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 #: HL307652220M
Compliance #: HL307651181C

Date Concluded: October 16, 2024
Date Revised: February 7, 2025

Name, Address, and County of Licensee Investigated:
Arbor Lane
13810 Community Drive
Burnsville, MN 55337
Dakota County

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

Evaluator's Name: Yolanda Dawson, RN
Special Investigator
Revised by: Rebekah Nelson,
Reconsideration Analyst

Finding: Inconclusive

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), facility unlicensed personnel, neglected a resident when they administered as needed medications to a resident without obtaining permission from a registered nurse prior to the administration of Morphine (narcotic) and lorazepam (anti-anxiety medication.)

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was ~~substantiated~~ inconclusive. ~~The AP was responsible for the maltreatment.~~ The facility policy, staff education, and the resident's medication administration record all directed unlicensed personnel to contact a facility nurse or on-call trigae nurse prior to administering any prn (as needed) medication. Instead of contacting the nurse, the AP dispensed Morphine (narcotic) and lorazepam to the resident. For

the next three days following the administration of the medications, the resident experienced a decreased level of consciousness.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of resident records, hospice records, employee records, and facility policy and procedures.

The resident resided in an assisted living memory care unit and received hospice nursing care. The resident's diagnoses included Parkinson's disease, dementia, heart disease, and heart failure. The resident's service plan included assistance with activities of daily living and with medication management. The resident's provider orders included Morphine 5mg (milligrams) 1 tablet every one hour as needed for pain or shortness of breath, and lorazepam 0.5mg, one tablet as needed every 1 hour for anxiety and agitation.

The incident report indicated one day the resident's family was concerned the resident was not responding appropriately to stimulation. The family questioned what medication the resident was given. After the director inquired with nursing it was determined the previous evening, the AP gave the resident as needed Morphine and lorazepam even though staff were previously instructed to provide the resident with Tylenol for agitation and pain. That evening dose of Morphine was the first time the resident received Morphine.

The resident's medication administration record indicated one day in the later afternoon the resident was given his scheduled lorazepam 0.5mg 1 tablet. The AP documented giving the resident as needed Morphine and lorazepam about four hours later. The resident's medication administration record directed staff to contact the facility nurse or on-call triage nurse prior to the administration of any as needed medication including the Morphine and lorazepam and to first give the resident Tylenol.

During an interview, the AP stated a couple of days before she administered the Morphine and the lorazepam, it was discussed in a staff meeting that the resident was increasingly agitated and had blood in his brief. The AP stated because of that conversation, the next time the resident appeared agitated, the AP decided the resident might be experiencing pain and administered the as needed Morphine and lorazepam. The AP stated she did not follow protocol which was to call the facility nurse or on-call triage nurse to get permission to give the Morphine and lorazepam prior to the administration to the resident. In addition, the AP stated she falsely documented she notified the nurse prior to the administration of the Morphine and lorazepam.

During an interview the registered nurse stated during a staff meeting, there was a discussion about the resident's increased use of the call pendant, agitation, and the possibility of pain. Staff were instructed to use non-medicine interventions or to give the resident Tylenol. The nurse stated staff are trained to notify a nurse to get permission prior to giving a resident any as

needed medications. The nurse stated the AP did not contact the nurse for permission prior to giving the resident Morphine and lorazepam.

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

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 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 resident unable to participate because of cognitive decline.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
Facility staff provided the staff including the AP education on dispensing as needed medications.

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
Burnsville City Attorney
Burnsville Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30765	A. BUILDING: _____ B. WING _____	C 06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR LANE	**13810 COMMUNITY DRIVE BURNSVILLE, MN 55337**

(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 **REVISED DUE TO RECONSIDERATION PROCESS** ******ATTENTION****** INITIAL COMMENTS: #HL307651181C/#HL307652220M On June 5, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider. At the time of the complaint investigation, there were 45 residents receiving services under the provider's Assisted Living with Dementia Care license. No correction orders were issued.	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 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.	