Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL34150001M
Compliance #: HL34150002C

Date Concluded: October 20, 2022

Name, Address, and County of Licensee Investigated:
Harrison Bay Senior Living
1861 Commerce Blvd
Mound, MN 55364
Hennepin County

Evaluator's Name:
Lisa Coil RN, Special Investigator

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

Finding: Not Substantiated

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):
The facility neglected the resident when staff discontinued the residents blood pressure medication and the resident fell resulting in a laceration on his left upper eyelid requiring stitches.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the resident medications were discontinued and the resident had a fall, the resident was sent to the emergency room for treatment, the provider was active in the resident's care and the blood pressure medication was restarted.

The investigator conducted interviews with facility staff, including nursing and administrative staff. The investigator interviewed the resident and contacted the resident's family member.

The investigation included review of the resident's facility and hospital record. Also, the investigator toured the facility and observed staff to resident interactions.

The resident resided in an assisted living facility with his wife. The resident's diagnoses included Alzheimer's dementia with behavior disturbances and high blood pressure. The resident's service plan included assistance toileting and medication administration.

Review of the resident's orders indicated the resident's provider wrote an order to hold the resident's blood pressure medication if the resident blood pressure or heart rate were under a certain number. The orders further indicated the provider wrote a new order 14 days later adding the blood pressure medication back.

The facility incident report indicated the resident's wife pushed the call pendant to alert staff the resident had fallen. When facility staff member(s) arrived at the resident's apartment, they found the resident on the floor with a laceration above his left eye. The report indicated the resident fell when getting up from bed to go to the bathroom. The report also indicated the resident had a history of falls, had dementia, and did not recognize safety hazards. The resident was sent to the emergency room for stitches and then returned to the facility.

Review of the resident's progress notes indicated the resident had five falls withing four weeks prior to the blood pressure medication being discontinued. The progress notes further indicated the provider had adjusted medications, checked blood work, and made referrals to therapy within the month surrounding the incident. Further, a review of the resident's vital signs record indicated the resident's blood pressure fluctuated and had not change during the time he did not receive the blood pressure medication.

Review of the resident's medication administration record (MAR) indicated the blood pressure medication was discontinued instead of adding the hold orders as the provider ordered. The MAR further indicated the blood pressure medication was started again according to the new order 14 days after it was discontinued.

During an interview family member (FM) stated the resident's mental health deteriorated quickly when he moved to the facility, and missing medications could have added to that. FM stated he asked the facility to take over the resident's medication administration, but the transition of care from the resident's previous provider to the facilities provider and facility and pharmacy processes took time. FM stated the resident improved and returned to baseline after time.

During interviews, staff members stated they were not aware the resident's blood pressure medication had been discontinued without an order. One of the staff members confirmed the medication error process was not completed because to her knowledge, no one in the facility was aware a medication error had occurred.

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 sent the resident to the emergency room.
The provider wrote an order to restart the medication.

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
	34150	A. BUILDING: _____ B. WING _____	C 09/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON BAY SENIOR LIVING	1861 COMMERCE BOULEVARD MOUND, MN 55364

(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: #HL34150002C/#HL34150001M #HL34150004C/#HL34150003M On September 21, 2022, 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 65 residents receiving services under the provider ' s Assisted Living with Dementia Care license. The following correction order is issued for #HL34150002C/#HL34150001M and #HL34150004C/#HL34150003M, tag identification 1760.	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 for Assisted Living License Providers. 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 surveyors' 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 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 subd. 1, 2, and 3.	
01760 SS=G	144G.71 Subd. 8 Documentation of administration of medication	01760		

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01760	Continued From page 1 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 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 according to provider prescribed orders for two of two residents (R1 and R2) with records reviewed. R1 and R2 had medication errors including transcription, order implementation and administration errors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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). Findings include: R1 R1's face sheet indicated the resident admitted to the facility on January 20, 2022, from his home	01760		

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01760	Continued From page 2 with diagnoses including Alzheimer's dementia with behavioral disturbance and hypertension. R1's service addendum signed on January 20, 2022, effective the same date, indicated R1 required escort assist, and safety checks. R1's service addendum signed on April 22, 2022, indicated R1 required medication assistance and management effective February 9, 2022. R1's provider order, signed and dated March 21, 2022, indicated hold morning metoprolol for systolic blood pressure greater than 120 and/or heart rate greater than 60. R1's March 2022 medication administration record (MAR) indicated metoprolol was discontinued on March 23, 2022. R1's assessment, dated March 25, 2022, indicated R1 resided in an apartment with his wife and had significant cognitive deficits. R1's assessment further indicated R1 received medication management by the licensee which included. R1's provider order, signed and dated April 27, 2022, indicated the following: - restart Artificial tears 1.4 % - one drop to right eye two times per day - restart prednisolone suspension 1% ophthalmic - one drop into right eye two times per day for five days, then daily for five days, then every other day for five days then discontinue. R1's April MAR did not indicate Artificial tears or prednisolone were started on April 27, 2022, as the provider ordered.	01760		

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01760	Continued From page 3 During an interview on October 10, 2022, at 5:30 p.m., family member (FM)-A stated R1's mental health deteriorated quickly when R2 moved to the facility, and missing medications could have added to that. FM-A stated he asked the facility to take over R1's medication management, but the transition of care from R1's previous provider to the facilities provider and facility and pharmacy processes took time. FM-A stated R1 improved and returned to baseline after time. R2 R2's face sheet indicated R2 was admitted to the facility on March 3, 2022, with diagnoses including dementia and chronic obstructive pulmonary disease. R2's face sheet indicated R2 used oxygen as needed to keep her oxygen saturation level greater than 90%. R2's service addendum signed on March 11, 2022, indicated R2 required medication assistance and administration. R2's assessment dated February 15, 2022, indicated R2 had severe cognitive impairment and received medication management. Another assessment dated April 2, 2022, indicated R2 resided in a secured memory care unit. R2's progress notes dated April 14, 2022, at 1:16 p.m., indicated R2 was admitted to the hospital on April 14, 2022, for positive blood cultures. R2's hospital discharge summary, dated April 20, 2022, at 11:40 a.m., indicated the resident admitted to the hospital on April 14, 2022, with sepsis secondary to right lower lobe pneumonia. The same document indicated R2 returned to the licensee on April 20, 2022. The discharge record indicated R2 should:	01760		

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01760	Continued From page 4 Start taking the following medications: - Levofloxacin 750 mg tablet, one tablet oral, once daily starting April 21, 2022. - Melatonin 3 mg tablet, two tablets oral at bedtime. - Metoprolol tartrate 25 mg tablet, 12.5 mg oral two times daily. - Olanzapine 5 mg disintegrating tablet, one tablet oral every evening. Continue taking the following oral medications: - Albuterol HFA 108 (90 Base) MCG/ACT inhalation aerosol, two puffs inhalation, every four hours as needed, shake before using. - Aspercreme Lidocaine 4% topical, two times daily. - citalopram 20 mg tablet oral, once daily. - DM-guaifenesin ER 60-1200 mg tablet extended release 12 hours, one tablet oral, three times daily as needed. - Senna-Lax 8.6 mg tablet, two tablets oral, two times daily as needed. - Trelegy Ellipta 100-62.5-25 MCG/ING Aerosol Powder breath activated, one puff inhalation, once daily, rinse mouth after use. - Tylenol 325 mg capsule, take 650 mg oral, three times daily. - Tylenol 325 mg capsule, take 650 mg oral, one time daily as needed. R2's progress notes dated April 20, 2022, at 4:38 p.m., indicated the resident returned from the hospital but the facility sent R2 to the emergency department due to coughing, wheezing, lethargy, and oxygen saturation of 74%. R2's emergency department (ED) record dated April 20, 2022, at 5:15 p.m., indicated the resident	01760		

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01760	Continued From page 5 was brought to the ED via ambulance for shortness of breath. The record indicated the resident discharged earlier that day following a hospital stay for sepsis and pneumonia. The record indicated the resident was discharged back to the facility with a short course of steroids and albuterol nebulizer treatments for wheezing or shortness of breath. R2's April 2022 medication administration record (MAR) indicated no medication were given to R2 from April 21, 2022, through April 23, 2022. The following medications were listed on R2's April MAR and indicated: - Aspercreme CRE LIDOC 4%, apply topically to lower back twice daily. April 21, 2022, through April 23, 2022, had "X" in the squares. - Acetaminophen Tab 325 mg, take two tablets by mouth (650 mg) three times daily. April 21 through April 23, 2022, through April 30, 2022, had "H" in the squares - Trelegy 100/62.5/25 mcg (Fluticasone-Umeclidin-Vilant), Inhale 1 puff by mouth every day. April 21, 2022, through April 21, 2022, had "H" in the squares - Citalopram Tab 20 mg, one tablet by mouth every day. April 21, 2022, through April 23, 2022, had "H" in the squares. - Albuterol AER HFA, inhale two puffs by mouth every four-six hour as needed. April 21, 2022, through April 23, 2022, had an "H" in the squares. R2's service checkoff list indicated facility staff members provided vital signs checks on April 21, 2022, April 22, 2022, and April 23, 2022,	01760		

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01760	Continued From page 6 documented the results. The same documents indicated the facility staff members provided warm compress to the resident's eyes. Additionally, staff members documented providing the resident escort services. The same document indicated the resident "refused" toileting/incontinence assistance on April 22, 2022, at 1:00 p.m. R2's an ED to hospital admission record, dated April 23, 2022, at 1:55 p.m., indicated the resident was brought to the ED via ambulance for shortness of breath. The record indicated the resident was hospitalized the past week from April 14 to April 20 for pneumonia and bacteremia, was discharged with oral antibiotics, had an ED visit the same day as discharge, was sent home with an order for steroids; however, it was unclear whether the resident received the medications. The record indicated the resident was admitted for COPD (chronic obstructive pulmonary disease) exacerbation. R2's facility progress notes dated May 3, 2022, at 11:33 a.m., indicated R2 returned from the hospital with orders for oxygen as needed. During an interview on October 13, 2022, at 11:30 a.m., family member (FM)-D stated someone from the hospital called him and said R2 did not receive her antibiotics following her April 20, 2022, hospital discharge. FM-D stated someone at the facility acknowledged the mistake but never provided details about the incident. During an interview on October 18, 2022, at 11:20 a.m., the Regional Clinical Director (RCD)-F stated she was not aware R1's blood pressure medication had been discontinued on March 23, 2022, without an order. RCD-F confirmed the	01760		

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01760	Continued From page 7 medication error process was not completed because to her knowledge, no one in the facility was aware a medication error had occurred. RCD-F stated R2 had returned from a hospital stay on April 20, 2022, went back to the ED just a few hours later, and was admitted to the hospital again. RCD-F stated the facilities electronic record indicated the resident had been on a leave of absence (LOA) from April 14, 2022, to April 20, 2022, and from April 20, 2022, to May 3, 2022. RCD-F also stated according to R2's progress notes R2 left to the ED on April 20, 2022, and never returned to the facility until May 3, 2022. The facility provided Medications & Treatments Guideline dated March 2021 indicated upon receipt of a medication order, a licensed nurse must take action to implement the order withing 24 hours. The guideline also states if a medication is not given the reason should be documented, including if there is no supply. Also, if there is no supply, the nurse is to call the pharmacy, family and medical practitioner, and document it in the resident record. Further, the guideline indicated medication errors should be documented according to the proper procedures by the person responsible for the error or the person who caught the error in order to track and resolve the error for quality improvement. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		