Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL205681841M **Date Concluded:** May 19, 2023
Compliance #: HL205683509C

Name, Address, and County of Licensee Investigated:
Lakeside Generations Assisted
441 William Avenue
Dassel, MN 55325
Meeker County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Erin Johnson-Crosby, RN
Special Investigator

Finding: Inconclusive

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 failed to administer antibiotics as ordered. The resident was hospitalized for a hand infection requiring treatment with intravenous (IV) antibiotics.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. Although facility staff did not administer four doses of the resident's prescribed oral antibiotic, it could not be determined if the missing doses led to worsening of the infection or if the prescribed antibiotic would have treated the infection.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted the nurse practitioner (NP).

The investigation included review of the resident record and facility policies and procedures. Also, the investigator observed the medication administration process.

The resident resided in an assisted living facility. The resident's diagnoses included dermatitis, eczema, and history of a stroke. The resident's service plan included assistance with medication administration. The resident's assessment indicated the resident had a history of rash with scabs and was previously followed by dermatology.

The resident's medical record indicated staff observed a small open area, near the knuckle, on the fifth finger of the resident's right hand. The skin surrounding the open area was swollen, warm to the touch, and pus and blood were draining from the area. The NP was contacted and prescribed Keflex (antibiotic) twice daily for five days for cellulitis (skin infection). The resident's medication administration record (MAR) indicated the resident did not receive four of the ten prescribed doses of the antibiotic. The resident's infection worsened, the resident was sent to the hospital and treated with intravenous (IV) antibiotics.

The facility's internal investigation identified the antibiotic order was sent to the pharmacy and facility staff called to verify the order was received. The next day, unlicensed personnel (ULP) notified nursing staff the antibiotic was not delivered. Nursing staff assumed the antibiotic would be delivered that evening. The following evening, nursing staff were notified the antibiotic was still not available and the resident was concerned about his hand. Nursing staff offered to send the resident to the emergency room and called the pharmacy to inquire about the delay in obtaining the medication. The antibiotic arrived later that evening and was administered to the resident. Due to worsening symptoms of his right hand, the resident was sent to the hospital for an evaluation. The resident was admitted to the hospital and treated with IV antibiotics.

The resident's hospital records included documentation of a wound culture (a lab test to determine organism of infection) which showed Methicillin Resistant Staphylococcus Aureus (MSRA). The original antibiotic (Keflex) prescribed would not have effectively treated a MRSA infection.

During an interview, nursing staff said the resident usually received medications via the Veterans Affairs (VA) pharmacy, however, since the antibiotic needed to be administered as soon as possible, the facility used another pharmacy. Nursing staff confirmed the resident did not receive four of the ten scheduled doses of the medication due to the delay in delivery from the pharmacy. Nursing staff said the pharmacy technician entered the order incorrectly, so the order was not filled. The nursing staff member verified when the resident's hand worsened, the resident was sent to the hospital.

During an interview, the NP stated Keflex is ordered to treat a variety of infections and wound cultures are not usually ordered at assisted livings. The NP indicated Keflex would not have

been an effective treatment, as the culture indicated the wound was positive for MRSA. The NP had no concerns regarding the care provided at the facility.

During an interview, the resident did not recall the hand infection and had no concerns regarding the care he received.

During an interview, the resident's family member stated the facility notified her about the missed antibiotics. The family member indicated the resident had a long history of skin problems and was now followed by dermatology. The family member had no concerns with the facility and was very happy with the care the resident received.

In conclusion, the Minnesota Department of Health determined neglect was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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:
The facility reported the incident, contacted the pharmacy, completed an internal investigation, and re-trained staff.

Action taken by the Minnesota Department of Health:
No further action taken at this time.

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
	20568	A. BUILDING: _____ B. WING _____	C 04/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKESIDE GENERATIONS ASSISTED	441 WILLIAM AVENUE EAST DASSEL, MN 55325

(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 On April 11, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL205683509C/#HL205681841M. No correction orders are issued.	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	

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0 000	Continued From page 1	0 000	ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	