Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL246753043M
Compliance #: HL246753073C

Date Concluded: August 8, 2024

Name, Address, and County of Licensee Investigated:
West Bloomington Residence
10441 Johnson Avenue South
Bloomington, Mn 55437
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: James Larson, RN
Special Investigator

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 Allegation(s):
The facility neglected the resident when they failed to administer scheduled medications as ordered.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although there were inconsistencies reported surrounding medication administration, there was not a preponderance of evidence to support that neglect occurred.

The investigator conducted interviews with facility staff members, and unlicensed staff. The investigator contacted a member of the resident's family and nursing staff from other facilities where the resident received care. The investigation included review of the resident records, personnel files, staff schedules, and related facility policies and procedures. Also, the investigator toured the facility, observed staff to resident interactions, and medication administration.

The resident resided in an assisted living facility The resident's diagnoses included Parkinson's disease. The resident's service plan included assistance with activities of daily living, medication administration, meals, and housekeeping. The resident's assessment indicated the resident required supervision with transfers and ambulation to ensure safety due to risk of falling.

A review of the complaint documents indicated concerns over facility staff not following policies and procedures resulting in medication errors and inaccurate entries in the electronic health records.

During an interview, a staff member voiced concerns over unlicensed personal failing to follow facility policies while performing medication administration. The staff member stated there were discrepancies from what was documented in the resident's record versus what medication was administered. The staff member also discussed ongoing concerns surrounding unlicensed professional not following proper procedures related to care and abuse prevention after the resident experienced repeated falls and the nurse was not immediately contacted for guidance on how to care for the resident.

During an interview, administration stated a staff member alerted them to concerns with medication administration. After being notified of the concern, an internal investigation was initiated. The investigation could not determine if medications were missed in the weekly set up of medications but identified instances where staff failed to document in the electronic health record as required. As a result, all staff were provided additional training on medication administration and documentation. When asked about falls, the administration stated upon the admission to the facility, the resident resided in an apartment on the lower unit. The resident independently transferred and attempted to complete activities without staff's assistance. Nursing staff identified this as a safety issue after they noted an increase in falls. As a result, the facility, in coordination with the family, relocated the resident to an apartment on the main floor.

During an interview, the resident could not recall any concerns related to medication administration.

During an interview, the resident's family member stated that they were pleased with the facility's flexibility to move the resident from the lower floor to the main floor. The family stated that medication administration concerns decreased over the past months, and they had no concerns with the current staff or care provided at 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:
The facility moved the resident from a lower-level apartment to the main floor to increased supervision. All staff were retrained on facility policies and medication administration.

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
	24675	A. BUILDING: _____ B. WING _____	C 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST BLOOMINGTON RESIDENCE	10441 JOHNSON AVENUE SOUTH BLOOMINGTON, MN 55437

(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 11, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL246753073C/#HL246753043M. No correction orders are issued.	0 000		