Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL381655301M
Compliance #: HL381657207C

Date Concluded: December 10, 2024

Name, Address, and County of Licensee Investigated:
Second Home Healthcare, LLC
2421 18th AVE NW 2
Rochester, MN 55901
Olmsted County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Deb Schillinger RN BSN, 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 facility did not administer insulin according to the medical provider's orders.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility administered insulin as ordered by the resident's primary care provider and provided by the pharmacy.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the insurance case worker, and the pharmacy provider. The investigation included review of the resident records, hospital records, pharmacy records, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed resident and staff interactions during an onsite visit.

The resident resided in an assisted living facility. The resident's diagnoses included type 1 diabetes mellitus. The resident's service plan included assistance with medication administration. The resident's assessment indicated the resident worked outside of the assisted living facility and independently made his own decisions. The resident used a cane for mobility inside the facility and a motorized scooter for mobility outside of the home.

A concern arose indicating the resident's insulin orders not being administered as ordered by his medical provider, and the resident was receiving sliding scale insulin without an active order.

At the time the concern arose the resident's medical record indicated the resident had both scheduled insulin and a sliding scale insulin order was in place. Those orders included:

- Lantus (long-acting) insulin with the morning meal
- Lispro (short-acting) insulin three times daily at lunch, dinner, and at bedtime
- A sliding scale insulin

Four days after the concern arose, the resident's medical provider discontinued the resident's sliding scale. -

The resident's medication administration record (MAR) indicated a long-acting insulin was to be given each morning, and doses of short-acting insulin was to be administered at mealtimes after the resident's blood sugar had been checked.

A review of the resident's medication administration record and blood sugar documentation for the same month indicated a sliding scale insulin dosage was not being utilized after orders were received.

During an interview, the nurse stated the resident was receiving insulin per sliding scale, when questioned regarding her understanding of sliding scale, she explained "sliding scale" is when the blood sugar is low, we do not give the short acting insulin ordered for mealtime. The nurse stated the resident was an active participant in his care, he would approve or decline the ordered insulin doses and at times was not compliant regarding his diet, and liked to eat chocolates he kept in his room.

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: Yes
Family/Responsible Party interviewed: No family member identified.
Alleged Perpetrator interviewed: NA

Action taken by facility:
No action taken.

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
	38165	A. BUILDING: _____ B. WING _____	C 11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SECOND HOME HEALTHCARE LLC	2421 18TH AVENUE NORTHWEST ROCHESTER, MN 55901

(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: #HL381657207C/#HL381655301M On November 13, 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 3 residents receiving services under the provider's Assisted Living license. The following correction order is issued/orders are issued for #HL381657207C/#HL381655301M, tag identification 1760 and 1820.	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.	
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication	01760		

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01760	Continued From page 1 Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to verify accuracy of prescriber orders when transcribing nor complete specific resident instructions relating to the administration of medications for one of one resident (R1) with injectable medications. 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, but was not likely to cause 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 diabetes. R1's service plan dated September 27, 2024, indicated R1 received the following services: medication administration.	01760		

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01760	Continued From page 2 R1's September 1 through September 23, 2024 medication administration record (MAR) included: -Lantus Solostar 100 u/ml. Inject 50 units subcutaneously every morning. -Lispro Insulin 100 u/ml. Inject 6 units subcutaneously with breakfast; 10 units with lunch; and 10 units with dinner. R1's MAR lacked specific parameters for insulin administration, lacked instructions to rotate and document injection sites and instructions for unlicensed personnel (ULP)s to document when insulin dose was not administered. -On September 2, 2024, the MAR "LUNCH" area was initialed by ULP indicating 10 units of insulin was administered to R1, however Insulin Log had 0 entered indicating no insulin given. No documentation was present indicating the reason the medication was or was not given. Nor was documentation present indicating the nurse was contacted. -On September 3, 2024, the MAR "BREAKF" area had a 0 indicating no insulin was administered. The Insulin Log "Morning" area for amount of insulin given was 0. No documentation was present indicating the reason the medication was not given. Nor was documentation present indicating the nurse was contacted. -On September 4, 2024, the MAR "LUNCH" area was initialed by ULP indicating 10 units of insulin was administered to R1, however Insulin Log had	01760		

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01760	Continued From page 3 0 entered indicating no insulin given. No documentation was present indicating the reason the medication was or was not given. Nor documentation present indicating the nurse was contacted. -On September 5, 2024, the MAR "DINNER" area was initialed by ULP indicating 10 units of insulin was administered to R1, however Insulin Log had 0 entered indicating no insulin given. No documentation was present indicating the reason the medication was or was not given. Nor documentation present indicating the nurse was contacted. -On September 8, 2024, the MAR "BREAKF" area was initialed indicating 6 units of Lispro insulin was administered. The Insulin Log "Morning" area for amount of insulin given was 0. No documentation was present indicating the reason the medication was or was not given. Nor documentation present indicating the nurse was contacted. -On September 12, 2024, the MAR "LUNCH" area was blank. The Insulin Log "Lunch" area for amount of insulin given was 0. No documentation was present indicating the reason the medication was or was not given. Nor documentation present indicating the nurse was contacted.	01760		

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01760	Continued From page 4 -On September 13, 2024, the MAR "LUNCH" area was initialed by ULP indicating 10 units of insulin was administered to R1, however Insulin Log had 0 entered indicating no insulin given. No documentation was present indicating the reason the medication was or was not given. Nor documentation present indicating the nurse was contacted. -On September 15, 2024, the MAR "BREAKF" and "DINNER" areas were initialed by ULP indicating 6 units and 10 units of insulin was administered to R1, however Insulin Log had 0 entered in the "Morning area and Dinner area" indicating no insulin given. No documentation was present indicating the reason the medication was or was not given. Nor documentation present indicating the nurse was contacted. -On September 16, 2024, the MAR "DINNER" area was initialed by ULP indicating 10 units of insulin was administered to R1, however Insulin Log had 0 entered in the "Dinner" area indicating no insulin was given. No documentation was present indicating the reason the medication was or was not given. Nor documentation present indicating the nurse was contacted. -On September 17, 2024, the MAR "DINNER" area was blank. The Insulin Log "Dinner" area for amount of insulin given was 0.	01760		

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01760	Continued From page 5 No documentation was present indicating the reason the medication was or was not given. Nor documentation present indicating the nurse was contacted. -On September 18, 2024, the MAR "BREAKF" and "LUNCH" areas were blank, the Insulin Log had 0 entered in the "Morning" area and "Lunch" area indicating no insulin was administered. No documentation was present indicating the reason the medication was or was not given. Nor documentation present indicating the nurse was contacted. Lantus Solostar instructions from manufacturer dated June 2023, and Lispro instructions from the manufacturer dated September 2023 noted it is important to rotate injection sites to avoid lipohypertrophy (an abnormal fat deposit under the skin caused by not rotating injection sites). A review of R1's medical records did not identify documentation showing the facility tracked what injection site was used for injections. The licensee's provided policy 3.5 titled "Medication Documentation", dated August 1, 2021, indicated if the administration of one or more medications was not completed, staff will document the following: -The reason why the medication was not administered. -Follow up procedures to meet the resident's needs in compliance with the Medication Management Plan -Appropriate notification to RN Supervisor or	01760		

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01760	Continued From page 6 other persons as instructed regarding missed dosages. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain current medication orders for one of one resident (R1). 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, but was not likely to cause 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 diabetes. R1's service plan dated September 27, 2024, indicated R1 received the following services: medication administration. On November 13, 2024, at 11:40 a.m., the nurse stated the orders from providers are sent directly	01820		

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01820	Continued From page 7 to the pharmacy, stated she would receive notification of new orders when delivered by pharmacy. The nurse reported new usage of electronic medical record once fully operational would provide notification from the pharmacy when new orders are received from provider. The nurse stated there were no written orders received from provider. No signed record of current orders were present in R1's medical record. The licensee's provided policy 2.6, titled "Prescriber's Orders", dated August 1, 2021 indicated written orders from an authorized prescriber will be obtained for all medications and treatments with which the assisted living facility assists residents, including over the counter medications and the medication and treatment orders will be renewed at least every year or when changes occur. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		