Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL312145283M
Compliance #: HL312149004C

Date Concluded: July 17, 2023

Name, Address, and County of Licensee Investigated:
Nagel Assisted Living
232 South Elm Street
Waconia, MN 55387
Carver County

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

Evaluator's Name: Danyell Eccleston, RN, 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(s):
The facility neglected a resident when the resident did not receive medication according to physician orders. The resident experienced a manic episode that required hospitalization.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility did not administer the residents Clozapine (antipsychotic medication) for approximately 8 days. The resident had increased behaviors, a mental health crisis, and was admitted to the hospital.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's pharmacy. The investigation included review of medical records, pharmacy records, staff training and education, and facility policies and procedures. In addition, the investigator observed staff administering medication and services to residents at the facility.

The resident resided in an assisted living facility memory care unit. The resident's diagnoses included schizoaffective disorder, altered mental status, and generalized anxiety. The resident had mild cognitive impairment and required frequent redirection, The resident received assistance with medication management, behavioral interventions, and assistance with appointments.

The residents progress notes written by a facility nurse indicated the resident was having increased manic behaviors the past week which included physical aggression and screaming at staff. The resident was sent to the emergency room related to the behaviors and the resident was placed on a mental health hold. The hospital staff notified the nurse the resident had not been receiving Clozapine 300 mg at the facility for approximately eight days prior to hospitalization for the mental health crisis. The progress note indicated the nurse investigated and determined several staff had documented the Clozapine was not available for administration. The note indicated the nurse spoke with hospital staff and, "We agree that [resident] Clozapine levels likely dropped low enough that her behaviors resurfaced."

During interview a nurse stated prior to the resident's hospitalization, the resident went several days without Clozapine being administered due to lack of supply, and the resident became manic. The nurse stated the resident went to the emergency room and emergency room staff discovered the medication omission and contacted the facility.

During interview another facility nurse stated prior to hospitalization the resident became violent and belligerent and was striking out at staff members. The resident went to the hospital emergency room and was placed on a mental health hold. Hospital staff noted the resident had not received Clozapine the week prior to hospitalization. The nurse stated the staff members who assisted the resident with medication administration did not inform the nurses or facility leadership the resident did not receive Clozapine as ordered.

During an interview, a pharmacist stated stopping Clozapine abruptly can cause psychotic behaviors, and restarting the medication requires dose titrations.

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 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:
The facility conducted an internal investigation of the incident.

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
Carver County Attorney
Waconia City Attorney
Waconia Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31214	A. BUILDING: _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NAGEL ASSISTED LIVING	232 ELM STREET SOUTH WACONIA, MN 55387

(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: #HL312149004C/ #HL312145283M On June 12, 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 47 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for # HL312149004C/ #HL312145283M, tag identification 1760, and 2360.	0 000		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who	01760		

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01760	Continued From page 1 administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure follow-up procedures were implemented and/ or documented for 1 of 3 residents, R1, reviewed for medication administration. 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: R1's service agreement, dated February 1, 2023, indicated the resident received assistance with medication storage, set-up, and administration. R1's medication administration record (MAR), dated February 2023, indicated R1 was prescribed 300 mg of Clozapine (antipsychotic) at bedtime. The MAR indicated R1 did not receive	01760		

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01760	Continued From page 2 Clozapine as ordered on February 3, 4, 5, 8, 9, and 10, 2023. No documentation of actions taken to meet the resident's need were found. When interviewed on June 12, 2023, at 1:09 p.m. registered nurse (RN)-A stated R1 went several days without Clozapine being administered and the resident became manic. RN-A stated while R1 went to the emergency room because of her manic episode, the emergency room staff discovered the medication omission and contacted the licensee. During interview on June 13, 2023, at 3:07 p.m., RN-B stated at the beginning of February, 2023, R1 became violent and belligerent and was striking out at staff members. RN-B stated R1 went to the hospital emergency room and was placed on a hold. Hospital staff noted R1 had not received Clozapine. RN-B stated there were no progress notes regarding R1 not receiving the medication and staff members did not inform the nurses about R1 not having a supply of Clozapine. The facility policy titled 7.22 Medication and Treatment Record - Documentation and Refusal, dated August 1, 2021, indicated if medication administration was not completed as prescribed, documentation must include the reason why it was not completed and any follow-up procedures that were provided. Time Period for Correction: Fourteen (14) days. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		

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02360	Continued From page 3	02360		
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 incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		