Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL202573483M
Compliance #: HL202575627C

Date Concluded: January 26, 2023

Name, Address, and County of Licensee Investigated:
Assisted Living at North Ridge
5500 Boone Ave North
New Hope, MN 55428
Hennepin County

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

Evaluator's Name: Lena Gangestad, RN
Special Investigator

Finding: Not Substantiated

Nature of the 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 failed to order her medications leading to her missing her medications. Additionally, the facility neglected the resident when facility caregivers did not use a transfer belt during a transfer resulting in a fall.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. There was an occasion when the facility ran out of the resident's medications, however it was an isolated event, and the resident was uninjured. The resident did fall while at the facility, however it was not due to an improper transfer and no serious injury occurred.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator interviewed the resident's family members. The investigation included a review of residents' records, the facility's policies and procedures,

and incident reports. The investigation included an onsite visit, observations, and interactions between residents and facility staff members.

The resident resided in an assisted living facility. The resident's diagnoses included stroke and muscle weakness. The resident's service plan included medication management and one-person assistance with transfers. The resident's service plan indicated the facility provided medication setup, but the resident self-administered her medications. The resident's medical record indicated the resident had a history of EZ stand (a stand-assist lift) but her current service plan indicated she transferred with one-person assistance.

During the first month after the resident admitted to the facility, the resident's medication record (MAR) indicated there were several days some medications not given because it was necessary to reorder a supply. The same documents indicated there were no other incidents of the resident missing medications due to no supply. The MAR also indicated the resident had begun self-administering her medications.

During an interview, the unlicensed caregiver stated she had worked with the resident since she first moved into the facility. The unlicensed caregiver stated it initially took two people to help the resident transfer, but now it required only one person. She stated when the resident first moved into the facility the staff members administered the resident's medications to her, but this had since changed so the nurse set-up the resident's medications and she self-administered her medications.

During an interview, the physical therapist stated she worked with the resident when she moved into the assisted living apartment. The physical therapist stated initially the resident required full assistance with mobility including transfers. The physical therapist stated the resident's ability to transfer had since improved and an EZ stand was not required.

During an interview, the licensed practical nurse stated she was one of the staff members who re-orders medications for residents. The licensed practical nurse stated the resident admitted with a two-week supply of her medications and the list should have been faxed to the pharmacy for re-order but for some reason the medications were not delivered. One of the unlicensed caregivers alerted her R1's medications had run out so she faxed the pharmacy.

During an interview, the registered nurse stated he admitted the resident to the facility, and he recalled faxing the pharmacy her medications and he was unsure why the medications did not arrive. The registered nurse stated the resident had used an EZ stand prior to coming to the facility but the facility did not have EZ stands so she was initially care planned for assistance with two caregivers and a transfer belt.

During an interview, the resident stated she used the EZ stand while she was in the transitional care unit before coming to the facility. The resident stated she assumed the facility had an EZ

stand but they did not. She did fall once when she wheeled herself into the bathroom and slid off the wheelchair, but no staff members were present. She stated the nurse sets up her medications once a week and she take the medications herself.

During an interview, the family member stated the resident was able to administer her own medications. The family member stated the resident had fallen one time while she was waiting to use the bathroom when she slid out of wheelchair, but she was not injured. He stated sometimes the response to the resident's call lights could be timelier, but that was something the facility was working on, and it was getting better.

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: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
As described in the body of the report, the facility did re-order the resident's medications, and the issue has not recurred. The facility also implemented a monitoring system to ensure medications are ordered timely. The facility has also implemented call light audits to reduce the response time to call lights.

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
	20257	A. BUILDING: _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSISTED LIVING AT NORTH RIDGE	5500 BOONE AVENUE NORTH NEW HOPE, MN 55428

(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 LICENSING 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: #HL202575627C/#HL202573483M On January 6, 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 124 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL202575627C/#HL202573483M, tag identification 1760.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. 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 surveyors' 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 subd. 1, 2, and 3.	
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted	01760		

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01760	Continued From page 1 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 interview and record review, the licensee failed to ensure medications were re-ordered and administered as prescribed for one of three residents (R1) with records reviewed. Additionally, the facility failed to document follow-up with R1's provider regarding the missed 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) 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 hemiplegia (one-sided muscle paralysis) and muscle weakness. R1's service plan, dated October 6, 2022, indicated R1 received the following services:	01760		

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01760	Continued From page 2 medication administration, assistance with dressing, grooming, bathing, mobility, and transfers. R1's prescriber orders, dated October 6, 2022, included Amlodipine (indicated for high blood pressure), aspirin (stroke), diclofenac sodium gel 1% (pain), Lopressor (high blood pressure), melatonin (sleep), polyvinyl alcohol solution (dry eye), multiple vitamin minerals (eye health), Prilosec (acid reflux) and Tylenol (pain). R1's October 2022 electronic medication administration record (eMAR) indicated: Aspirin Tablet Chewable 81 milligram (mg) give one tablet by mouth one time a day was not administrated and charted by two unlicensed personnel (ULP) as supply reorder from October 18 to October 24, 2022. Melatonin Tablet 5 mg give one tablet by mouth at bedtime was not administrated and charted by two unlicensed personnel (ULP) as supply reorder from October 21 to October 24, 2022. Prilosec tablet delayed release give 20 mg by mouth one time a day was not administrated and charted by two unlicensed personnel (ULP) as supply reorder from October 18 to October 20, 2022. Lopressor tablets give 25 mg by mouth two times a day was not administrated and charted by two unlicensed personnel (ULP) as supply reorder from October 21 to October 24, 2022. Multiple vitamin minerals give one capsule by mouth two times a day was not administrated and charted by two unlicensed personnel (ULP) as	01760		

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01760	Continued From page 3 supply reorder from October 18 to October 24, 2022. Tylenol extra strength tablet 500 mg give two tablets by mouth three times a day was not administrated and charted by two unlicensed personnel (ULP) as supply reorder from October 22 to October 24, 2022. A review of the medical did not identify documentation indicating the facility updated R1's provider of the missed medications. On January 10, 2023, at 11:24 a.m., the licensed practical nurse (LPN)-A stated she was one of the staff members re-orders medications for the residents. LPN-A stated R1admitted with two weeks' worth of medications on October 6, 2022, and the medication list should be faxed over to the pharmacy on the same day. LPN-A stated one of the unlicensed personnel (ULP) notified her R1's medication ran out, so she faxed the pharmacy on October 21, 2022. She then re-faxed the medication list again on October 23rd. LPN-A stated she was unsure why R1's medications had not arrived nor if R1 had enough medications to the end of October. She was not sure if R1's provider was notified. On January 10, 2023, at 1:42 p.m., the registered nurse (RN)-F stated he was the one who admitted her. He stated he faxed R1's list of medications over to the pharmacy when she got admitted but did not know why the pharmacy did not receive her medication list. An email received from the licensee on January 10, 2022, at 5:55 p.m. from licensed assisted living director (LALD)-H indicated R1 admitted with medications and the RN did the intake orders	01760		

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01760	Continued From page 4 came with on October 6, 2022. The same document indicated the facility had the order but could not prove the order was faxed and the LPN was not working. The email indicated the orders were faxed on October 21 and October 23. The licensee's Medication and Treatment Orders-Reordering policy dated August 2021, indicated the nurse was responsible for reordered from the pharmacy or supplier, the staff will contact them by faxing, calling, or following the pharmacy's directions for refilling prescriptions or requests. Prior to holidays and weekends the RN or designated staff will plan ahead for the needs of residents for refills on prescriptions. TIME PERIOD TO CORRECT- Seven (7) days.	01760		