Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL390341743M. **Date Concluded:** July 2, 2025
Compliance #: HL390342928C

Name, Address, and County of Licensee Investigated:
NorBella of Champlin
8700 Emery Parkway North
Champlin, MN 55316
Hennepin County

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

Evaluator's Name:
Maerin Renee, RN, 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 staff did not administer her inhaler for three days. The resident was hospitalized with chronic obstructive pulmonary disease (COPD) exacerbation.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. Through a series of systemic errors, staff did not administer the resident's Trelegy inhaler (a medication used for the maintenance treatment of asthma and COPD) for four days. There was no standard process in place to receive medications from the pharmacy, to log receipt of medications, or to ensure all medications that had been ordered were received in a timely manner. The facility also did not have a reliable way for staff to contact the after-hours triage nurse, resulting in further delay in locating and administering the resident's inhaler. After four days without using her Trelegy inhaler, the resident was hospitalized and intubated in the ICU with respiratory distress. The resident returned to the facility after a week in the hospital on hospice care.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted family. 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 interactions with staff.

The resident resided in an assisted living facility. The resident's diagnoses included COPD. The resident's services included assistance with activities of daily living, meals, housekeeping, laundry, oxygen management, and medication management. The resident's assessment indicated the resident was unable to self-administer medications due to memory impairment and polypharmacy. Medications would be managed by nursing staff.

The facility's adverse event investigation indicated the resident missed Trelegy doses for four days. A staff member who received the medication from the pharmacy did not check the manifest or store the medication properly. There was also a failure to ensure an adequate supply of medication prior to it running out. On the fifth day, the resident developed respiratory distress. The resident was short of breath and weak. The resident's oxygen saturation (O2 sat) was 85% on 2 liters of oxygen (normal range: 95%-100%). Staff administered a rescue inhaler without improvement. Respirations were 32 breaths per minute (normal rate for an adult: 12-20 breaths per minute). The resident was sent to the hospital, where she was diagnosed with respiratory failure. A supervisor was notified that the resident's Trelegy inhaler was not administered over the weekend because it was placed in the wrong medication cart.

A supervisor reviewed video footage and saw an unlicensed personnel (ULP) receive a package from the pharmacy delivery after hours and walk it to the memory care unit. The ULP said she signed for the medication delivery and saw a memory care resident's name on the package, so she delivered the package to memory care. The ULP gave the package of medication to the memory care medication passer, who placed the medications in the memory care medication cart. It was later determined one of the medications in the bag that was delivered was the resident's Trelegy inhaler. The resident lived in assisted living, not memory care.

The resident's medical administration record (MAR) indicated her Trelegy inhaler was held for four days. On day one staff documented the medication had been ordered. On day two staff documented "no supply." On day three staff documented "Other: not available." On day four staff documented "other: delivered on 4/3/25," although the medication was still held.

The resident's progress notes indicated staff notified a nurse the resident was not feeling well. A nurse assessed the resident, and other staff administered a rescue inhaler without success. The resident's lung sounds, O2 sats, and respirations were outside of normal limits and staff called 911.

The resident's hospital records indicated she was admitted to the intensive care unit (ICU) with a diagnosis of acute respiratory failure secondary to COPD. The resident had developed hypoxia (low levels of oxygen in body tissues) and hypercapnia (high levels of carbon dioxide in the blood). The resident was unable to breath on her own and required intubation. The resident was extubated and discharged back to the facility on hospice care after seven days in the hospital.

When interviewed, the ULP said she accepted a medication delivery from the pharmacy. The bag of medication was labelled with the name of a memory care resident. She did not open the bag to review or log the contents. She brought the bag to the medication passer in memory care and returned to her assignment in assisted living.

When interviewed, a medication passer said she was passing medications in the memory care unit when a colleague brought a bag of medication to her. The bag was labelled with a memory care resident's name. The medication passer put the memory care resident's medication in his medication box. The medication passer said she did not recall seeing the resident's inhaler in the bag. The medication passer said she did not inspect each parcel that was in the bag because her colleague had signed for the medication and told her it was for memory care.

When interviewed, a staff member said she was assigned to pass medications in assisted living one evening and could not find the resident's Trelegy inhaler. The staff member searched extensively for the inhaler but could not locate it. She attempted to call the after-hours nurse on the triage line but only got a busy signal. She attempted to call the line using her personal phone and was met with a busy signal as well, so she was unable to contact a nurse or even leave a voicemail. The staff member called and left a voicemail for the facility nurse but did not receive a response. The staff member said she was forced to document the medication as held due to not being available. Later the staff member asked the nurse why she did not call her back, the nurse said staff are to call the triage line after hours, not facility nurses.

When interviewed, a facility nurse said she came into work on a Monday morning and staff informed her the resident was short of breath. After assessing the resident's condition, staff called 911 and the resident was transported to the hospital. The facility nurse discovered the resident had missed several doses of her Trelegy inhaler. The inhaler was delivered to the facility several days earlier, later in the evening. The ULP accepted the delivery and saw it was labelled with a memory care resident's name. The ULP brought it to the medication passer in memory care. The medication passer opened the bag and saw the resident's inhaler in it. Since the resident lived in assisted living, the medication passer put her inhaler in a bottom drawer of the memory care medication cart, away from the memory care residents' medications. Days later, the facility nurse found the resident's inhaler in the memory care medication cart. The facility nurse said the assisted living medication passer did not contact the after-hours nurse via the triage line regarding the missing medication, per protocol.

When interviewed, a family member expressed disappointment with the resident's care at the facility. The family member said the facility did not follow orders for appropriate meal preparation, skin care/repositioning, and respiratory management. The family member was concerned when a staff member informed her they were out of the resident's Trelegy. The facility's pulse oximeter did not work, so the family member used her own the check the resident's O2 sat, which was at 85%. The next morning, the facility called the family member to inform her the resident needed to be hospitalized.

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: Declined.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility updated policies for ordering and receiving medication deliveries and provided staff with training regarding those policies.

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
Hennepin County Attorney
Champlin City Attorney
Champlin Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39034	A. BUILDING: _____ B. WING _____	C 05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORBELLA OF CHAMPLIN LLC	8700 EMERY PARKWAY NORTH CHAMPLIN, MN 55316

(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: #HL390342928C/#HL390341743M On May 28, 2025, 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 40 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL390342928C/#HL390341743M, tag identification 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.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

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02360	Continued From page 1 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 reviewed (R1) was free from maltreatment. Findings include: 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		