Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL334352320M
Compliance #: HL334351361C

Date Concluded: August 7, 2024

Name, Address, and County of Licensee Investigated:
Walker Methodist Levande
2011 6th Lane SE
Cambridge MN 55008
Isanti County

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

Evaluator's Name: Maggie Regnier
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 the resident the facility delayed administration of anxiety and pain medications.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. While there was some delay obtaining the resident's medications upon admission, this delay was caused by confusion in the orders between the hospice provider and the pharmacy. The facility took appropriate steps to address the miscommunication.

This medication was to be given as needed (prn). The Pharmacist caught the mistake and contacted the facility to clarify the order. The facility then contacted the hospice RN for the correct order which caused a 36-hour delay in the correct medication being sent to the facility and given to the resident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted family members and the hospice agency. The investigation included review of medical records, facility records, email communications plus policies and procedures. Also, the investigator observed interactions between staff, residents, and visitors.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's dementia, and history of multiple TIA's (transient ischemic attack which is a brief blockage of blood flow to the brain). The resident's service plan included assistance with ambulation, meals, dressing, grooming, medication, and behavior redirection. The resident's assessment indicated he had wandering behaviors and could get agitated at times. The resident was on hospice prior to admission to the facility and continued hospice services at the facility due to end stage dementia.

Upon admission to the facility, the facility had difficulty obtaining his medications including as needed medications. During the admission process the facility nurse and the hospice nurse communicated to understand the roles and responsibilities for the facility and the hospice organization. It was determined the hospice agency would be manage the residents' medications, which included ordering medications, and changes such as starting or stopping medications.

The resident's medical record indicated the hospice nurse placed orders for the resident's medications including lorazepam (an anti-anxiety mediation) to be given as needed. However, when the pharmacy received the orders, it was late in the day and most of the medications were sent to the facility early the next day. Unfortunately, the pharmacy required clarification of the lorazepam orders and could not be sent immediately. The pharmacy contacted the facility nurse who subsequently contacted the hospice nurse who provided clarification so the order could be filled by the pharmacy.

A review of electronic communication between the between the facility and the hospice provider indicated both took action to address the resident's medications.

During an interview, the facility nurse stated the resident did have some wandering behaviors and did not sleep at night during the first week or so, but this was the resident's baseline. The facility nurse also stated although the resident did not come to the dining room during this time, he was offered and refused, the staff did bring him food in his room.

During an interview, the hospice nurse stated people with dementia often exhibit the types of behaviors the resident did when entering a new and unfamiliar environment as he did upon admission. The hospice nurse stated resident was calm and did not seem agitated when she saw him in-person at the facility so she would not have given the resident an as-needed medication on those occasions.

During an interview, the family member had concerns about pain medication not given in a timely manner.

A review of email communication regarding the resident's pain medications indicated hospice addressed updating the resident's pain medications including morphine and fentanyl patch.

The resident's medication administration record indicated the facility began administering these medications the same day as the email.

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: No, passed away
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility appropriate action while coordinating cares with the hospice provider.

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
	33435	A. BUILDING: _____ B. WING _____	C 06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER METHODIST LEVANDE LLC	2011 6TH LANE SE CAMBRIDGE, MN 55008

(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 June 25, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL334351361C/#HL334352320M. No correction orders are issued.	0 000		