*Protecting, Maintaining and Improving the Health of All Minnesotans*

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL378685163M
**Compliance #:** HL378687042C

**Date Concluded:** November 8, 2024

**Name, Address, and County of Licensee Investigated:**

Living Hope Homes
5641 Babcock Trail
Inver Grove Heights MN 55077
Dakota County

**Facility Type:** Assisted Living Facility (ALF)

**Evaluator's Name:** Maggie Regnier
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 they failed to verify a topically medication the resident ordered online used for wound cleansing.

**Investigative Findings and Conclusion:**
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The resident's physician ordered acetic acid 3% to be used topically (on the outside of the body) on the residents wound. While the facility initially ordered the acetic acid, the resident ordered some but with the wrong concentration. The facility used the wrong concentration on the resident's skin, which caused injury.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record(s), hospital records, pharmacy records, facility internal investigation, facility incident reports,

personnel files, staff schedules, related facility policy and procedures. Also, the investigator observed staff interactions with other staff, residents, family members and visitors.

The resident resided in an assisted living facility. The resident's diagnoses included heart failure, respiratory failure, and cellulitis on the abdominal wall. The resident's service plan included assistance with medication management including ordering and administering, dressing, bathing, and grooming, toileting, transferring, oral care and wound care. The resident's assessment indicated she was on continuous oxygen and was only able to stand briefly if assisted with 1-2 staff members. The resident was able to make her own decisions.

The resident's medical record indicated the medical provider ordered acetic acid 3% to be applied to the resident's wound twice a day.

However, a concern arose that the wrong concentration of acetic acid had been applied to the resident's wound and skin. Initially, the facility ordered the medication from the pharmacy, but the resident wanted to find the medication cheaper than what the pharmacy had charged so the resident ordered it from Amazon and had it delivered to the facility. A facility caregiver applied the acetic acid to the resident, but the resident reported pain immediately and the skin turned black. It was discovered afterwards that the acetic acid from Amazon was not 3% concentration but rather 99% concentration acetic acid.

An internal investigation document indicated the resident found a less expensive acetic acid solution on Amazon and told a facility nurse she had ordered it. The document also indicated the nurse informed staff member(s) the solution would be delivered one evening and then left for the evening. The solution was delivered, and an unlicensed caregiver applied it to the resident's skin without verifying the strength of this acetic acid with the medical provider's orders. The caregiver stopped immediately, contacted the on-call nurse, and call for paramedics.

The facility policy titled medication management states a nurse will correctly and accurately document any medication setup provided. This policy further states unlicensed caregivers will verify medications.

During an interview, a nurse stated she knew the resident was purchasing the product on Amazon. The nurse also stated she told staff that the acetic acid would be coming in the mail and to watch for it. The acetic acid was delivered it, and the strength was not verified by either the nurse or the unlicensed caregiver.

During an interview, the unlicensed caregiver stated she was told to watch out for the delivery of the solution, and it could be used when it arrived.

During an interview, the resident stated she thought she ordered the correct medication but did not think to verify the strength.

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.

**Vulnerable Adult interviewed**: Yes
**Family/Responsible Party interviewed**: NA
**Alleged Perpetrator interviewed**: Not Applicable

**Action taken by facility:** The facility sought treatment for the resident.

**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
Dakota County Attorney
Inver Grove Heights City Attorney
Inver Grove Height Police Department

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 37868 | A. BUILDING: _____ B. WING _____ | C 10/24/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LIVING HOPE HOMES-AUDREY'S PLACE | 4660 SLATER ROAD #230 EAGAN, MN 55122 |

| (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 |
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| 0 000 | Initial Comments<br><br>******ATTENTION******<br><br>HOME CARE PROVIDER/ASSISTED LIVING PROVIDER CORRECTION ORDER<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>#HL378687042C/#HL378685163M<br><br>On October 24 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 5 residents receiving services under the provider's Assisted Living license.<br><br>The following correction order is issued/orders are issued for #HL378687042C/#HL378685163M, tag identification 1690 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.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>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<br><br>(a) This section applies only to assisted living facilities that provide medication management services.<br>(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.<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview, and record review, the licensee failed to implement measures to ensure security and accountability for the overall management, control, and disposition of medications in compliance with state and federal | 01690 | | |

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| 01690 | Continued From page 2<br>regulations.<br><br>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).<br><br>The findings include:<br><br>R1 admitted to the licensee on July 24, 2024, and began receiving assisted living services.<br><br>R1's diagnoses included, cellulitis of the abdominal wall, anxiety disorder, obesity, and chronic respiratory failure.<br><br>R1's Service Plan indicated R1 received assistance with medication management, and wound care.<br><br>R1's prescriber orders signed July 16, 2024, included cleanse left pannus wound with 3% acetic acid 2 times daily.<br><br>During an interview on October 24, 2024 at 11:30 a.m., registered nurse (RN)-B stated the resident was of sound mind and capable of making decisions for herself but did need medication management and assistance with wound care.<br><br>During an interview on October 24, 2024 at 12:30 p.m. RN-B stated the resident's insurance did not cover the cost of a new bottle of acetic acid, the resident was informed of this and stated she wanted to shop around to find a cheaper option. | 01690 | | |

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| 01690 | Continued From page 3<br><br>During an interview on October 24, 2024, at 12:30 a.m., RN-B stated they were aware of the resident ordering acetic acid from an online store but did not verify what the resident ordered was what the physician ordered.<br><br>During an interview on October 24, 2024, at 12:30 p.m. RN-B stated the resident's order would be delivered on Saturday. RN-B instructed the unlicensed care giver (ULP)-C to watch for the medication delivery.<br><br>During an interview on October 28, 2024 at 2:45 p.m., ULP-C stated she received the residents ordered acetic acid on a Saturday and used it without checking the order to verify the correct medication.<br><br>During an interview on October 28, 2024 at 2:45 p.m. ULP-C stated when she applied the resident's acetic acid, the resident immediately had pain, and the ULP stated the residents skin turned black. ULP-C stopped the wound care and rinsed the wound, called a nurse and was instructed to send the resident to the emergency room via ambulance.<br><br>During an interview on October 24, 2024 R1 stated she wanted to find the acetic acid cheaper, which she did and ordered it, but did not verify the strength was what the medical provider ordered. R1 stated she should have checked that before ordering the medication.<br><br>A document dated August 2, 2024, indicated the RN-B directed staff that the resident's acetic acid order was going to be delivered that evening. The staff member(s) started to use the medication as ordered but the acetic acid solution was 99% | 01690 | | |

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| 01690 | Continued From page 4<br>instead of the 3% solution that was ordered by the physician.<br><br>A facility policy dated August 01, 2021, titled 7.08 Medication Management-Administration and setup, states the nursing staff and unlicensed personnel trained to provide medication administration at Living Hope Homes will document any medication administration provided accurately in each resident record. A licensed nurse will correctly and accurately document any medication setup provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01690 | | |
| 02360 | 144G.91 Subd. 8 Freedom from maltreatment<br><br>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.<br><br>This MN Requirement is not met as evidenced by:<br>The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment.<br><br>Findings include:<br><br>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 | | |

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