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 #: HL307457206M
Compliance #: HL307453581C

Date Concluded: October 6 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: Deb Schillinger, RN and Lisa Coil, RN, Special Investigators

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(s):
The alleged perpetrator (AP) neglected the resident when the AP failed to follow the residents care plan and reevaluate the residents low blood sugar after 30 minutes resulting in ongoing low blood sugar, fall and hospitalization.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The AP was not provided with resident specific instructions pertaining to low blood sugar, consequently, the resident had a low blood sugar with inadequate follow-up contributing to the resident falling, becoming unresponsive, and requiring transfer to the emergency room.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator attempted to interview the resident. The

investigation included review of the resident's medical record, and licensee's policies and procedures. Also, the investigator observed the staff and resident interactions.

The resident resided in an assisted living facility. The resident's diagnoses included type I diabetes (a type of diabetes in which the body makes little or no insulin). The resident's medical record indicated resident required assistance with medication management, blood sugar monitoring and insulin administration. The resident ambulated with a wheeled walker. One morning at 8:00 a.m. the resident's notes indicated his blood sugar was within normal limits.

At 12:00 noon, the resident's Electronic Medication Administration Record (EMAR) indicated the resident's blood sugar was very low (less than 70 milligrams per deciliter or mg/dL).

Three hours later, a progress note entered by the nurse indicated the resident was found on the floor in his room with an urgently low blood sugar, unresponsive, and bleeding from a head injury. 911 was called and the resident was transported to the emergency room.

The resident's EMAR indicated the resident received insulin (a hormone that lowers level of glucose in the blood) four times daily, before meals and at bedtime. However, the same document did not include instructions to address low blood sugars for the unlicensed caregivers doing the resident's medication pass.

During an interview, the AP stated when she obtained the low blood sugar level before the noon meal, she gave the resident a glass of orange juice with two sugar packets mixed in and notified the nurse. The AP stated she did not go back in the resident's room until an hour to an hour and a half later, which is when she found the resident on the floor. The AP stated she notified the nurse of the fall and the resident's low blood sugar.

The facility-provided policy regarding blood sugar management indicated "unusual results" should be reported to the nurse. A definition for "unusual results" was not found in the policy.

The resident's care plan, provided by the facility, did not include a definition of "unusual results" for the resident's low blood sugar nor did it include interventions until weeks after the low blood sugar and fall occurred.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

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, attempted but declined.
Family/Responsible Party interviewed: N/A
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
Sent the resident to the hospital.

Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance. 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

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

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
Anoka County Attorney
Lino Lakes City Attorney
Lino Lakes Police Department

Minnesota Department of Health

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 07/25/2023

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 ******ATTENTION****** ASSISTED LIVING PROVIDER 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: HL307453581C/HL307457206M and HL307453519C On July 25, 2023, 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 91 residents receiving services under the provider ' s Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for HL307453581C/HL307457206M, tag identification 1470, 1480 and 2360. There were no correction orders issued for HL307453519C. Additional correction orders were issued due to non-compliance identified during the course of the investigation.	0 000	Assisted Living Provider Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. 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 evaluators ' 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 SUBDIVISION 1-3.	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research	01470		

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01470	Continued From page 2	01470		

based, may include online training, and must include training on one or more of the following topics:
(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication;
(2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or
(3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure employees received orientation training to the assisted living licensing requirements and regulations for one of three employees (licensed practical nurse (LPN)-E) before providing resident care.

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, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

LPN-E was hired on March 7, 2023.

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01470	Continued From page 3 LPN-E's employee records included an Employee Orientation Checklist document which was blank and unsigned. The record included a Relias transcript which included orientation on the following topics: (1) hearing loss; (2) dementia; (3) infection control; (4) fire safety; (5) blood borne pathogens; (6) resident rights; and (7) abuse. LPN-E's employee record also included an undated application, and a job description which was undated and unsigned. A review of LPN-E's employee record did not identify documentation LPN-E received orientation the following topics: (1) an overview of 144G, and (2) facility's policies and procedures. LPN-E was observed provideing resident care on July 25, 2023, during the survey visit. The licensee did not provide a policy related to assisted living licensing requirements and regulations orientation. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01480 SS=F	144G.63 Subd. 3 Orientation to resident Staff providing assisted living services must be oriented specifically to each individual resident and the services to be provided. This orientation may be provided in person, orally, in writing, or electronically. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to ensure staff providing assisted living services were oriented	01480		

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01480	Continued From page 4 specifically to each individual resident and the services to be provided for three of three employees (registered nurse (RN)-A, unlicensed personnel (ULP)-D, and licensed practical nurse (LPN)-E). 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, but was not likely to cause serious injury, impairment, or death), 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: RN-A RN-A was hired on June 26, 2023. A review of RN-A's employee record did not identify documentation RN-A received resident specific orientation. ULP-D ULP-D was hired on November 14, 2022. A review of ULP-D's employee record included an Orientation Checklist which included a check mark in front of a description indicating ULP-D completed an overview of client/tenants. The document was signed by ULP-D on January 19, 2023, which was 66 days after her start date. LPN-E LPN-E was hired on March 7, 2023. A review of LNP-E's employee record did not identify documentation LPN-E received resident	01480		

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01480	Continued From page 5 specific orientation. During interview on July 25, 2023, at 3:15 p.m., RN-A stated she began working in the facility on June 26, 2023, did not receive much orientation, and did not have access to resident's assessments. The licensee did not provide a policy related to assisted living licensing requirements and regulations orientation. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01480		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with an incident which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No plan of correction is required for this tag.	