Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL356215785M
Compliance #: HL356219930C

Date Concluded: August 2, 2023

Name, Address, and County of Licensee Investigated:
Global Pointe Senior Living
5200 Wayzata Boulevard
Golden Valley Minnesota 55416
Hennepin County

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

Evaluator's Name:
Holly German, RN
Special Investigator
Nicole Myslicki, RN
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 when the resident had been sick for four days and asked to see a doctor multiple times before presenting to the emergency department. Additionally, the resident had a large pressure ulcer present on her coccyx.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the facility held the resident's medication, the resident and family made the decision to remain off anticoagulation. Additionally, evidence did not indicate the resident had a change of condition days prior to presenting to the emergency department (ED). Regarding the pressure ulcer, the facility had arrangements with a home health group who provided regular treatments and wound monitoring. The facility staff monitored skin during showers and toileting.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the provider. The investigation included review of the resident's medical record, facility policies, facility grievances, staffing schedules, and pharmacy invoices. The investigation also included review of the resident's hospital record, home health visit notes, and provider notes. Also, the investigator observed resident cares and interactions with facility staff.

The resident resided in an assisted living facility. The resident's diagnoses included heart failure and atrial fibrillation (an irregular heartbeat). The resident's service plan included assistance with toileting, dressing, medication administration, and transfers. The resident's assessment indicated the resident used a wheelchair and identified her as alert and oriented.

A nursing note indicated staff contacted the on call registered nurse due to the resident experiencing nausea, vomiting, and an elevated pulse. The registered nurse encouraged fluids and a recheck of the pulse. A second progress note, less then one hour later, indicated staff reported the resident had no more episodes of vomiting, but had not been responding to questions and had difficulty breathing. The resident had an oxygen level of 85%. The registered nurse instructed staff to call 911 and have the resident sent to the hospital.

The resident presented to the ED with weakness and atrial fibrillation. Additionally, the hospital records indicated the resident reported not feeling well for three days and had a non-blanchable pressure ulcer on the coccyx. While in the ED, the resident stated she stopped taking her Eliquis (a medication used to prevent blood clot formation due to irregular heartbeat) due to insurance issues. The hospital record indicated the resident experienced low blood pressures, low oxygen levels and identified the concern that atrial fibrillation caused acute chronic heart failure. The resident died in the ED.

The death certificate identified the resident's cause of death as atrial fibrillation, heart failure, and aortic stenosis (a narrowing of the aortic valve).

Approximately one month prior to the resident presenting to the ED, the resident's medication administration record indicated the facility held the resident's Eliquis. This medication had been held for three weeks before the provider became aware of the hold.

The provider's visit note indicated she learned the resident's Eliquis had been on hold due to cost at the time of her visit. She informed the resident who had not been made aware. The provider reviewed the risks and benefits of anticoagulation with the resident's family member. The family member planned to speak with the resident about staying off anticoagulation or starting a new medication and would get back to the provider with the decision.

The home health notes indicated they assessed the resident three days prior and the day of the resident's ED visit. There were no concerns voiced by the resident and no change to the

resident's health noted during the visits. Both notes indicated skin assessments were completed.

During an interview, the provider stated she became aware the resident had not been taking Eliquis while reviewing the resident's medical record during a visit. The provider contacted the family and discussed the risks and benefits of this medication. Family discussed the Eliquis with the resident, and they decided to not resume it. Regarding the pressure ulcer, the provider stated it had been a chronic issue but had been improving the month the resident passed away.

During an interview, the nurse stated the medication had not been available from the pharmacy, so she followed the facility process of holding the Eliquis until family paid for it, or it became available. The facility also received notification from the pharmacy regarding the high cost of Eliquis. The nurse stated addressing the medication issue would have been a coordination between the provider, the family and resident, and there had been multiple communications between them. The family and resident were going to decide whether to resume the Eliquis or not.

During an interview, the family member stated he had not been aware of the medication being held until he reviewed a pharmacy invoice, which did not include Eliquis. Over the course of four days, he emailed facility staff multiple times, seeking clarification on the Eliquis before a nurse finally responded. The family member believed he should have been contacted sooner. The family member spoke to the resident the day before she went to the emergency department. He thought she seemed very tired but did not recall anything being wrong. Regarding the pressure ulcer, the family member stated she had been getting treated for a while.

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 sent the resident to the emergency department in a timely manner.

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
	35621	A. BUILDING: _____ B. WING _____	C 06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLOBAL POINTE SENIOR LIVING	5200 WAYZATA BOULEVARD GOLDEN VALLEY, MN 55416

(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: #HL35619930C/#HL35621785M On June 29, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were 94 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL35619930C/#HL35621785M, tag identification 1690.	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 listedin 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.	
01690 SS=G	144G.71 Subdivision 1 Medication management services	01690		

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01690	Continued From page 1 (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement their policy regarding medication management when staff did not communicate a medication concern involving one of one residents (R1). This created a risk of	01690		

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01690	Continued From page 2 serious harm. 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: A website review performed on July 26, 2023, at 10:20 a.m. of https://www.eliquis.bmscustomerconnect.com/afib/faq indicated the following: Some important safety information to know about ELIQUIS is: (1) Do not stop taking ELIQUIS without talking to the doctor who prescribed it for you. For patients taking ELIQUIS for atrial fibrillation: stopping ELIQUIS increases your risk of having a stroke. R1's diagnoses included paroxysmal atrial fibrillation and chronic diastolic congestive heart failure. R1's service plan dated March 1, 2023, indicated R1 received assistance with toileting and transfers. This service plan failed to indicate R1 received assistance with medication administration. R1's nursing assessment dated February 3, 2023, indicated R1 received assistance with medication administration. R1's provider orders signed June 18, 2022, indicated R1 had an order for Eliquis 2.5 milligrams (mg) one tablet by mouth twice daily. R1's medication administration record (MAR) dated February 2023, indicated R1 received	01690		

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01690	Continued From page 3 Eliquis as ordered from February 1, 2023 to February 13, 2023. On February 14, 2023, R1 received one dose of Eliquis in the morning prior to it being held. The licensee held the Eliquis from February 14, 2023 at 8:00 p.m. through February 28, 2023. A nursing note dated February 14, 2023, indicated licensed practical nurse (LPN)-B called the pharmacy to request R1's Eliquis. The pharmacist informed LPN-B of the high cost of the copay, and family and R1 decided to wait. This progress note indicated Eliquis had been placed on hold until authorization could be met. R1's record lacked a physician order to stop Eliquis. R1's MAR dated March 2023, indicated the Eliquis remained held through March 1, 2023 until her transfer to the hospital on March 17, 2023. R1 missed 63 doses of Eliquis. During email correspondence to the director of nursing (DON)-A on March 9, 2023, at 3:55 p.m., family member (FM)-G indicated he learned the Eliquis had been held and wanted clarification on who decided to hold or authorize the discontinuation of the medication without his or R1's approval. DON-A failed to respond to this email. During email correspondence on March 10, 2023, at 3:43 p.m., FM-G sent a follow up email to DON-A regarding the Eliquis after not receiving a response. DON-A failed to respond to this email as well. During email correspondence on March 13, 2023,	01690		

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01690	Continued From page 4 at 2:43 p.m., FM-G directed a third email to licensed assisted living director (LALD)-I indicating DON-A had not responded to his messages regarding the Eliquis. FM-G requested an investigation and response. On March 13, 2023, at 2:51 p.m., LALD-I forwarded this email to LPN-B and asked her to address it. A nursing noted dated March 17, 2023, at 11:47 p.m. indicated R1 had not been responding to questions and had difficulty breathing. The on-call nurse instructed staff to call 911 and have R1 sent to the hospital. R1 died in the hospital on March 18, 2023. R1's death certificate identified the cause of death as atrial fibrillation. During an interview on July 6, 2023, at 10:06 a.m., FM-G stated he had not been aware of the medication being held until he reviewed the pharmacy invoice for March 2023, which did not include Eliquis. On March 9, 2023, March 10, 2023, and March 13, 2023, FM-G emailed the licensee, seeking clarification on the Eliquis before a nurse responded. FM-G believed he should have been contacted sooner. FM-G spoke to R1 the day before she went to the emergency department. He thought she seemed very tired but did not recall anything being wrong. FM-G stated he wondered if the Eliquis had anything to do with shortening R1's life. During an interview on July 6, 2023, at 12:04 p.m., LPN-B stated Eliquis had not been available from the pharmacy, so she followed the facility process of holding the Eliquis until family paid for it, or it became available. LPN-B stated addressing the medication issue would have been a coordination between the provider and the	01690		

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01690	Continued From page 5 family and resident, and there had been multiple communications between them. The family and R1 were going to decide whether to resume the Eliquis or not. During an interview on July 13, 2023, at 11:20 a.m., nurse practitioner (NP)-H stated she became aware R1 had not been taking Eliquis while reviewing R1's medical record during a visit on March 6, 2023. NP-H spoke with R1 who did not know the Eliquis had been held. NP-H contacted FM-G and discussed the risks and benefits of this medication and FM-G wanted her to consult with R1's cardiologist. Later, FM-G discussed the Eliquis with R1, and they decided to not resume it. The licensee policy Requesting and Receiving Medication Prescriptions and Refills, dated July 28, 2021, indicated if concerns arose about a medication, the nurse would contact the prescriber and facilitate communication between the resident, the resident's representative, and the prescriber to resolve the problem. TIME PERIOD FOR CORRECTION: Seven (7) Days	01690		