Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL305479407M
Compliance #: HL305477205C

Date Concluded: May 23, 2024

Name, Address, and County of Licensee Investigated:
Lake Song Assisted Living
206 North Elm Street
Onamia, MN 56359
Mille Lacs County

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

Evaluator's Name: Barbara Axness, RN
Special Investigator

Finding: Substantiated, facility responsibility

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 failed to administer the resident's medications according to physician orders and the resident required hospitalization.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. Facility staff failed to supervise administration of medication and the resident missed various medications over an approximate two-month period. The resident was hospitalized for fluid overload and NSTEMI (non-ST segment elevation myocardial infarction), a type of heart attack.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident's records, death record, hospital records, facility internal investigation documentation, facility incident

reports, staff schedules, hospital records, and related policies and procedures Also, the investigator observed medication administration at the facility.

The resident resided in an assisted living facility. The resident's diagnoses included congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), hypertension (high blood pressure), and type two diabetes. The resident's service plan included assistance with bathing, medication administration, blood glucose monitoring, and daily weight monitoring. The resident's assessment indicated the nurse set-up medications in a Medi-set box and staff administered the medication per the electronic medication administration record (eMAR) as delegated by the nurse and per physician's orders.

The resident's medication administration record (MAR) documentation indicated all medications were administered as ordered. Approximately two months before the resident was hospitalized, the resident was prescribed an antibiotic to be taken twice a day for seven days. The MAR indicated all doses of the antibiotic were administered as ordered.

Facility documentation indicated the resident reported chest tightness and trouble breathing and was transferred to the hospital. Three days after hospital admission, facility cleaning staff found "51 pills in and around her reclining chair…" 12 different types of medications were found. Eight pills which were prescribed for reducing extra fluid, four pills for reducing cholesterol/preventing heart attacks and strokes, and four antibiotic pills.

Hospital records indicated the resident's admission diagnoses included severe hypertension (high blood pressure) with hypertensive emergency (acute elevation in blood pressure that is associated with signs of organ damage), acute NSTEMI (non-ST-elevation myocardial infarction, a type of heart attack that happens when heart's need for oxygen can't be met), ischemic cardiomyopathy (a condition of weakened heart muscles due to a heart attack or coronary heart disease), and atrial fibrillation (irregular heartbeat) and fluid overload. The resident was admitted to the intensive care unit (ICU) due to multiple organ failure and increasing weakness, debility, and frailty. The resident was hospitalized for nine days and later discharged to a facility that could provide a higher level of care. The resident died of heart failure a few weeks later.

During an interview, a facility nurse stated staff were expected to watch the resident take her medications, but the resident put her medications on a blanket in her lap "so I assume that's how it got messed up." The nurse verified that staff did not administer medications according to facility protocol and did not ensure the resident swallowed all medications that staff provided.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

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: No, deceased.
Family/Responsible Party interviewed: Attempts to contact were unsuccessful.
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility reported the medication error to the primary care provider.

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

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
Mille Lacs County Attorney
Onamia City Attorney
Onamia Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30547	A. BUILDING: _____ B. WING _____	C 04/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE SONG ASSISTED LIVING	206 NORTH ELM STREET ONAMIA, MN 56359

(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: #HL305479407M/ #HL305477205C On April 15, 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 29 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL305479407M/ #HL305477205C, tag identification 0620, 2320, 2360.	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 License Providers. 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 surveyors' 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 subd. 1, 2, and 3.	
0 620 SS=D	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma (a) The assisted living facility must comply with	0 620		

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0 620	Continued From page 1 the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has	0 620		

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0 620	Continued From page 2 reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to report an allegation of suspected neglect to Minnesota Adult Abuse Reporting Center (MAARC) within 24 hours of staff becoming aware of the incident for one of one resident (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, but was not likely to cause serious injury, impairment, or death) 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: R1's diagnoses included congestive heart failure, chronic obstructive pulmonary disease (COPD),	0 620		

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0 620	Continued From page 3 hypertension (high blood pressure), and type two diabetes. R1's service plan dated August 23, 2023, indicated the resident received assistance with bathing, medication administration, blood glucose monitoring, and daily weights. R1's assessment dated August 23, 2023, indicated the nurse would set up medications in a medi-set box and staff would administer the medication per the electronic medication administration record (eMAR) as delegated by the RN and per MD orders. Progress notes indicated on October 29, 2023, the resident reported chest tightness and trouble breathing. The resident was sent to the emergency room and and admitted to the hospital. Progress notes indicated licensed practical nurse (LPN)-B was notified of the alleged neglect on November 2, 2023, after "Cleaning staff found 51 pills in and around her recliner chair and was reported to this writer..." LPN-B updated the hospital and the resident's primary care provider, but failed to make a MAARC report. A hand written note dated November 1, 2023, indicated the following medications were found in the resident's room: -8 Torsemide 20 mg -4 Amoxicillin 500 mg/125 mg (an antibiotic) -4 Rosuvastatin 20 mg -4 Allopurinol 100 mg -1 Aspirin 81 mg -10 Vitamin B12 1000 mcg -15 Vitamin C -4 Melatonin	0 620		

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0 620	Continued From page 4 -4 Escitalopram 10 mg -1 Tylenol (pain medication) -2 vitamin D3 -4 Ferrous Gluconate Hospital records indicated the resident's admitting diagnoses were severe hypertension (high blood pressure) with hypertensive emergency (acute elevation in blood pressure that is associated with signs of organ damage), acute NSTEMI (non-ST-elevation myocardial infarction, a type of heart attack that happens when heart's need for oxygen can't be met), ischemic cardiomyopathy (a condition of weakened heart muscles due to a heart attack or coronary heart disease), and atrial fibrillation with RVR (when the heart doesn't have a normal signaling process telling the heart when to beat. The signaling is disorganized and the parts of the heart beat out of sync). The resident also had fluid overload. The resident was admitted to the intensive care unit (ICU) due to "multiple organ failure, increasing weakness debility and frailty." R1 was hospitalized for nine days and was discharged to a facility that could provide a higher level of care on November 7, 2023. R1 died on November 24, 2023. On April 15, 2024, at 12:35 p.m., LPN-B stated he had reported the error to the registered nurse and he was under the impression she was making a MAARC report. The licensee's Vulnerable Adult Maltreatment Policy dated August 1, 2021, and revised January 11, 2024, indicated any staff person who witnessed or suspected maltreatment of a vulnerable adult would report the incident immediately to their Assisted Living Director and that person would complete an incident report	0 620		

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0 620	Continued From page 5 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
02320 SS=G	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide care and services in accordance with the service plan, when staff failed to administer medications as ordered, resulting in medication error(s) for one of one resident (R1) reviewed. After being hospitalized with chest pain, 62 pills were found in the resident's recliner. Medications found included various vitamins, an antibiotic, a medication to reduce extra fluid in the body. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) 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).	02320		

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02320	Continued From page 6 The findings include: R1's diagnoses included congestive heart failure, chronic obstructive pulmonary disease (COPD), hypertension (high blood pressure), and type two diabetes. R1's service plan dated August 23, 2023, indicated the resident received assistance with bathing, medication administration, blood glucose monitoring, and daily weights. R1's assessment dated August 23, 2023, indicated the nurse would set up medications in a medi-set box and staff would administer the medication per the electronic medication administration record (eMAR) as delegated by the RN and per MD orders. R1's medication administration record (MAR) for October 2023 indicated the resident took medications including: -Torsemide 20 milligram (mg) (a medication to reduce extra fluid in the body) one tablet daily -Rosuvastatin 20 mg (a medication to lower cholesterol and prevent heart attacks and strokes) one tablet daily -Allopurinol 100 mg (a medication to treat gout and certain types of kidney stones) one tablet twice a day -Aspirin 81 mg (a medication used for pain and can also prevent blood clots) one tablet daily -Vitamin B12 1000 micrograms (mcg) (supplement) one tablet daily -Vitamin C (supplement) one tablet daily -Melatonin (medication to help with trouble sleeping) one tablet daily -Escitalopram 10 mg (antidepressant) one tablet daily -Vitamin D3 (supplement) two capsules daily	02320		

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02320	Continued From page 7 -Ferrous Gluconate (iron supplement) one tablet daily -Tylenol 500 mg give two tablets every eight hours as needed for pain The MAR indicated all doses of medication were administered as ordered. R1's August 2023 MAR indicated the resident started Amoxicillin and clavulante 500 mg/125 mg on August 24, 2023, and was to take the antibiotic twice daily for seven days. The MAR indicated all doses of the medication were administered as ordered. R1's progress notes included the following: -October 29, 2023, the resident reported chest tightness and trouble breathing. The resident was sent to the emergency room and and admitted to the hospital. -November 2, 2023, "Cleaning staff found 51 pills in and around her recliner chair and was reported to this writer. This writer reported this issue to the nurse manager at 10:30 and her current PCP [primary care provider] at the [hospital name] on 11/2/23 at 11:45 and left a message for her in house PCP this am on 11/2/23 at 10:25. The pills were counted and the providers were notified which medication was missed." A hand written note dated November 1, 2023, indicated the following medications were found in the resident's room: -8 Torsemide 20 mg -4 Amoxicillin 500 mg/125 mg (an antibiotic) -4 Rosuvastatin 20 mg -4 Allopurinol 100 mg -1 Aspirin 81 mg -10 Vitamin B12 1000 mcg	02320		

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02320	Continued From page 8 -15 Vitamin C -4 Melatonin -4 Escitalopram 10 mg -1 Tylenol (pain medication) -2 vitamin D3 -4 Ferrous Gluconate Hospital records indicated the resident's admitting diagnoses were severe hypertension (high blood pressure) with hypertensive emergency (acute elevation in blood pressure that is associated with signs of organ damage), acute NSTEMI (non-ST-elevation myocardial infarction, a type of heart attack that happens when heart's need for oxygen can't be met), ischemic cardiomyopathy (a condition of weakened heart muscles due to a heart attack or coronary heart disease), and atrial fibrillation with RVR (when the heart doesn ' t have a normal signaling process telling the heart when to beat. The signaling is disorganized and the parts of the heart beat out of sync). The resident also had fluid overload. The resident was admitted to the intensive care unit (ICU) due to "multiple organ failure, increasing weakness debility and frailty." R1 was hospitalized for nine days and was discharged to a facility that could provide a higher level of care on November 7, 2023. R1 died on November 24, 2023 due to heart failure. While hospitalized, the resident was started on an intravenous (IV) diuretic and her weight went from 199 pounds to 187 pounds. The resident's weight at a clinic visit in June 2023 was noted to be 182 pounds. The resident's weight at the facility the day she was admitted to the hospital on October 29, 2023, was documented to be 191.4 pounds. On April 15, 2024, at 12:35 p.m., licensed	02320		

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02320	Continued From page 9 practical nurse (LPN)-B stated staff were to watch the resident take her medications but the resident would put her medications on a blanket in her lap "so I assume that's how it got messed up." LPN-B verified staff administering medications were expected to ensure medications administered to the resident were swallowed by the resident to ensure appropriate administration of the medication. The licensee's Administration of Medication, Treatment, and Therapy by Unlicensed Personnel policy dated August 1, 2021, and revised January 1, 2024, indicated unlicensed personnel that will provide assistance with medication, treatment and therapy administration will be trained and competency tested by the RN on several categories, including administration of the medication, treatment and therapy to the resident (or assistance with self-administration). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		
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 residents reviewed (R1) was free from maltreatment.	02360	No plan of correction is required for this tag.	

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02360	Continued From page 10 Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		