Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL317336905M
Compliance #: HL317331480C

Date Concluded: January 14, 2025

Name, Address, and County of Licensee Investigated:
New Perspectives of Woodbury
2195 Century Ave So
Woodbury, MN 55125
Washington County

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

Evaluator's Name: Deb Schillinger, RN BSN
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 insulin was not given per order causing hospitalization.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated with facility responsibility. While it was true the resident did miss doses of long-acting insulin due to a pharmacy error this did not result in neglect. However, the facility did neglect the resident when unlicensed caregivers were not provided with sufficient instructions for the administration of short-acting insulin resulting in two instances of hypoglycemia (low blood sugar) and hospitalization.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the pharmacy and the resident's family member. The investigation included review of the resident record, pharmacy records,

facility internal investigation, facility incident reports, staff schedules, and related facility policy and procedures. Also, the investigator observed unlicensed personnel interact with residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included type 1 diabetes. The resident's service plan included medication administration and blood sugar monitoring. The resident's assessment indicated the resident used a wheeled walker for ambulation and was alert to person only. The resident medical record indicated the resident received hospice services at the assisted living facility.

Long-Acting Insulin

One day a concern arose as the resident did not receive long-acting insulin dose as ordered by her medical provider.

An internal investigation indicated an error occurred at the contracted pharmacy. It was discovered that a pharmacy technician reconciled an order that was sent fifteen days prior which cancelled out the current order for the scheduled long-acting insulin. This incident occurred on a weekend and the resident missed the Friday and Saturday scheduled doses of long-acting insulin. The triage nurse was notified on the third day, the error was identified, the long-acting insulin order was rescheduled, and the resident received the ordered dose of long-acting insulin on Sunday. The resident was transferred to the hospital for treatment and returned after 2 days.

The residents EMAR indicated there was no order for the long- acting insulin for unlicensed caregivers to administer on Friday and Saturday, the Sunday dose was administered after the error was discovered.

During an interview with the pharmacy representative, it was found a pharmacy technician processed an order received fifteen days earlier, which caused the current order for long-acting insulin to be discontinued. This action removed the order for long-acting insulin for unlicensed caregivers to administer.

The error caused a review of current process and updates to the process was made. The pharmacy representative stated there had been no further errors or issues similar to this since the updates were made.

MDH determined that this issue did not result in neglect.

Short-Acting Insulin

The resident's progress notes indicated on one evening before the evening meal, the resident was found to have slid to the floor in her apartment and was experiencing what looked like seizure activity. The resident was transferred by emergency medical services to the hospital.

The progress notes later indicated the resident had a blood sugar level of 89 on that day before the evening meal and was given 6 units of insulin.

The resident's electronic medication administration record (EMAR) indicated the resident's insulin order was to give 6 units of insulin if the blood sugar level was 100-150 mg/dL (milligrams per deciliter).

The resident's comprehensive assessment indicated the resident needed an escort to meals due to the resident experience trouble remembering to go after blood sugar check and insulin.

The resident's progress notes indicated the resident remained hospitalized for two days then returned to the assisted living facility on the evening of the third day. The resident was transferred by emergency medical services to the hospital again the following morning for hypoglycemia (low blood sugar).

After the resident returned from the hospital, the provider changed the order for the short-acting insulin to 5 units before each meal if the blood sugar level was greater than 120 mg/dL.

Two days later, the resident's progress note indicated the resident's blood sugar was 59 mg/dL. The EMAR indicated the resident was administered 5 units of insulin. The resident was later given sugar tablets, juice, and a meal. The resident's blood sugar was monitored and did not require hospitalization for this incident.

A review of the resident's service plan did not indicate the facility changed the insulin administration instructions were provided to unlicensed caregivers after either incident.

During an interview, the nurse stated the EMAR order is reflective of what the medical provider ordered and additional orders clarifying the directions would have to come from the medical provider. The nurse stated no other orders clarifying the instructions were obtained.

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.
(4) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult which does not result in injury or harm which reasonably requires medical or mental health care; or
(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, due to cognitive impairment
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility investigated the incident and provided additional education to unlicensed care givers.

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
Washington County Attorney
Woodbury City Attorney
Woodbury Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31733	A. BUILDING: _____ B. WING _____	C 12/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - WOODBURY	2195 CENTURY AVENUE SOUTH WOODBURY, MN 55125

(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****** HOME CARE PROVIDER/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: #HL317331480C/#HL317336905M On December 17, 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 69 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for #HL317331480C/#HL317336905M, tag identification 1750 and 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.	
01750 SS=G	144G.71 Subd. 7 Delegation of medication administration	01750		

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01750	Continued From page 1 When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (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 observation, interview and document review, the licensee failed to ensure the registered nurse (RN) prepared in writing specific instructions in the record for one of one resident (R1) receiving insulin whose medication administration was delegated to unlicensed personnel. 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's diagnoses included type one diabetes mellitus with long-term insulin use. R1's service plan indicated R1 received services including medication management and administration.	01750		

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01750	Continued From page 2 On August 16, 2024, R1's electronic medication administration record (EMAR) indicated the following insulin order: Humalog 100 units/milliliter(ml) insulin inject per sliding scale three times daily before meals and indicated the following unit amounts be administered for the following blood sugar amounts: -100-150 milligram per deciliter (mg/dL) = 6 units -151-200 mg/dL = 7 units -201-250 mg/dL = 8 units -251-300 mg/dL = 9 units -Over 300 mg/dL = 10 units The EMAR indicated the facility listed the timing of the insulin administration to: -Morning -Mid-day -1630 (430 PM) On September 23, 2024, at 1630 indicated the facility administered Humalog 6 units. A late entry for September 23, 2024 [dated September 25, 2024] indicated R1's blood sugar was 89 mg/dL at 4 PM, the facility then administered Humalog insulin 6 units. The same document indicated R1 was found at 4:50 PM on the floor unresponsive. 911 was called and R1 was transferred to the hospital. A review of the resident's sliding scale order indicated 6 units of Humalog insulin would be given for a blood sugar result of 100-150 mg/dL. However, the same document did not provide direction to caregivers what to do if the blood sugar result was below 99 mg/dL. R1 was admitted to the hospital September 23,	01750		

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01750	Continued From page 3 2024, and was discharged on September 25, 2024. On September 25, 2024, at 1630 the EMAR indicated the facility administered 10 units of Humalog insulin. A review of the EMAR provided by the facility did not include the blood sugar result for September 25, 2024 at 1630. On September 26, 2024, at 7 AM, the progress notes indicated R1 was found screaming and shaking at approximately 630 AM. R1's blood sugar was found to be 44 mg/dL and R1 became unresponsive. 911 was called and R1 was transferred to the hospital. On September 26, 2024, R1's order for insulin was discontinued. On September 27, 2024 R1's insulin orders were changed to: -Humalog 100 units/ml: three times daily administer 5 units of Humalog insulin for blood sugar 120 mg/dL or greater. A review of the order indicated the new order did not provide direction to caregivers what to do if the blood sugar result was below 120 mg/dL. On September 28, 2024, at 6:25 p.m., the progress note indicated at 4:00 p.m. R1's blood sugar was 59 mg/dL, however at 4:30 PM the facility administered 5 units of Humalog insulin. When the medication error was identified, the nurse and the medical provider were notified. The nurse instructed to give glucose tablets, juice, and assure R1 consumed their meal. The facility continued to monitor R1's blood sugar and the	01750		

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01750	Continued From page 4 resident returned to their baseline condition. A review of R1's medical record did not identify instructions specific to the resident addressed to the unlicensed caregivers: -How long before the meal the blood sugar check should occur -When to administer the insulin in relationship to mealtime The licensee's Medication Administration policy dated November 21, 2024, indicated: -Team members who are appropriately licensed or who, where allowable by law, have been trained, evaluated for competency, and delegated/ authorized by a licensed nurse will administer medication to residents receiving medication and treatment management services in accordance with provider orders, applicable law, and Company policy and procedure and applicable law. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, 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:	02360		

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02360	Continued From page 5 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		