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 #: HL324527685M
Compliance #: HL324524485C

Date Concluded: March 6, 2024

Name, Address, and County of Licensee Investigated:
The Meadows
1761 Eagle View Drive
Albert Lea, MN 56007
Freeborn County

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

Evaluator's Name: Willette Shafer, RN
Special Investigator

Finding: Not Substantiated

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 facility failed to administer medications to a resident that were necessary for the resident to breath. The resident transported to the hospital.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The medications were readily available to the resident. The resident declined to take his medications.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family. The investigation included review of medical records, facility policies, incident reports, grievances, and personnel records. Also, the investigator observed medication administration, meals, and call light response time.

The resident resided in an assisted living memory care unit. He resided in the memory care unit because he shared a room with his wife who needed memory care services. The resident left the memory care unit as desired. The resident's diagnoses included lung disease, anxiety, heart disease and anxiety. The resident's service plan included assistance with medication administration, meals, and housekeeping. The resident's assessment indicated he was oriented and vulnerable to self-neglect due to refusing medications and meals.

During an interview, a member of management said medications were ordered through an outside pharmacy. She described the process for reordering medication and said the staff who passed medications are trained on the process. There was one time where a medication was not available, and it was because of an insurance issue, and the medication was for a different resident.

The resident's medication administration record indicated the resident took his inhaler consistently but then declined the inhaler for several days in a row.

During an interview, the resident said he declined the inhaler because it did not work. He said, "I can't get a deep enough breath." He used the inhaler for a while but then quit using it, "that was my refusal." He stated his medications have always been available.

During an interview, a medication trained unlicensed personnel (ULP) said she worked with the resident since he admitted. The resident refused his inhaler. She said the resident complained about the mouthpiece on the inhaler. The facility ordered a special mouth attachment to encourage the resident to use the inhaler. The ULP said the inhaler was always available in the resident's medication closet.

The resident's hospital record indicated the resident admitted for shortness of breath. The hospital provider prescribed the resident an antibiotic and steroid medication.

The resident's medication administration record indicated, the resident received the antibiotic and the steroid the day he returned from the hospital.

During an interview, the resident's family member said the facility failed to administer the resident's medications upon hospital return. The resident had new medications ordered while at the hospital. Family member said he called the facility several times to ensure the resident received the medication the day after he returned from the hospital. The family member said the resident received the medication after he called several times. The facility also failed to administer an inhaler medication for the resident's breathing. The family member said the inhaler was not available.

In conclusion, the Minnesota Department of Health determined 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 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 completed an internal investigation and completed staff education.

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
	32452	A. BUILDING: _____ B. WING _____	C 03/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MEADOWS	**1761 EAGLE VIEW CIRCLE ALBERT LEA, MN 56007**

(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 On March 5, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL324524485C/#HL324527685M. No correction orders are issued.	0 000		