Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL298562101M
Compliance #: HL298569945C

Date Concluded: August 1, 2024

Name, Address, and County of Licensee Investigated:
The Homestead at Anoka
3002 4th Avenue
Anoka, MN 55303
Anoka County

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

Evaluator's Name: Willette Shafer, 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 staff were unaware the resident admitted, therefore the resident missed meals and medications. The staff sent the resident to the hospital after her physical health declined.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility alerted staff of the resident's admission via verbal and written notification. The resident never missed any meals, and staff administered all medications other than a medication that family was aware was unavailable when admitted.

The investigator conducted interviews with facility staff members, including administrative staff. The investigator also interviewed the resident and the resident's family member. The investigation included review of the resident records, facility internal investigation, facility

incident reports, staff schedules, facility policies and procedures. Also, the investigator toured the facility and observed medication administration and a meal service.

The resident had recently transferred from transitional care to assisted living. The resident's diagnoses included weakness and aftercare following nervous system surgery. The resident's service plan included assistance with medication administration, meals, dressing, bathing, and housekeeping. The resident was able to walk with a walker and made breakfast independently in her apartment from personal food supply.

During an interview, a family member said the resident reported she never received her medications Friday evening or Saturday morning. Also, the resident missed two doses of her evening blood pressure medication because the facility was unable to obtain the medication from the pharmacy until Monday. The family member denied the resident missed a meal while at the facility but said the resident reported the food was cold and unappetizing.

During an interview, the resident said she transferred from transitional care to assisted living on a Friday. She said transitional care was out of her blood pressure medication and the assisted living was unable to obtain the medication until Monday. She said she received all other medications over the weekend. The blood pressure medication missing was a morning medication and she did not receive it Saturday morning. The resident said she was able to walk with a walker, had food in her apartment, and made her own breakfast. She ate lunch and dinner provided by the facility and her family member brought in lunch on Saturday. She never missed a meal, but her dinner came late Friday and Saturday. She said a family member visited Friday, Saturday, and Sunday. On Sunday, she felt weak and had a temperature. She went to the hospital. The resident had a personal cell phone and was able to contact people.

According to the resident's medication administration record, the resident received her medications as ordered.

During an interview, a member of management said the resident arrived at the facility without one of her medications. The facility was unable to obtain the medication from pharmacy due to the timing of arrival. The facility informed both the family and resident of the missing medication. The nurse informed staff of the resident's admission and entered an alert on the computer home page to alert staff. She said the resident never missed any meals and staff administered medications during her stay. The member of management was onsite Friday, Saturday, and Sunday and met with the resident all three days. Staff sent the resident to the hospital on Sunday for weakness and fever. She recovered and discharged back to 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 completed an internal investigation and implemented a communication book between shifts. The facility provided medications available and meals.

Action taken by the Minnesota Department of Health:
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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29856	A. BUILDING: _____ B. WING _____	C 06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD AT ANOKA	3002 4TH AVENUE NORTH ANOKA, MN 55303

(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 CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are 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: #HL298569945C/#HL298562101M On June 20, 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 78 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL298569945C/#HL298562101M, tag identification 0460.	0 000	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. 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. 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.	
0 460 SS=D	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request	0 460		

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0 460	Continued From page 1 assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to provide a means for one of one resident (R1) to request assistance for health and safety needs 24 hours a day, seven days a week. A pendant light was provided but failed to alert staff assigned to R1. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include:	0 460		

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0 460	Continued From page 2 During an interview July 3, 2024, at 12:00 p.m., R1 said when she pressed her call light it would take staff 45 minutes for staff to respond. During an interview July 3, 2024, at 10:07 a.m., the director of health services (DHS)-A stated the licensee recently renovated the room layout. Four resident rooms were recently converted from memory care to assisted living. The doors going into the memory care unit were pushed back to allow four care extra suites in assisted living. Although, the four care suites were now a part of assisted living, the call light still rang to the memory care nurses station. She stated memory care staff thought assisted living staff answered R1's call light. The pendent push log dated February 8, 2024, through February 11, 2024, indicated the pendant alert rang in the memory care, not on the assisted living side where R1 resided. The log indicated R1 pushed her call light three times. They are logged as follows: - Saturday, February 10, 2024, at 10:30 a.m., duration of call was 29:02. - Saturday, February 10, 2024, at 2:57 p.m., duration of call was 14:35. - Sunday, February 11, 2024, at 6:17 a.m., duration of call was 43:53. The licensee's undated agreement indicated the call system is answered 24 hours a day, seven days per week. TIME PERIOD FOR CORRECTION: Seven (7) days	0 460		