Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL281252787M
Compliance #: HL281254612C

Date Concluded: May 4, 2023

Name, Address, and County of Licensee Investigated:
Loren on Park
2623 Park Avenue
Minneapolis, MN 55407
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Peggy L. Boeck, RN
Special Investigator

Finding: Substantiated, individual responsibility

Nature of Visit:
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 alleged perpetrator (AP), facility staff, neglected a resident when the AP gave the resident the wrong medication and failed to notify anyone. This led to the resident requiring hospitalization in intensive care.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The AP was responsible for the maltreatment. The AP did not follow the appropriate medication administration procedure of identifying the recipient of the medication and gave the resident an antipsychotic medication not prescribed to the resident. The resident was found by staff the next morning with slurred speech, drooling, incontinence, difficulty breathing, and altered mental status. The resident required hospitalization for 8 days.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a family member and interviewed

the resident. The investigation included review of medical records, facility medication errors, personnel files, policies, and procedures related to medication administration, reporting medication errors, and maltreatment of vulnerable adults. Also, the investigator observed medication administration.

The resident lived in an assisted living facility. The resident's diagnoses included hypertension, dementia, and depression. The resident's service plan included assistance with medication set up and reminders to take medications. The resident's assessment indicated he was independent with dressing, bathing, grooming, and other activities of daily living. The resident received twice daily safety checks, assistance with weekly medication set-ups in a Medi-planner container (which remained in the resident's apartment for him to self-administer), and reminders to take medications.

A progress note indicated a nurse entered the resident's apartment one morning when he did not answer the door. The nurse found the resident sitting partially clothed, incontinent, drooling extensively, working hard to breathe, and was difficult to understand due to slow/slurred speech. The note indicated the nurse called 911 and emergency medical services transported the resident to the hospital.

Hospital records indicated the hospital ruled out a heart attack or stroke and screened the resident's blood looking for the cause of his altered mental status. The resident required a tube for breathing and was in the intensive care unit for several days. The records indicated the resident transferred to a medical floor, then required skilled nursing care for approximately two weeks in a step-down facility.

A medication error report indicated the facility received information from the hospital the day after the incident indicating the resident's blood test detected clozapine, an antipsychotic medication not prescribed to the resident. The medication error report indicated the facility investigated a possible medication error.

During an interview, a managerial nurse stated she verified the resident's Medi-planner medications were accurate and did not contain clozapine. The nurse stated she reviewed all resident medications and verified that a peer who lived next door to the resident received prescribed clozapine. The nurse viewed the peer's medication (which was in a bubble pack in the medication cart and administered by staff) and discovered two similarly looking sets of initials signed out two doses of clozapine on the evening of the incident. The nurse interviewed the peer, who stated he recalled a couple days earlier a staff had forgotten his clozapine and had to go back to the medication cart to bring it to him. The nurse interviewed the AP, who administered the peer's medications on the evening of the incident. The AP told the nurse she identified the resident based on the apartment number and could not distinguish the resident from the peer just by looking at them.

During investigative interviews, multiple staff members stated the facility policy for identification of a resident included using the photo that was part of the medication administration record.

During an interview, a family member stated she was grateful the nurse went into the resident's room or there could have been a worse outcome. The family member stated the resident had mixed feelings about returning to the facility after his hospital stay but was doing well.

During an interview, the AP stated on the night of the incident she was confused as she was not working her normal shift, and probably rushing to get her work done. The AP stated she did take the medication out twice but did not realize she made a medication error by giving it to the wrong resident until the facility called her during their investigation. The AP stated she did not want to deny her error and no longer works in healthcare.

In conclusion, neglect occurred.

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: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility completed a thorough investigation, retrained all staff passing medications, and required all staff passing medications to demonstrate competency passing medications.

The AP no longer works for the facility.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Hennepin County Attorney
Minneapolis City Attorney
Minneapolis Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28125	A. BUILDING: _____ B. WING _____	C 04/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOREN ON PARK	2625 PARK AVENUE MINNEAPOLIS, MN 55407

(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, this correction order is 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: #HL281252787M/ #HL281254612C On April 27, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were 76 residents receiving services under the provider's Assisted Living license. The following correction order is issued for #HL281252787M; #HL281254612C tag identification #2360.	0 000	The Minnesota Department of Health documents 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the Surveyors and/or Investigators ' findings is the Time Period for Correction. Per Minnesota Statute §144G.30, Subd. 5 (c), the assisted living facilities must document any action taken to comply with the state correction order. A copy of the provider ' s records documenting those actions may be requested for follow-up surveys and/or complaint investigations. 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28125	A. BUILDING: _____ B. WING _____	C 04/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOREN ON PARK	2625 PARK AVENUE MINNEAPOLIS, MN 55407

(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	Continued From page 1	0 000	THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPY AND LEVEL ISSUED PURSUANT TO THE MINN. STAT. § 144G.31, SUBDIVISION 2 and 3.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	