Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL307508784M
Compliance #: HL307506267C

Date Concluded: February 26, 2024

Name, Address, and County of Licensee Investigated:
Oak Ridge Assisted Living
1128 Bahls Drive
Hastings MN, 55033
Dakota County

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

Evaluator's Name: Kris Detsch, RN
Special Investigator

Finding: Substantiated, individual 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 residents when he consumed alcohol while working and became intoxicated. As a result, multiple residents did not receive their medications, or received the wrong medications.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The AP was responsible for the maltreatment. The AP neglected 20 residents when he consumed alcohol before and throughout his evening shift to the point his blood alcohol content was close to four times the legal limit. The AP was responsible for the care and services of 20 residents on the assisted living unit of the facility. The facility had staff in the memory care unit, however, memory care staff are not allowed to leave a memory care unattended and they were unaware of the AP's incapacitation. Although the residents did not suffer ill effects from medication errors, the extent of errors could not be determined because the AP falsified documentation.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement. The investigation included review of resident records, court documentation, and employee files. Also, the investigator toured the facility and observed staff members administer medications.

The AP provided medication services for 20 residents at the time of the incident during the evening shift (2:00 p.m. to 10:00 p.m.). All residents lived in the assisted living area of the facility. Specifically, nursing staff affirmed resident #1, resident #2, resident #3, and resident #4 received incorrect medications after the AP's shift. Two other unlicensed personnel (ULP) were also scheduled on the evening shift; however, they worked in the memory care unit of the facility.

Resident #1's diagnoses included heart disease, asthma, and a history of back problems. Resident #1's service plan indicated she required assistance with medications. Resident #1's nursing assessment indicated she was alert, but forgetful. Resident #1's was at risk for falls and wandered when she was confused.

Resident #2's diagnoses included diabetes (high blood sugar levels), atrial fibrillation (irregular heart rhythm), and arthritis. Resident #2's service plan indicated she required assistance with bathing, toileting, and medications. Resident #2's nursing assessment indicated she was alert and could walk, but she had balance problems and required a cane.

Resident #3's diagnoses included heart failure, anxiety, osteopenia (bone loss), and atrial fibrillation (irregular heart rhythm). Resident #3's service plan indicated she required assistance with dressing and medications. Resident #3's nursing assessment indicated she was alert, but forgetful. Resident #3 was able to walk with supervision but used a wheelchair without assistance.

Resident #4's diagnoses included diabetes, chronic pain, and asthma. Resident #4's service plan indicated he received assistance with bathing, dressing, and medications. Resident #4's nursing assessment indicated he was alert and walked without assistance.

The facility's internal investigation indicated the facility nurse received a call from the night shift ULP who reported she found the AP at 11:30 p.m. in resident #1's room. The night shift ULP reported the AP seemed drunk and smelt like alcohol. Recalling the narcotic count at the start of her shift around 10:00 p.m., he kept covering his mouth. Five minutes later, another ULP called the nurse to report she went to check on the AP after the night shift ULP reported her concerns and found the AP passed out on resident #1's couch. The nurse contacted 911 to report the AP was found intoxicated in a resident's room, nearly two hours after the end of his shift. Law enforcement arrived and found whiskey in the AP's cup and more alcohol in his car. The AP said throughout his shift he continued to go out to his car and fill up his cup with alcohol. There were eight residents involved in suspected medication errors.

During an interview, a manager said facility staff told him they found the AP “passed out” in a resident’s room. The manager said the staff member told him the AP smelled of alcohol, so he told her to call emergency assistance (911). The manager said it was difficult to decipher which residents received their medications and which residents did not receive their medications because the AP’s documentation was inaccurate. The manager said there were other staff members working at the time of the incident, however they did not see the AP during their shift. The manager said it would not be unusual for other staff members not to see him, because the AP worked on a floor by himself. The manager said the nurse contacted the residents’ medical providers and monitored the residents for ill effects from medication errors. The manager said the facility notified family members about the incident.

During an interview, resident # 1 said she saw the AP throughout the shift, and he seemed “pretty happy”, but he kept disappearing. Resident #1 said she had back problems and was supposed to receive narcotic medication for pain. She asked the AP for the pain medication, but was unsure if she received the medication, and could not recall what medications the AP gave her. Resident #1 said the AP entered her room in the evening and told her he needed to go to sleep. Resident #1 asked the AP if he had been drinking and he responded, “yeah”. Resident #1 said the AP sat on her couch and then fell asleep. Resident #1 said the AP slept there until another staff member entered her room and saw him, then the police came to her room and woke him up. Resident #1 said she was concerned about the incident and was fearful the facility would kick her out because the AP slept on her couch, however she did not know what to do in the situation.

Resident #1’s medication administration record (MAR) indicated the AP gave her all her medications for the evening. The AP documented he gave the medication to her late, outside the time frame she was supposed to receive them. Also, the MAR lacked indication the AP gave her narcotic (pain) medication during his shift.

Resident #2’s MAR indicated she required insulin. Documentation indicated the AP administered the insulin to the resident, along with another medication. The AP documented he gave the medications late, outside the time frame allotted for their administration.

Resident #3’s MAR indicated the AP gave her all her scheduled evening medications within the allotted time frame including her blood thinning medication.

Resident #4’s MAR indicated the AP gave him all his medications for the evening, but gave them late, outside the time frame allotted for their administration. Resident # 4’s medications included an insulin injection, narcotic (pain), cardiac (heart), and psychoactive (affects mental process) medications.

During an interview, a nurse said she went to the facility at the time of the incident and looked though the medication cart with law enforcement. The nurse said they could tell the AP made multiple medication errors during his shift. The nurse said she spoke to resident #1 who told her

she took medications given to her by the AP, but there was a different room number written on the medication cup he gave to her. The nurse said resident #2 told her she did not receive her insulin. The nurse said resident #3 did not receive her blood thinning medication. Although the AP documented he administered the medication, he could not have administered the medication because the tracking system for the medication indicated he did not remove the medication from the package. The nurse said resident #4 did not receive his medications because those were the medications the AP gave to resident #1.

District court documentation indicated the AP was charged with criminal neglect (intentional neglect). The AP's job duties included every two-hour safety checks on 20 residents and medication administration. Law enforcement observed the AP sleeping on a resident's couch. Law enforcement woke the AP and detected a strong odor of alcohol coming from him and noticed his eyes were red and watery. The AP's movements were slow and uncoordinated, and he slurred his speech. The AP fell into the wall and required law enforcement to hold onto him to prevent him from falling. The AP told law enforcement he consumed alcoholic beverages before work in addition to consuming alcohol while he was working. Law enforcement administered a preliminary breath test (PBT), and his result was 0.297 (legal limit for driving a car is 0.08).

The AP declined the interview.

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

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

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; Resident #1. No; Resident #2, #3, #4, #5, #6, #7, #8 due to family request.
Family/Responsible Party interviewed: Yes; for Resident #1, #2, #3, #4, #5, #6, #7, #8.
Alleged Perpetrator interviewed: No. Declined.

Action taken by facility:

The facility contacted law enforcement, physicians, and families. The facility monitored the residents for ill effects from medication errors.

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.

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
Dakota County Attorney
Hastings City Attorney
Hastings Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30750	A. BUILDING: _____ B. WING _____	C 01/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK RIDGE ASSISTED LIVING OF HASTINGS	1128 BAHLS DRIVE HASTINGS, MN 55033

(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: #HL307506267C/#HL307508784M On January 5, 2024, 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 61 clients/residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL307506267C/#HL307508784M, tag identification 2360.	0 000	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 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.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial	02360		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK RIDGE ASST LVG OF HASTINGS	1128 BAHLS DRIVE HASTINGS, MN 55033

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02360	Continued From page 1 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 20 of 61 resident(s) reviewed, was free from maltreatment. In addition, the maltreatment directly affected 4 of 4 residents (R1, R2, R3, R4) Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No plan of correction is required for this tag.	