DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL307456791M
Compliance #: HL307452844C

Date Concluded: October 20, 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: 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:
The facility neglected the resident when the facility did not administer the resident's medications as ordered by the medical provider.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the facility did not implement the medications as ordered and the resident continued to experience symptoms of COPD exacerbation (chronic obstructive pulmonary disease) (a lung condition that makes it hard to breathe), the resident received some of the medications and the rest of the medications the following week.

The investigator conducted interviews with multiple facility staff members. The investigator contacted the medical provider regarding the medication ordering process. The investigation

included review of facility policies and resident records. Also, the investigator observed multiple medication passes and interactions of staff with residents.

The resident resided in an assisted living facility memory care unit. The resident's diagnoses included dementia, heart failure and COPD with continuous oxygen. The resident's service plan included assistance with bathing, dressing, incontinence care, meals, housekeeping, and staff managed all medications.

The resident's medical record indicated the resident was seen by the medical provider for increased COPD symptoms and heart failure exacerbation that included fatigue, occasional wheezing, and shortness of breath with conversation. Vital signs were obtained, and the resident's oxygen saturation was 97%. The provider ordered to increase the Lasix dose (medication to remove fluid), schedule the albuterol nebulizers (medication to help ease breathing), add prednisone (steroid medication for breathing) once daily for five days, and start an antibiotic twice daily to give for five days. The provider noted the resident remained at high risk of hospitalization. Facility staff were instructed to call provider or emergency services for increased symptoms and change in condition.

When the provider returned for a follow-up the following week, the provider noted that the resident only received increased Lasix and three days of the Prednisone. It was also noted that the rest of the medications that were not given were still in the medication drawer and staff could not provide an explanation of why the medications were not given. The resident reported shortness of breath, cough and confirmed she did not receive the antibiotics. Vital signs were obtained, and the resident's oxygen saturation was 92%. The provider ordered the medications again and the resident received the medications that week.

A review of the resident's medical record indicated the facility administered the medications although some medications were give later then originally ordered by the medical provider.

During an interview, a nurse stated if a medication does not get started right away or if no one is follows through, it will fall off the medication record. The nurse did not know why the resident's medications were not given as ordered.

During an interview, the resident stated she did not all her medications but knew she needed her oxygen.

During an interview, the resident's family member stated he/she was not aware the resident had not received ordered medications which was a concern since the resident had breathing problems and was on oxygen continuously.

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: Yes.
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 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		