Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL307456146M
Compliance #: HL307451601C

Date Concluded: August 5, 2023

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: Maggie Regnier
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):
Allegation #1: The facility neglected the resident when the resident was not provided a bed and belonging were missing when the resident was admitted to the facility.

Allegation #2: The facility neglected the resident when the resident was sent to the emergency room and found to have lithium toxicity.

Investigative Findings and Conclusion:
Allegation #1: The Minnesota Department of Health determined neglect was not substantiated. The resident transferred from another facility which did not send the residents belonging initially as had been arranged. While the facility's contract states the resident is responsible to furnish a bed, the facility did have a bed available for the resident until his was delivered.

Allegation #2: The Minnesota Department of Health determined neglect was not substantiated. While it is true the resident did develop lithium toxicity, the facility administered the medication according to the providers orders.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff care coordinators and providers. The investigator contacted the resident's family member, and the resident's provider The investigation included review of the resident's medical record, the hospital records, provider notes, facility incident reports, facility policy's, contracts, service plans and staff training and schedules. Also, the investigator observed staff interactions with other staff, residents, and visitors.

The resident resided in an assisted living facility. The resident's diagnoses included bipolar disorder, cognitive impairment, and chronic respiratory failure. The resident's service plan included assistance with medications, and grooming.

The resident was transferred from a different facility to this facility. The transferring facility delayed sending the residents belongings including a bed. This facility was able to find a bed for the resident the day he arrived, and he was able to use it until his bed arrived. He was also provided basic grooming supplies until his items arrived.

Approximately two months later, the resident was found to be incoherent, and the provider sent the resident to the hospital for care. The hospital obtained blood work which showed that the resident had lithium toxicity, which is high levels of lithium in his blood, a medication used to treat bipolar disease.

During an interview, a member of the management team stated the staff determined the resident arrived at the facility without a bed but was able to locate an unused bed for the resident to use the day he arrived.

During an interview with the resident's family member, it was stated the resident was very non-compliant with many of his medical care. He often refused wearing his oxygen, which he should have on all the time.

During an interview with the medical provider, she stated she did not make a referral to psychiatric providers but did think about it. The provider also stated she did not order any lab work to check for lithium levels in the resident's blood but did state that is a common practice for residents on lithium.

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, deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility was able to provide the resident with a bed and basic grooming supplies until his belonging were delivered**.** The facility administered the medication as ordered.

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
	30745	A. BUILDING: _____ B. WING _____	C 06/21/2023

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 On June 21, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL307452322C; HL307452281C, HL307456565M; HL307451601C, HL307456146M. No correction orders are issued.	0 000		