Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL286053223M
Compliance #: HL286055258C

Date Concluded: September 18, 2023

Name, Address, and County of Licensee Investigated:
Summit Hill Senior Living
1824 Old Hudson Road
Saint Paul, MN 55119
Ramsey County

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

Evaluator's Name: Yolanda Dawson, RN, Special Investigator
Jill Hagen, 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 alleged perpetrator (AP), facility staff, neglected a resident when the AP left resident #3's medication on a table in the resident's room however, resident #1 who was visiting resident #3 took the medications belonging to resident #3.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although resident #1 took resident #3's medications, the error was an isolated incident and resident #1 remained at her baseline health condition.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of resident records, employee training records, incident reports, and facility policies and procedures. Also, the investigator observed medication administration procedures.

Resident #1 resided in an assisted living facility. Resident #1's diagnoses included abnormal heart rhythm, diabetes, spinal compression fracture, high blood pressure, and acute kidney failure. Resident #1 was able to make her needs known to others. Resident #1's service plan included assistance with medication management including medication set up and dispensing, safety checks, and psychotropic medication monitoring.

A facility incident report indicated the AP set up and delivered morning medications to resident's #3's room and left them on the table in a medication cup next to the couch where resident #1 visiting resident #3, was sleeping. When resident #1 awoke, she took the medication thinking they were for her. Later that morning when the AP tried to administer resident #1's morning medications, resident #1 told the AP she had already taken them.

The AP immediately reported the medication error to the facility nurse. Later that afternoon resident #1 reported to the AP that she was dizzy. Resident #1's vital signs remained stable. Facility staff reported the medication error to resident #1's provider and were directed to monitor resident #1 by providing safety checks every one hour and vital signs every four hours for the remainder of the day. Resident #1 remained at her baseline health status.

During interviews, several staff members stated the proper procedure for medication administration was to follow the six rights of medication administration which included identifying the resident before administering medication.

During an interview, a registered nurse (RN) stated all employees are trained on proper medication administration. The RN stated the AP notified the nurse when the medication error was identified, and staff were educated on the policy for proper medication administration.

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: No, unable to reach.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: No, the AP did not respond to subpoena.

Action taken by facility:
Management provided education to staff members. The AP was no longer employed by the facility.

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
	28605	A. BUILDING: _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT HILL SENIOR LIVING	1824 OLD HUDSON ROAD SAINT PAUL, MN 55119

(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 6, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL286053223M/#HL286055258C/#HL286053025M/#HL286054947C. No correction orders are issued.	0 000		