Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306214743M
Compliance #: HL306218004C

Date Concluded: February 28, 2023

Name, Address, and County of Licensee Investigated:
Golden Horizons of Crosslake
13631 East Shore Road
Crosslake, MN 56442
Crow Wing County

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

Evaluator's Name:
Jana Wegener, 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 the resident when they failed to hold the resident's insulin as ordered causing the resident to have a dangerously low blood glucose level. The resident became unresponsive, fell, sustained laceration injuries, and was transferred to the emergency department.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The AP was responsible for the maltreatment. The AP failed to hold and/ or administer the resident's insulin according to physician orders. The day of the incident the AP failed to follow prescribed orders and gave the resident's insulin before the noon meal was served, and one hour and 17 minutes prior to the scheduled administration time. Later that day, the resident had a blood glucose

reading of 49 (critically low), and bleeding lacerations to her left wrist and right head from a fall. 911 was called to transport the resident to the hospital.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member. The investigation included review of the medication administration records (MAR), provider orders, progress notes, staff communication, personnel files, meal serving times, intake records, blood glucose readings, medical records, incident reports, and facility policies and procedures. Also, the investigator observed resident cares, and medication administration practices.

The resident resided in an assisted living facility with diagnoses including Diabetes Meletus. The resident's service plan indicated the resident required assistance with medication administration services and blood glucose monitoring.

Approximately two weeks prior to the incident a staff communication instructed all staff not to administer the residents NovoLog insulin until after she had eaten at least 50 percent of her meal. The communication indicated the registered nurse (RN) must be updated with any blood glucose readings less than 110 and if the resident consumed less than 50 percent of her meal. The communication was acknowledged by the AP.

The resident's medication administration record (MAR) summary notes indicated one day the AP documented administering all the resident's morning medications except her insulin. The AP documented administering the insulin after the resident had eaten her meal. Another day the AP documented asking other staff if the resident had eaten 50% of her meal because the AP had not cleared the resident's plate. Then, three days prior to the incident the AP documented NovoLog insulin was not administered because the resident had declined to get up and eat. The documentation indicated the AP understood the resident needed to consume 50% of her meal prior to administration of insulin.

The resident's medication administration record (MAR) included orders for Novolog (insulin) to be injected at lunch time scheduled at 12:30 p.m. The resident's order included administration instructions to HOLD the medication and call the RN if the resident's blood glucose was 110 or less, and in bold text "DO NOT GIVE THE RESIDENT's NOVOLOG INSULIN UNTIL AFTER SHE ATE 50 PERCENT OF HER MEAL OR MORE". The order directed staff if the resident ate less than 50 percent of her meal, staff were to hold the Novolog and notify the RN.

The residents MAR indicated the day of the incident the AP documented administering R1's NovoLog insulin at 11:15 a.m. one hour and 13 minutes prior to the scheduled administration time, and prior to the noon meal being served.

The resident's incident report indicated the resident was found on the bathroom floor unresponsive. The resident had a blood glucose reading of 49 (critically low), and bleeding

lacerations to her left wrist and right head. 911 was called to transport the resident to the hospital.

The resident progress notes indicated she returned to the facility later that day with orders to hold her evening dose of insulin. The note indicated staff should monitor the resident closely throughout the night, check blood sugars frequently, and make sure the resident ate 50 percent of her meal before administering insulin.

A disciplinary action form indicated the AP was not to administer the resident's lunch time dose of insulin prior to the meal, however the AP administered it prior to the meal being served. The form identified the resident declined her noon meal and the AP failed to contact the RN.

When interviewed the AP stated she interpreted the order wrong, she gave the insulin, and then the resident refused to eat. The AP stated she did not contact the RN. The AP stated she reported to the unlicensed staff at shift change that the resident received her insulin but refused her meal. The AP stated she told the staff to "keep an eye on her" and left for the day. Two hours later the AP stated she was called and told the resident became unresponsive, fell, was transferred to the emergency department.

When interviewed facility staff verbalized understanding of the resident's ordered parameters for insulin administration. Staff stated both parameters needed to be met prior to administering insulin, and if either parameter was not met the insulin was held, and the RN was notified.

When interviewed a nurse stated the AP did not follow orders to administer insulin after the resident ate 50 percent of her meal. The nurse indicated when she spoke to the AP following the incident the AP stated the resident's blood glucose met parameters, she gave the insulin right away, and did not wait for the resident to eat. The nurse stated the AP never called her to report the medication error.

When interviewed the resident did not remember what happened.

In conclusion, 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:
(a) 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.
(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility identified and reported the medication error. The facility provided disciplinary action, re-education, and monitoring to ensure accurate medication administration of the AP.

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
Crow Wing County Attorney
Crosslake City Attorney
Crosslake Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30621	A. BUILDING: _____ B. WING _____	C 02/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN HORIZONS OF CROSSLAKE	13631 E SHORE RD CROSS LAKE, MN 56442

(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, 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: #HL306214743M/ #HL306218004C On February 8, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders were issued. At the time of the complaint investigation, there were 33 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL306214743M/ #HL306218004C, tag identification 2360.	0 000	Minnesota Department of Health is documenting the State Licensing 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.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial	02360		

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02360	Continued From page 1 exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure one of one of one residents reviewed, (R1) was free from maltreatment. R1 was neglected. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual staff person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details. No plan of correction is required for this tag.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	