DEPARTMENT OF HEALTH

# Office of Health Facility Complaints Investigative Report
PUBLIC

| Facility Name: | Report Number: | Date of Visit: |
|---|---|---|
| Maple Hill Senior Living LLC | HL31955010 | June 29, 2017 |
| **Facility Address:** | **Time of Visit:** | **Date Concluded:** |
| 3030 South Lawn Drive | 7:30 a.m. to 4:30 p.m. | January 2, 2018 |
| **Facility City:** | **Investigator's Name and Title:** | |
| Maplewood | Kathleen Smith, DNP, RN, PHN, Special Investigator | |

| State: | ZIP: | County: |
|---|---|---|
| Minnesota | 55109 | Ramsey |

☒ **Home Care Provider/Assisted Living**

## Allegation(s):

It is alleged that a client was neglected when the alleged perpetrator failed to administer the client's medication as ordered. The client did not receive Diltiazem for 8-10 days. The clients condition declined and the client was hospitalized.

- ☒ State Statutes for Home Care Providers (MN Statutes, section 144A.43 - 144A.483)
- ☒ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
- ☒ State Statutes Chapters 144 and 144A

## Conclusion:

Based on a preponderance of the evidence, neglect is substantiated. Staff of the prior home care provider failed to administer medications as ordered to three clients.

The clients received medication management services from the home care provider.

Client #1 had a diagnosis of atrial fibrillation and mild cognitive impairment. Client #1 had a physician's order to receive diltiazem (a medication that will slow the heart rate) daily.

Client #2 received medication management services from the home care provider and had a diagnosis of dementia. Client #2 had physician orders for acetaminophen-codeine (for pain), one tablet every six hours as needed.

Client #3 received medication management services from the home care provider and had a diagnosis of vertebral fracture and diabetes. Client #3 had physician orders for evening medications.

Client #1 did not received the client's ordered diltiazem on three consecutive days. The notes for Client #1 indicated a nurse contacted the pharmacy the week prior to the incident to re-order the medication, but at that point, it was to early to refill the prescription. Upon admission, Client #1's heart rate was 62 beats per minute, with a blood pressure of 123/90. Eleven days later, the pulse was 139-142 beats per minute and the blood pressure was 100/60. Two days later, the heart rate was 126 beats per minute with a blood pressure of 100/80, and the client expressed interest in seeing the health care provider the next day. There were no nursing assessments or follow up notes. Two days later, Client #1 complained of nausea and vomiting, the heart rate was 130-140 and the blood pressure was 108/60, the client's health care provider was contacted, and Client #1 was sent to the hospital. According to hospital records, Client #1 presented with an irregular heart rate of 129 beats per minute. Client #1 required intravenous medication to reduce the heart rate and was admitted to the hospital overnight for monitoring.

An interview with a home care provider registered nurse indicated the client missed three doses of the medication, became symptomatic, and required hospitalization.

During an interview, home care provider administration stated Client #1 missed three doses of the medication. A report completed by the home care provider indicates the home care provider contacted a family member, the pharmacy, and another home care provider for the medication without success. According to the client notes, the physician was not contacted by the home care provider and not made aware that Client #1 was not receiving the medication as prescribed.

Review of Client #2's medical record indicated three different staff members administered two tablets of the client's acetaminophen-codeine, although the orders specified one tablet. All three incidents occurred during a two day period. Client #2 had nausea and vomiting, but did not required medical attention. According to home care provider reports the staff failed to follow the policies and procedures for administering and documenting narcotic medications.

Review of Client #3's medical record indicated that one morning, the client's evening medications were found on the client's nightstand. A review of facility reports revealed the medications had not been administered per policy and procedure the evening before.

Interviews with two unlicensed staff revealed medications are not counted with another staff. An interview with nursing administration revealed staff were not following policy.

During an interview, a direct care staff member stated no education was received regarding medication administration. The employee record revealed the unlicensed staff received oral medication training, and the same error was committed twice, however,there was no retraining after the first error. After the second occurrence, the unlicensed staff member resigned and the home care provider planned to reeducate all staff

The home care provider contacted the family, the health care provider, and reeducated staff in proper administration of medications.

Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557)

Under the Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557):

☐ Abuse ☒ Neglect ☐ Financial Exploitation

☒ Substantiated ☐ Not Substantiated ☐ Inconclusive based on the following information:

**Mitigating Factors:**

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ☐ Individual(s) and/or ☒ Facility is responsible for the

☐ Abuse ☒ Neglect ☐ Financial Exploitation. This determination was based on the following:

At the time of the incident, the clients were receiving services from a home care provider known as Meadow Ridge Senior Living. That license was closed prior to the investigation, however, that provider is responsible for the neglect. Meadow Ridge Senior Living did not provide adequate training and supervision to ensure medications were administered correctly. In addition, Meadow Ridge Senior Living's policy for medication administration did not clearly indicate clients needed to be observed taking the medication. A narcotic administration policy was not received for review.

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.

**Compliance:**

State Statutes for Home Care Providers (MN Statutes section 144A.43 - 144A.483) – Compliance Met
The facility was found to be in compliance with State Statutes for Home Care Providers (MN Statutes section 144A.43 - 144A.483). No state licensing orders were issued.

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) – Compliance Met
The facility was found to be in compliance with State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557. No state licensing orders were issued.

State Statutes Chapters 144 & 144A – Compliance Met
The facility was found to be in compliance with State Statutes for Chapters 144 & 144A. No state licensing orders were issued.

**Compliance Notes:**

No correction orders were issued because the licensee that is responsible for the neglect no longer exists.

## Definitions:

**Minnesota Statutes, section 626.5572, subdivision 17 - Neglect**

"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.

**Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated**

"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

## The Investigation included the following:

**Document Review: The following records were reviewed during the investigation:**

- ☒ Medical Records
- ☒ Medication Administration Records
- ☒ Nurses Notes
- ☒ Assessments
- ☒ Care Plan Records
- ☒ Facility Incident Reports
- ☒ Service Plan

**Other pertinent medical records:**

☒ Hospital Records

**Additional facility records:**

☒ Staff Time Sheets, Schedules, etc.

☒ Personnel Records/Background Check, etc.

☒ Facility In-service Records

☒ Facility Policies and Procedures

Number of additional resident(s) reviewed: Four

Were residents selected based on the allegation(s)? ◉ Yes ○ No ○ N/A

Specify: _____

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

◉ Yes ○ No ○ N/A

Specify: _____

**Interviews: The following interviews were conducted during the investigation:**

Interview with reporter(s) ◉ Yes ○ No ○ N/A

Specify: _____

If unable to contact reporter, attempts were made on:

| Date: | Time: | Date: | Time: | Date: | Time: |
|---|---|---|---|---|---|
| | | | | | |

Interview with family: ◉ Yes ○ No ○ N/A Specify: _____

Did you interview the resident(s) identified in allegation:

◉ Yes ○ No ○ N/A Specify: _____

Did you interview additional residents? ◉ Yes ○ No

Total number of resident interviews: Three

Interview with staff: ◉ Yes ○ No ○ N/A Specify: _____

**Tennessen Warnings**

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: Five

Physician Interviewed: ○ Yes ◉ No

Nurse Practitioner Interviewed: ○ Yes ◉ No

Physician Assistant Interviewed: ○ Yes ◉ No

Interview with Alleged Perpetrator(s): ◉ Yes ○ No ○ N/A Specify: _____

Attempts to contact:

| Date: | Time: | Date: | Time: | Date: | Time: |
|---|---|---|---|---|---|
| | | | | | |

If unable to contact was subpoena issued: ○ Yes, date subpoena was issued _____ ○ No

Were contacts made with any of the following:

☐ Emergency Personnel ☐ Police Officers ☐ Medical Examiner ☐ Other: Specify _____

**Observations were conducted related to:**

☒ Personal Care
☒ Nursing Services
☒ Call Light
☒ Medication Pass
☒ Cleanliness
☒ Dignity/Privacy Issues
☒ Safety Issues
☒ Meals
☒ Facility Tour

Was any involved equipment inspected: ○ Yes ○ No ◉ N/A

Was equipment being operated in safe manner: ○ Yes ○ No ◉ N/A

Were photographs taken: ○ Yes ◉ No Specify: _____

cc:

**Health Regulation Division - Home Care & Assisted Living Program**

**The Office of Ombudsman for Long-Term Care**

**Maplewood Police Department**

**Ramsey County Attorney**

**Maplewood City Attorney**

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H31955 | A. BUILDING: _____ B. WING _____ | C 12/15/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MAPLE HILL SENIOR LIVING | 3030 SOUTH LAWN DRIVE MAPLEWOOD, MN 55109 |

| (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<br><br>On June 22, 2017, a complaint investigation was conducted to investigate complaints #HL31955008, HL31955009, and HL31955010. 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/rules for Nursing Homes.<br><br>The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings, which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Time Period for Correction.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. | |

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

December 26, 2017

Ms. Stephanie Arpinar, Administrator
Maple Hill Senior Living
3030 South Lawn Drive
Maplewood, MN 55109

RE: Complaint Number HL31955008, HL31955009, and HL31955010

Dear Ms. Arpinar:

A complaint investigation of the Home Care Provider named above was completed on December 15, 2017 for the purpose of investigating complaint number HL31955008, HL31955009, and HL31955010 and assessing compliance with State licensing regulations. At the time of investigation, the investigator from the Minnesota Department of Health, Office of Health Facility Complaints, noted no violations of these rules promulgated under Minnesota Statutes Sections 144A.43 to 144A.484.

Attached is the State Form stating that no violations were noted at the time of the investigation. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Matthew Heffron

Matthew Heffron, JD, NREMT
Health Regulations Division
Supervisor, Office of Health Facility Complaints
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St. Paul, MN 55164-0970
Telephone: (651) 201-4221 Fax: (651) 281-9796

MLH

Enclosure

cc: Home Health Care Assisted Living File
Hennepin County Adult Protection
Office of Ombudsman for Long Term Care
MN Department of Human Services