medications involved included:

- Duloxetine 60 milligram (mg) (an antidepressant)
- Lyrica 150 mg (for nerve pain)
- Tylenol 1000 mg (pain reliever)
- Tamsulosin 0.4mg (used to treat benign prostatic hyperplasia AKA enlarged prostate)

The report indicated the provider and family were notified of the error. Resident #1 vital signs (blood pressure, pulse, etc.) were to be monitored and the provider and family were to be called back if they began to run low.

At the time of the incident, the vital sign record indicated resident #1's blood pressure was 113/60. However, an hour later, his blood pressure had decreased to 72/45 and within two hours the blood pressure had decreased to 70/40.

The progress notes indicated the facility contacted resident #1's medical provider regarding the low blood pressure and sent him to the emergency department via 911. The facility also updated resident #1's family regarding resident #1's low blood pressure. The note indicated resident #1 was alert and oriented when he left the facility.

Hospital notes indicated resident #1 presented with mild bradycardia (slow heart rate) and low blood pressures. He was treated with a small amount of intravenous (inside the vein) fluids and monitored for several hours. The same documents indicated resident #1's blood pressure normalized and resolved. The note indicated blood test showed kidney insufficiency and the

provider gave resident #1 and his family member options to be treated with a hospital admission, which were declined. The hospital records indicated resident #1 was discharged in stable and improved condition. Resident #1 and a family member chose to have resident #1 return to the facility with outpatient follow-up and repeat blood work.

Progress notes indicated resident #1 returned to the facility from the emergency room nine hours following the incident. The notes indicated resident #1's blood pressure was 115/59. The notes further indicated follow-up including resident #1 should see his medical provider within two days and additional laboratory blood testing in the following week.

The following day the progress notes indicated resident #1's medical provider several order changes, which included holding hydrochlorothiazide (an antihypertensive medication), which the facility implemented as ordered.

Two days after the medication error, the progress notes indicated resident #1 was not feeling well. The notes indicated resident #1 was sleepy, alert and oriented, and his blood pressure was 105/53. The facility updated the medical provider and the family; resident #1 went to the emergency room.

Hospital notes indicated resident #1 admitted with lethargy (tiredness, weakness) and decreased responsiveness

After five days, the hospital prepared to discharge resident #1 with his condition listed as stable with mental status back to baseline, and kidney function improved as indicated by his blood laboratory results. The same documents indicated resident #1 and family were interested in discussing hospice.

The facility progress notes indicated resident #1 was hospitalized for five days for hypotension and a urinary tract infection. The notes indicated a discussion regarding hospice was held during resident #1's hospital stay, but a decision had not been made. After resident #1 returned to the facility from the hospital, he enrolled in hospice within a few days. Resident #1 remained at the facility and passed away about two weeks later.

During an interview, unlicensed caregiver #1 stated her first shift working alone was two days prior to the incident. Caregiver #1 stated she picked this shift up and had never worked a "short shift" before so was not sure what to do. Unlicensed caregiver #2, who trained her, was working so she stuck with her. Caregiver #1 stated she and caregiver #2 went into resident #1's room to get him up for the morning but the nurse was in there, so she asked them to come back later. Caregiver #1 stated her and caregiver #2 were at the desk, caregiver #2 was preparing medications as they discussed resident #1 and the cares he needed. Caregiver #2 handed caregiver #1 a dish of medications and said, "can you give these to him?" Caregiver #1 stated she thought caregiver #2 meant resident #1 because they had been talking about his cares, so she went resident #1's room and started administering the medications. However, caregiver #2

walked in the room, told her to stop giving the medications, and asked me to come to the hallway where caregiver #2 told her the medications were for resident #2, not resident #1. Caregiver #1 stated they told the nurse right away, who came and assessed resident #1. Caregiver #2 stated in her experience it was common for unlicensed caregivers to administer medications that another unlicensed caregiver had dished up. She stated she did not realize it was a problem until the facility gave her a corrective action and education to not do this.

During an interview, a manager, who is also a nurse, stated caregiver #2 dished up the medication and handed it to caregiver #1, who was a new employee in training. The manager stated it was apparent caregiver #1 and caregiver #2 did not follow the medication administration policy and there was poor communication between the two caregivers. The manager stated staff receive training during orientation related to not dishing up medications and asking another caregiver to administer them and administering medications they did not dish up. The manager further stated she was not aware of other situations where this occurred nor had other unlicensed caregivers said they had seen this practice.

A medication training document, referenced in the manager interview, indicated the training included information such as to set-up one resident's medications at a time and the person who sets up the medication should also give the medication. No other medication errors of a similar nature were identified.

Attempts to interview unlicensed caregiver #2 were not successful.

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.

(d) 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. Resident #1 was deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: NA

Action taken by facility:
The facility investigated the incident and sent resident #1 to the hospital. The facility provided re-education and/or corrective action to the unlicensed caregivers to prevent a similar medication error from recurring.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30779	A. BUILDING: ______ B. WING ______	C 11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YORK GARDENS SENIOR LIVING	**3451 PARKLAWN AVENUE EDINA, MN 55435**

(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: #HL307797543C/#HL307795425M On November 5, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL307797543C/#HL307795425M. No correction orders are issued.	0 000	Assisted Living Provider 144G. 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.	

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