Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL347128324M
Compliance #: HL347125502C

Date Concluded: January 24, 2024

Name, Address, and County of Licensee Investigated:
Millers Landing Senior Living
155 5th Ave S
Minneapolis MN 55401
Hennepin County

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

Evaluator's Name: Maggie Regnier
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 a resident when the facility did not provide cares such as blood sugar monitoring.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident had blood glucose checked three times a day ordered, and the facility documentation indicated this was being done.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family members. The investigation included review of resident records, medical records, staffing records and policies. Also, the investigator observed staff and resident interactions.

The resident resided in an assisted living memory care unit. The client's diagnoses included Dementia, diabetes, and anxiety disorder. The resident's service plan included assistance with incontinence care, daily bathing care, medication management, nutrition and reorientation to person and place. The resident's assessment indicated he had a foley catheter in place, was often disorientated and needed cues for eating and drinking.

A concern arose that the resident's blood sugars were not being checked and that the resident's personal glucometer (a machine to check blood sugars) was missing.

The resident's diagnoses included type II diabetes and had blood glucose levels ordered for 3 times a day. The residents blood glucose levels were documented and usually ran higher than normal but occasionally were lower than normal. The medical record indicated the facility responded to these occasions appropriately. There was no documentation indicated whether it was a resident-owned or facility-owned glucometer in use within the resident's medical record.

During an interview, the facility leadership stated the facility policy is the facility will supply all the glucometers for all residents. The reasons for this were so the caregivers could be trained on one specific model of glucometer instead of trying to learn how to use multiple machines owned by individual residents.

During an interview, the registered nurse (RN) stated the unlicensed caregivers are trained to use the facility glucometers. The caregivers are also trained to call the RN if resident glucose levels are outside the normal range. The RN stated many residents may have had their own glucometers, but they are returned to the family members if there was a name on the glucometer. The RN stated the facility has a box of various glucometers do not have a name on them.

During an interview, a family member stated the resident had three glucometers when he moved in but could not be sure his name was on it. The family member also stated the resident could not use the glucometer himself because of his dementia.

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, deceased.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable
Action taken by facility: The facility provides glucometers for caregivers to use when checking blood sugars.

Action taken by the Minnesota Department of Health:
No further action at this time.

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
	34712	A. BUILDING: _____ B. WING _____	C 12/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLERS LANDING SENIOR LIVING	155 5TH AVENUE SOUTH MINNEAPOLIS, MN 55401

(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, section144G.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: HL347123222C/HL347126944M & HL347128324M/HL347125502C On December 5,2023, 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 68 residents receiving services under the provider'sAssisted Living with Dementia Care license. The following correction order is issued/orders are issued for #HL347123222C/#HL347126944M, tag identification 1910. No orders are issued for HL347128324M/HL347125502C.	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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34712	A. BUILDING: _____ B. WING _____	C 12/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLERS LANDING SENIOR LIVING	155 5TH AVENUE SOUTH MINNEAPOLIS, MN 55401

(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
01910	Continued From page 1	01910		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include all the required content for 2 of 2 discharged residents (R1 and R2) plus one current resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34712	A. BUILDING: _____ B. WING _____	C 12/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLERS LANDING SENIOR LIVING	155 5TH AVENUE SOUTH MINNEAPOLIS, MN 55401

(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
01910	Continued From page 2 of the residents). The findings include: R1 was discharged from the licensee on May 30, 2023. R1 progress note dated May 31, 2023 indicated his medications would be bagged up for his nephew to pick up. His medications included 7 - 5 milligram (mg) morphine tablets. R2 deceased the facility May 30, 2023. A document titled Discharge summary dated May 31, 2023 indicated R2's medication were destroyed via "destroyer". R2's medication included 1 oxycodone tablet and 16 Ativan tablets. An internal facility investigation dated June 15, 2023, registered nurse (RN-C) was setting up a Medi planner for R3 when she noticed a sheet of 30 tablets of Tramadol was missing. She notified the licensed assisted living director (LALD-A). They discovered that medication for R2 and R3 that had been stored locked in the office was missing narcotics. R1 was missing 7 5mg morphine tablets and R2 was missing the 1 oxycodone and 16 Ativan tablets. The same doucment indicated the facility determined controlled medications had been removed from multiple discharged residents' supply stored in the nurse's office. R1's and R2's record lacked a medication disposition record with required record to include: - medication's name; - strength; - prescription number as applicable; - quantity; - to whom the medications were given;	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34712	A. BUILDING: _____ B. WING _____	C 12/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLERS LANDING SENIOR LIVING	155 5TH AVENUE SOUTH MINNEAPOLIS, MN 55401

(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
01910	Continued From page 3 - date of disposition; and - names of staff and other individuals involved in the disposition. During an interview on December 6, 2023, at 2:05 p.m., LALD-A stated it was the facility's practice to keep and store a discharged resident's medication to give to the family, this includes narcotics. During an interview on December 8, 2023 RN-C stated that it is the facility practice to bag up medications for discharged residents until a family can pick them up including narcotics. A policy titled, 7.23 Medication disposal, dated 8/1/2021, states that unused controlled substances remaining when the resident's medications are not managed by Millers Landing, the medications are expired, or the medication has been discontinued by the prescriber, must be disposed of in accordance with accepted practices of the Minnesota Board of Pharmacy. this policy also states that upon disposition, the facility must document in the resident's record the disposition of the expired medication including the medication's name, strength, prescription number if applicable, quantity, date of disposition, and names of staff (including a witness) and other individuals involved in the disposition. A copy of the destruction record will be kept on file at the facility of two (2) years. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		