Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL313327006M
Compliance #: HL31337007C

Date Concluded: October 12, 2022

Name, Address, and County of Licensee Investigated:
Highland GW LLC
1925 Graham Ave
St. Paul, MN 55116
Ramsey County

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

Evaluator's Name: Yolanda Dawson, RN
Special Investigator

Finding: Inconclusive

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):
A staff member/alleged perpetrator (AP) neglected a resident when the resident was found unresponsive and thought to have received the incorrect medication. The resident required medical intervention to stabilize his condition.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. It is unable to be determined if the resident received the incorrect medication. An initial emergency room toxicology screen showed the resident was positive for an antidepressant medication that he was not prescribed. However, the subsequent blood test was negative for the medication. The

resident was hospitalized, responded to medical intervention, and transferred to another facility.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of hospital records, policies regarding supervision of staff, medication errors, and resident rights. The investigator also observed administration and storage of medications.

The resident resided in an assisted living. The resident had a diagnosis of Parkinson's disease. The resident's service plan included assistance with medication management and reassurance checks. The resident's assessment indicated the resident was alert and responsive.

One morning, staff found the resident unresponsive in bed. Emergency services were contacted, and the resident was sent to the hospital for an evaluation.

Hospital emergency department lab results indicated the resident was positive for an antidepressant medication he was not prescribed. To ensure accuracy of the first test, a subsequent lab test was completed which was negative for the medication.

The facility conducted an internal investigation of the incident after receiving information the resident tested positive for an antidepressant. The internal investigation identified the resident's most recent medication administration time was the evening prior to him being found unresponsive.

Internal investigation notes indicated the evening prior to the resident being found unresponsive, the resident left the facility before receiving his scheduled 4:00 p.m. medications. When the resident returned to the facility around 8:00 p.m., the resident's 4:00p.m., 8:00p.m., and 10:00p.m. medications were all administered at the same time. The AP indicated she had pre-set-up the medications in a medication cup and administered all three of the scheduled medication doses upon the resident's return to the facility.

During an interview, the AP confirmed the resident returned to the facility around 8:00 p.m., and she administered his 4:00p.m., 8:00p.m., and 10:00p.m. medications all together. The AP stated she received training for medication administration and identified she should not have administered all the medications together. The AP stated it was a hectic day; the facility was short staffed, and she was busy helping other staff and passing medications at the same time. Although the AP identified there was a possibility the resident received the wrong medication, she denied this is what had occurred.

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

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that

maltreatment did or 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: No hospitalized
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility conducted an internal investigation. The AP was removed from the work schedule and the family and provider were contacted. AP was reeducated on proper medication administration protocol.

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.

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
	31337	A. BUILDING: _____ B. WING _____	C 08/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND GW LLC	1925 GRAHAM AVENUE SAINT PAUL, MN 55116

(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 ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING 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: #HL31337007C #HL31337006M On August 2, 2022, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order was issued. At the time of the complaint investigation, there were 34 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for #HL31337007C #HL31337006M, tag identification 1760.	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	01760		

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01760	Continued From page 1 include the signature and title of the person who 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 document review, the licensee failed to ensure medications were administered as prescribed for one of seven (R1) residents reviewed for medication administration. R1 was given medication scheduled for six different times all at once. 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) 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). Findings include: R1 admitted to the facility on August 3, 2021, with diagnoses that included Parkinson's disease. R1's service agreement dated March 7, 2022, indicated R1 received medication management and administration from facility staff. Review of R1's April 2022 Medication Administration Record (MAR) indicated	01760	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 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	

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01760	Continued From page 2 medications were scheduled for 4:00 p.m., 5:00 p.m., 7:00 p.m., 8:00 p.m., 9:00 p.m., and 10:00 p.m. The MAR indicated that on April 17, 2002, all of these scheduled medications were initialed by the AP as given. The schedule indicated that Carb/Levo 25-100mg 1 tablet orally 3 times a day for Parkinson's was scheduled at 4:00 p.m. and 9:00 p.m. Internal investigation notes dated April 18, 2022, indicated the AP reported that on the evening of April 17, 2022, R1 left the facility before receiving his 4:00 p.m. medications. AP reported when R1 returned at around 8:00 p.m. she administered R1's medications that were scheduled for 4:00p.m., 8:00p.m., and 10:00p.m. all at one time. The AP also reported she had dispensed the medications into a medication cup and set them aside before administering them to R1. Because the AP administered all scheduled medication at one time, R1 received a double dose of his Parkinson's medication. During an interview on August 3, 2022, at 2:16pm, AP stated R1 came back to the facility at around 8:00 p.m., and she administered his 4:00 p.m. 8:00 p.m. and 10:00 p.m. medications at one time. AP stated she received training for medication administration, and she should not have given all of the medications at one time. AP stated it was a hectic day and they were short staffed, and she was busy helping other staff members with direct care of residents and passing medication at the same time. AP stated she could have but did not believe that she administered the wrong medication to R1. A facility policy, dated August 2, 2021, entitled "Medications Error" indicated for the safety of the residents at White Pine/Gracewood Senior Living,	01760	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.	

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01760	Continued From page 3 the facility has a goal of zero medication errors. In the event an error occurs, staff will document, track, and resolve medication administration errors for quality improvement. Staff will be retrained if necessary. TIME PERIOD FOR CORRECTION: Twenty- one (21) days	01760		