Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL307809803M
Compliance #: HL307809403C

Date Concluded: June 6, 2025

Name, Address, and County of Licensee Investigated:
Minnehaha Senior Living
3733 23rd Avenue South
Minneapolis, MN 55407
Hennepin County

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

Evaluator's Name:
Maerin Renee, RN, Special Investigator

Finding: Inconclusive

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 did not administer the residents Pulmicort nebulizer treatment for 12 days. The resident experienced increasing shortness of breath and coughing. requiring hospitalization. The resident's oxygen saturation (O2 sat) in the hospital was 82% on room air and she was diagnosed with asthma exacerbation.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. The resident's medication administration record (MAR) indicated she went 12 days without using her Pulmicort nebulizer. However, the resident stated she self-administered the nebulizer during that timeframe, although the facility had no documentation. The resident's medication management plan changed frequently between self-administration of medications and treatments, and at other times staff would be assigned to do so. Staff were unclear as to whether the resident was evaluated to self-administer her Pulmicort nebulizer during this timeframe, or if staff were to administer the nebulizer. The resident said two days before she

went to the hospital, her nebulizer solution got low, so she started using it once a day instead of twice a day as ordered. The resident was hospitalized for chronic obstructive pulmonary disease (COPD) exacerbation, received treatment at the hospital, and returned to the facility at baseline.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator notified family. The investigation included review of the resident records, hospital records, pharmacy records, the facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed medication processes and staff providing cares to residents.

The resident resided in an assisted living facility. The resident's diagnoses included COPD and asthma. The resident's services included assistance with activities of daily living, meals, housekeeping, laundry, and medication management. The resident's assessment indicated the resident was approved to self-administer her nebulizer treatment.

The facility's internal investigation indicated after a delivery of the resident's Pulmicort solution from the pharmacy, a staff member brought it to the resident's apartment. The staff member left the medications on the resident's table, as she thought the resident was still self-administering her own medications. That same night, an evening shift staff member documented "No Supply" for the resident's evening dose of the Pulmicort nebulizer. A nurse said the resident was assessed to self-administer medications.

A staff nurse said he completed weekly medication checks, but did not document them. The staff nurse ordered Pulmicort nebulizer solution from the pharmacy mid-month. Eight days later, the staff nurse noticed the resident still did not have Pulmicort nebulizer solution, so he entered another refill request via the electronic medication administration record (eMAR). The staff nurse suspected the resident was using the Pulmicort nebulizer on her own but was unable to locate it.

Unknown to staff, the resident's family member took the resident to the hospital for wheezing. The resident was admitted with a diagnosis of acute/chronic respiratory failure with hypoxia. The resident was admitted, treated, and returned to the facility two days later in stable condition.

After returning to the facility, the resident stated she administered her own nebulizer treatments for about two weeks prior to her hospitalization. Two days before she went to the hospital, she noticed her supply of nebulizer solution was getting low and began to self-administer one nebulizer treatment per day, instead of two as ordered. The resident requested to continue to self-administer her nebulizer and inhaler treatments.

The resident's progress notes indicated the pharmacy delivered a 15-day supply of the Pulmicort nebulizer solution mid-month. Staff were unable to locate the supply of nebulizer solution in the resident's apartment. Staff documented the resident had been "hiding" medications and was unwilling to give them to staff. After her hospitalization, staff discussed a new plan regarding medication management with the resident and her family member, who agreed.

The resident's MAR indicated the resident was prescribed Pulmicort suspension 0.5mg/2, one vial to be inhaled via nebulizer every 12 hours for asthma. For the first week of the month, staff documented the Pulmicort nebulizer as "self-administer." Then, for eight days, staff documented administering the Pulmicort nebulizer to the resident. For the rest of the month, staff documented the Pulmicort as not administered due to "no supply." The MAR did not indicate specifically whether R1 was self-administering the Pulmicort nebulizer or if staff were to administer it.

The resident's medication assessment indicated she was evaluated and competent to self-administer inhalers and nebulizer treatments. Staff and nursing were to monitor the nebulizer solution was refilled before running out.

The resident's hospital record indicated her chief complaints were chest pain, shortness of breath, and asthma. Diagnoses included acute on chronic respiratory failure with hypoxia, chest pain, shortness of breath, and moderate persistent asthma with acute exacerbation. Upon arrival to the hospital, the resident's oxygen saturation (O2 sat) on room air was 95% (normal range is 95%-100%). After a nebulizer treatment and walking a short distance, the resident was still short of breath and became hypoxic (a condition in which the body is deprived of adequate oxygen supply at the tissue level) with O2 sats dropping to 82%. After receiving more nebulizer treatments, the resident was discharged after two days in stable condition.

When interviewed, an administrator said the staff were unaware when the resident's family took the resident to the hospital. After investigating, leadership determined the resident had been self-administering her Pulmicort nebulizer. Although staff had been requesting refills from the pharmacy via their electronic MAR (eMAR) system, a refill never arrived. Nursing was aware the resident was out of her Pulmicort nebulizer solution. There had been many discussions and disagreements with the resident and her family member about whether she could self-administer her medications. There were also times when the resident and family member disagreed with each other about the medication management plan as well.

When interviewed, a nurse said at one point the resident was self-administering her nebulizer treatments. Due to concerns about the resident taking medications properly, occasionally medication administration would be re-assigned to staff. The resident, however, wanted to continue self-administering her medications and would occasionally hide medications from

staff. The continued changes regarding the resident's medication administration caused confusion for staff and the resident.

The resident stated she was happy with the current plan for her to self-administer her inhaler and nebulizer treatments.

In conclusion, the Minnesota Department of Health determined neglect was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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: No, did not respond.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
Services were added for nursing to check the resident's apartment weekly to ensure medications were not low on supply. The process to clarify which medications were self-administer and staff-administer were clarified for staff members.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30780	A. BUILDING: _____ B. WING _____	C 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNEHAHA SENIOR LIVING	3733 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(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: #HL307809403C/#HL307809803M On April 29, 2025, 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 76 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for #HL307809403C/#HL307809803M, tag identification 1750.	0 000	The Minnesota Department of Health documents the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule number out of compliance are listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings, which are in violation of the state statute after the statement, "This Rule 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/RULES.	
01750 SS=G	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has:	01750		

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01750	Continued From page 1 (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on interview, and record review, the facility failed to provide oversight and specific written instructions for medication administration when delegated to unlicensed personnel (ULP) for one of one resident (R1). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted to the facility and began receiving assisted living services on September 23, 2020. R1's diagnoses included chronic obstructive pulmonary disease (COPD) and severe, persistent asthma. R1's Service Plan, dated March 5, 2025, indicated R1 received services including	01750		

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01750	Continued From page 2 assistance with medication management. R1's Medication and Treatment Evaluation and Management Plan, dated January 21, 2025, completed by assistant director of health services (RN)-C, indicated R1 was evaluated and competent to self-administer inhalers and nebulizer treatments. Facility staff provided medication set up, and both staff and R1 were responsible for medication administration. R1 was responsible for self-administering treatments, including inhaler and nebulizer treatments. The document indicated a nurse was responsible for monitoring and reordering medications and/or supplies from the pharmacy or supplier before they ran out. R1's Medication Administration Record (MAR) dated February 1 through February 28, 2025, indicated R1 was prescribed Pulmicort suspension 0.5 milligrams (mg)/2. R1 was to inhale one vial per nebulizer every 12 hours for asthma. From February 5, 2025, at 8:00 p.m. through February 8, 2025, at 10:00 a.m., staff documented the Pulmicort as "self-administer." From February 9, 2025 at 10:00 a.m. to February 16, 2025 at 10:00 a.m. staff documented administering the nebulizer to the resident. From February 16, 2025, at 8:00 p.m. to February 27, 2025, at 8:00 p.m., staff documented the Pulmicort as not administered due to "no supply." The MAR did not indicate specifically whether R1 was self-administering the Pulmicort or if staff were to administer it. R1's MAR and progress notes did not indicate any additional measures taken by nursing between February 16, 2025 to February 27, 2025 to follow up on refill requests to which the pharmacy had not responded. Not until February	01750		

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01750	Continued From page 3 27, 2025 did nursing call the pharmacy to discover a 15-day supply of Pulmicort solution had been delivered on February 16, 2025. Staff were unable to locate the Pulmicort solution in the resident's medication cupboard or in her apartment. R1's hospital record indicated she was admitted to the hospital on February 28, 2025 after being triaged in the emergency department on February 27, 2025. R1's chief complaints were chest pain, shortness of breath, and asthma. Diagnoses included acute on chronic respiratory failure with hypoxia, chest pain, shortness of breath, and moderate persistent asthma with acute exacerbation. Upon arrival to the hospital, the resident's oxygen saturation (O2 sat) on room air was 95%. After a nebulizer treatment and walking a short distance, she was still short of breath and became hypoxic with O2 sats dropping to 82%. After more nebulizer treatments, R1 was discharged from the hospital in stable condition on March 1, 2025. On April 29, 2025, at 1:30 p.m., RN-C said at one point the resident was self-administering her nebulizer treatments. Due to concerns about the resident taking medications properly, occasionally medication administration would be re-assigned to staff. The resident, however, wanted to continue self-administering her medications and would occasionally hide medications from staff. The continued changes regarding the resident's medication administration caused confusion for staff and the resident. On April 29, 2025, at 1:00 p.m., licensed assisted living director (Admin)-A said when leadership reviewed R1's MAR, it appeared there was a medication error in which R1 did not receive her	01750		

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01750	Continued From page 4 Pulmicort inhaler for 12 days, staff having documented it as "no supply." Upon investigation, R1 said she self-administered the Pulmicort nebulizer, without staff knowledge, and ran out of the solution early, leading to her hospitalization. Although staff had been requesting refills from the pharmacy via their eMAR system, a refill never arrived. Nursing was aware the resident was out of her Pulmicort. However, there was no follow-up by nursing to the pharmacy beyond requesting refills through the eMAR. On February 27, 2025, the day R1 went to the hospital, a nurse called the pharmacy to inquire about the Pulmicort refill and was told it had been too early to refill and that is why it was never sent. The facility's policy titled Medications & Treatments, dated March 2021, indicated when staff documented a medication as "no supply," a nurse was to call the pharmacy, family, and medical practitioner, and document in the resident record. A nurse was responsible for communicating medication/treatment changes to staff. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		