Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL307456223M
Compliance #: HL307451712C

Date Concluded: October 18, 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: Christine Bluhm, R.N.
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 a resident when they did not ensure the resident's medications were administered per medical provider's orders.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the resident did not immediately receive important inhaler medications for breathing, there were multiple factors that contributed, and it is not evident that it was only due to facility error.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the medical provider for information regarding the medication ordering process. The investigation included review of facility policies and multiple resident records. Also, the investigator observed multiple medication passes and interactions of staff with residents.

The resident resided in an assisted living facility. The resident's diagnoses included chronic obstructive pulmonary disease (COPD) (a lung condition that makes it hard to breathe) and oxygen dependence. The resident's service plan included assistance with meals, housekeeping, and staff managed all medications. The resident's assessment indicated she was independent with most activity and used a wheelchair for mobility. The resident could make her needs known.

The resident's medical provider visit notes indicated the resident had poor air movement in the lungs and wheezing. At the visit, the provider noted that the resident did not have the previously ordered inhalers on her current medication administration record (MAR). The provider reordered the inhalers and noted to continue them as soon as possible. The facility provided an explanation that the orders may have fallen off the MAR when the facility made a transition from paper records to electronic records. At the next follow up, there was question whether or not the resident was using the inhalers. Response from the facility was that they were awaiting prior authorization approval from the resident's insurance company for one of the inhalers. Records indicated that the approval was made the day after the order was made but the pharmacy claimed that they did not receive the approval. The pharmacy sent the inhaler medication right away but by that time, the resident was already in the hospital again.

During an interview, a facility nurse stated that the resident was using the one inhaler, and the medical provider wanted her to use a second inhaler as well. She stated the resident kept her inhalers on her a lot of the times, did not always take them correctly and was often short of breath.

The resident was hospitalized and could not be reached for interview at the time of the facility visit. The resident passed away in the hospital.

A family member was interviewed and stated they were not aware that the resident missed medications and the resident continued to smoke even with her breathing issues and continuous oxygen use.

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

Action taken by facility:
No action taken.

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 06/22/2023

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, and June 22, 2023, the Minnesota Department of Health initiated an investigation of complaints #HL307456790M/ HL307452843C, HL307456791M/HL307452844C, HL307456223M/HL307451712C. No correction orders are issued.	0 000		