Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL232173304M
Compliance #: HL232175337C

Date Concluded: October 4, 2023

Name, Address, and County of Licensee Investigated:
Augustana Regent at Burnsville
14500 Regent Lane
Burnsville, MN 55306
Dakota County

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

Evaluator's Name: Christine Bluhm, RN
Deb Schillinger, RN
Special Investigators

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 Allegations:
The facility neglected a resident when they failed to provide medication to the resident due to the lack of staff and the resident had to be admitted to the hospital. The facility also failed to provide oral cares for the resident which resulted in loss of teeth.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident started a medication for Parkinson's to see if it would be effective and there were supply issues with the medication. The resident also had multiple medication changes as the facility provided updates to the medical provider, and multiple predisposing health conditions which contributed to hospitalization.

The investigator conducted interviews with facility staff members, including administrative staff and nursing staff. The investigator contacted the resident's case worker. The investigation

included a review of facility policies, and incident reports, which included medication errors. The resident's facility record, and hospital records were reviewed. Other resident records were also reviewed for medication administration. Also, the investigator observed resident activities and staff interactions with residents at the facility.

The resident resided in the assisted living facility. The resident's diagnoses included Parkinson's disease, autism, and major depressive disorder. The resident's service plan included assistance with bathing, dressing, meals, and set up assistance with verbal reminders to complete hygiene and oral care. The resident required full assistance with medication administration and management. The resident's cognitive assessment indicated she was alert and oriented with mild intellectual disorder.

A concern arose that the resident was hospitalized for suicidal ideation because the resident did not receive her medications, although the name of the medication(s) was not specified.

Several months of the resident's medication administration records and progress notes were reviewed, and indicated the facility administered the resident's medications and medication entries were complete. During these months and through the resident's hospitalization, there were medication adjustments and changes. The notes also indicated the resident was followed by a medical provider for anxiety, depression, adjustment issues, sleep difficulties and seen by physical therapy for gait and strength therapy. The notes made reference to the resident feeling down about her Parkinson's progression.

The facility progress notes indicated the resident was trying a new medication for Parkinson's. The facility experienced supply issues and waiting for samples of the new medication to arrive.

The resident's emergency room (ER) notes indicated it was reported to ER staff that there was a miscommunication with the facility and the neurology clinic, and the resident missed approximately five days of the new medication.

During interviews, multiple staff members stated the resident had health issues and other circumstances that caused the resident emotional distress. Staff members stated the resident was monitored and given reassurance during these times. One nurse stated that at the time of hospitalization, the resident had dealt with the loss of a family member which may have been a factor. Another staff member stated that when the resident talked of harming herself or others, it was advised that for the resident's safety, the resident be sent for hospital evaluation. Staff members also stated they would offer verbal reminders and encouragement for the resident to complete oral care, but the resident often refused and was her right to refuse.

During an interview, the resident stated she wanted to continue to live at the facility. She did not recall any missed medications but stated there were times when staff brought medications late, but she was able to use the call button or ask for them, so it was not a problem.

During an interview, a family member stated the resident struggled with mental health issues and had a history of making suicidal remarks prior to living at the facility. She stated that the resident had multiple medication changes and a Parkinson's medication was started on a trial basis, but it did not work so it was stopped. As for oral hygiene, the family member also stated that the resident had dental issues prior to admission to the facility and historically had not been good with brushing her teeth so could not confirm if the dental problems was due to a lack of care on the part of the facility.

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:
No action taken.

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
	23217	A. BUILDING: _____ B. WING _____	C 07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENT AT BURNSVILLE	14500 REGENT LANE BURNSVILLE, MN 55306

(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 July 12, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL232175337C/#HL232173304M. No correction orders are issued.	0 000		