Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL308381541M
Compliance #: HL308382934C

Date Concluded: September 9, 2022

Name, Address, and County of Licensee Investigated:
Lakewood Pines
1702 Airport Road NE
Staples, MN 56479
Wadena County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:
Jana Wegener, RN - Special Investigator
Barbara Axness, RN – Special Investigator

Finding: Not Substantiated

Nature of Visit:
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 resident was neglected when an electronic Medi-set alarm was programmed inaccurately causing the device to open medication slots at the wrong times. As a result, the resident did not receive accurate medication administration, which caused the resident to develop an elevated blood pressure.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was not substantiated. Although the resident's electronic Medi-set device was programmed incorrectly, the resident did not have an increase in blood pressure and sustained no harm. The programming error was not reported until eleven days after the device was set up and it is unknown if errors occurred in medication administration or dosing as the resident self-administered their own medications.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator interviewed the resident involved and additional residents who received medication set-up services provided by the facility. The investigation included a review of the resident's medication administration record, progress notes, service plan, and facility policies and procedures. In addition, the investigator observed the resident's Medi-set device and set up of medications.

The resident resided in an assisted living facility and had diagnoses including dementia. The resident's service plan included assistance with medication set up and monitoring from the registered nurse. The resident's assessment indicated the resident was able to self-administer medications safely using the Medi-set device and medication set-up was completed every two weeks by nursing staff.

The facility incident report indicated this was the first time an error with the Medi-set device had occurred. The resident reported hearing the alarm on the device going off at odd times in the middle of the night and reported the issue to facility staff approximately 11 days in to the 14-day Medi-set cycle.

The resident's blood pressure was checked daily for two weeks after the device programming error occurred. The resident's blood pressures remained near her baseline readings.

When interviewed, three other residents in the facility receiving medication set-up services by facility nursing staff reported no concerns with accurate set up of their medications.

The resident's progress note indicated the healthcare provider was updated and the resident had not been harmed as a result of the programming error.

During an interview, a nurse stated she had set up the resident's medications in the Medi-set device. Another nurse was supposed to program the device medication times and place it in the resident's room. The nurse stated after the resident reported the device was alarming during the night, it was discovered an additional alarm was set in error which caused the device to advance medications to the next pill slot. The nurse indicated the Medi-set device had medications that remained and additional slots that had been open at incorrect times. The nurse stated she was unsure if any medication errors had occurred but noted that some of the medication slots that should have been empty still contained medication. The nurse stated it was unknown which medications remained in the Medi-set device.

When interviewed, the resident stated she had no concerns with her Medi-set device or care provided at the facility.

In conclusion, 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:
(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.
(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: No, not applicable.
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility conducted an internal investigation and updated the resident’s healthcare provider that a medication error had occurred. The facility monitored the resident’s blood pressure and re-educated the nurse responsible for programming the medi-set device.

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
	30838	A. BUILDING: _____ B. WING _____	C 07/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD PINES SENIOR HOUSING	1702 AIRPORT ROAD NE STAPLES, MN 56479

(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 Initial comments On July 26, 2022, the Minnesota Department of Health initiated an investigation of complaint HL308382934C/HL308381541M. No correction orders are issued.	0 000	Minnesota Department of Health is documenting the State Licensing 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.	