Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL307451181M
Compliance #: HL307451967C

Date Concluded: September 16, 2022

Name, Address, and County of Licensee Investigated:
Lino Lakes Assisted Living
725 Town Center Parkway
Lino Lakes MN, 55014
Anoka County

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

Evaluator's Name: Kris Detsch, RN
Special Investigator

Finding: Not Substantiated

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 facility neglected a resident when they failed to monitor the resident's blood sugar levels which resulted in the resident having multiple unresponsive episodes.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility monitored the resident's blood sugar levels as ordered by the physician and followed facility protocol for care management.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, the resident, and unlicensed staff. The investigator contacted law enforcement. The investigation included review of resident's records including hospital records, police reports, service plan, medication list, physician orders, employee records, and facility policies.

The investigator toured the facility and observed interactions between residents and staff. The investigator observed blood sugar checks and medication administration.

The resident resided in an assisted living facility. The resident's diagnoses included diabetes, depression, and high blood pressure. The resident had a history of uncontrolled blood sugars. The resident's service plan included assistance with medication management, toileting, hygiene, grooming, and bathing. The resident's nursing assessment indicated the resident had mild cognitive impairment but could communicate her needs.

During an interview, the manager said staff were instructed to call emergency medical services (EMS) when the resident's blood sugar levels were low. The manager said the facility staff had limited options to increase the resident's low blood sugar levels at the facility. The manager said glucose (sugar) injections were not able to be given by facility staff.

According to facility records, the resident's physician ordered a Libre device to continuously monitor the resident's blood sugar levels. The facility records indicated the residents blood sugar levels were being checked by staff four times daily. The facility records indicated the resident's physician was involved in diabetic management and ordered multiple medication changes.

During an interview, the resident said staff check her blood sugar levels frequently. The resident said she received enough food at meals and snacks were available.

During an observation, the resident was observed to have the Libre device in place and functioning properly. Staff were observed checking the device for blood sugar readings. Staff were observed administering insulin as directed by the physician orders.

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:
(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.

Vulnerable Adult interviewed: Yes.

Family/Responsible Party interviewed: Not Applicable.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility contacted the resident's physician in a timely manner and followed physician orders. The facility provided diabetic education to staff and implemented further diabetic monitoring.

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. 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 Or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30745	A. BUILDING: _____ B. WING _____	C 09/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINO LAKES ASSISTED LIVING	725 TOWN CENTER PARKWAY LINO LAKES, MN 55014

(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 Initial comments 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: #HL307451967C/#HL307451181M On September 9, 2022, 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 111 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for #HL307451967C/#HL307451181M, tag identification 1890.	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.	
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for	01890		

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01890	Continued From page 1 immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were maintained with the open date and the expiration date for time sensitive medications for four of four residents (R1, R2, R3, R4) reviewed. 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Medical record review indicated R1, R2, R3, and R4 received medication services for a diagnosis of diabetes. R1's medication list included Novolog FlexPen Solution Pen-injector and Lantus SoloStar Solution Pen-injector. R2's medication list included Humalog KwikPen Solution Pen-injector and Lantus SoloStar Solution Pen-injector. R3's medication list included Basaglar KwikPen Solution Pen-injector and Novolog FlexPen	01890		

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01890	Continued From page 2 Solution Pen-injector. R4's medication list included Lantus SoloStar Solution Pen-injector and Novolog Flex Pen Solution Pen-injector. During observation of medication administration on September 9, 2022, at 11:10 a.m ., with unlicensed personnel (ULP)-C, a review of the locked medication cart was conducted. The following was observed and confirmed with ULP-C: R1's insulin pens lacked pharmacy labels for instructions for use. The insulin pens lacked a date indicating when they were opened and when they would expire. R2's insulin pens lacked a pharmacy label which indicated the date the pens were opened and when they would expire. R3's insulin pens lacked a pharmacy label which indicated the date the pens were opened and when they would expire. R4's insulin pens lacked a pharmacy label which indicated the date the pens were opened and when they would expire. During an interview with on September 12, 2022, at 9:00 a.m., director of nursing (DON)- B said insulin medication should be labeled correctly with the resident's information, dated the pens were opened, and date when pens expire. The licensee's Medication and Treatments policy, dated August 1, 2021, indicated that medication should be labeled with the medication name, strength, and dosage, the route, time of	01890		

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01890	Continued From page 3 administration, and any special instructions. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		