

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL213873981M
Compliance #: HL213874534C

Date Concluded: October 2, 2024

Name, Address, and County of Licensee

Investigated:

Rose Arbor Wildflower Lodge
16500 92nd Ave North
Maple Grove, MN 55311
Hennepin County

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

Evaluator's Name: Brandon Martfeld, RN BSN
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 the facility failed to have a system in place to ensure medications were refilled timely. As a result, the resident missed several days of medications and required an evaluation at a hospital.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to have a system in place to ensure the resident's medications were refilled in a timely manner, including furosemide (given to help treat fluid retention and swelling), which resulted in an emergency room visit and intravenous medication to remove excess fluid around the resident's heart.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident and the resident's family member. The investigation included review of the resident records, hospital records,

facility internal investigation, facility incident reports, staff schedules, and related facility policy and procedures. Also, the investigator observed a facility staff member pass medications to a resident.

The resident resided in an assisted living facility. The resident's diagnoses included congestive heart failure, atrial fibrillation (irregular heartbeat), and depression. The resident's service plan included assistance with medication administration four times a day. The resident's assessment indicated the resident used the facility's pharmacy and was alert and oriented.

The facility's investigation indicated the resident missed four to seven days of regularly scheduled medications. The resident's missed medications included metoprolol (blood pressure), citalopram (antidepressant), Metamucil (fiber supplement), losartan (blood pressure), furosemide, and atorvastatin (lower cholesterol). One day the resident stated she was not feeling well and was brought to the emergency room for an evaluation.

The resident records indicated that day the resident complained of shortness of breath and was feeling nauseated. The resident was sent to the emergency room for an evaluation.

The hospital record indicated the resident arrived at the emergency room with shortness of breath and it was discovered the resident had not received her medications for several days. The hospital record indicated due to the resident not getting her furosemide, the resident had fluid around her heart and her heart failure became worse. The resident was given intravenous (into a vein) furosemide to remove the extra fluid and discharged back to the facility.

During an interview, nursing leadership stated one month the resident missed six different medications. Nursing leadership stated it was determined that staff had not reordered medications timely, and the pharmacy did not have the resident's correct doctor listed to request reordered medications. After missing medications for seven days, the resident reported not feeling well and was sent to the emergency room for an evaluation. The resident received intravenous furosemide because of extra fluid around her heart and returned to the facility. Nursing leadership stated had the resident received her medications, she could have avoided the emergency room visit.

During an interview, the resident stated she missed medications for a number of days and had shortness of breath.

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: No, attempted but did not reach.

Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:

The resident's medications were ordered and delivered to the facility prior to the resident returning from the emergency room. All staff that pass medications were educated on reordering medications. In addition, nursing staff was to complete weekly audits of the medication carts and ensure medications were reordered appropriately.

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
Maple Grove City Attorney
Maple Grove Police Department

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21387	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/26/2024
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NAME OF PROVIDER OR SUPPLIER ROSE ARBOR/WILDFLOWER LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 16500 92ND AVENUE NORTH MAPLE GROVE, MN 55311
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(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	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p>#HL213873981M/#HL213874534C</p> <p>On August 26, 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 102 residents receiving services under the provider's Assisted Living with Dementia Care license.</p> <p>The following correction order is issued/orders are issued for # HL213873981M/#HL213874534C, tag identification 2360.</p>	0 000	<p>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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>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.</p>	
02360	<p>144G.91 Subd. 8 Freedom from maltreatment</p> <p>Residents have the right to be free from physical,</p>	02360		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Minnesota Department of Health

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02360	<p>Continued From page 1</p> <p>sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act.</p> <p>This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment.</p> <p>Findings include:</p> <p>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.</p>	02360		