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 #: HL34150003M
Compliance #: HL34150004C

Date Concluded: October 20, 2022

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

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

Evaluator's Name:
Lisa Coil, RN Special Investigator

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 did not administer medications following the resident's hospital stay and the resident was readmitted to the hospital.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although a medication error did occur and the resident did not receive her medications as prescribed, the resident returned to the hospital for treatment and recovered.

The investigator conducted interviews with facility staff, including administrative staff and nursing staff. The investigator interviewed the resident and contacted the resident's family member. The investigation included review of the resident's facility record and hospital record. Also, the investigator toured the facility and observed staff to resident interactions.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia and a lung disease that makes it hard to breathe (chronic obstructive pulmonary disease). The resident's service plan included assistance with medication administration.

The resident's facility progress notes indicated the resident admitted to the hospital for positive blood cultures following a fever and low oxygen levels. The same documents indicated the resident returned to the facility six days later.

The resident's hospital discharge summary indicated the resident had a six-day hospital stay for sepsis secondary to pneumonia. The record indicated the resident had new medications orders upon discharge, including an antibiotic for pneumonia.

On the same day of the resident's return to the facility, the resident's facility progress notes indicated the facility transferred the resident back to the hospital due to low oxygen saturations and lethargy via emergency medical services (EMS).

Later that same day the resident's emergency room records indicated the resident discharged with an order for albuterol nebulizer treatment (a treatment to treat shortness of breath) back to the facility.

Over the next three days the resident's medical administration record indicated she did not receive her antibiotic or nebulizer. The resident's services checkoff list indicated she received toileting assistance, escort assistance, and facility staff members documented vital signs.

On the third day after returning to the facility, the resident admitted to the hospital again. The resident's hospital admission record indicated the resident was brought to the ED via ambulance for shortness of breath. The same documents indicated the resident was hospitalized the past week for pneumonia and bacteremia, discharged with oral antibiotics but went to the ED the same day and sent back to the facility. However, it was unclear whether the resident received her medications since returning to the facility three days ago. The record indicated the resident admitted for a ten-day hospital stay for COPD (chronic obstructive pulmonary disease) exacerbation.

The resident's facility progress notes indicated the resident returned to the facility after this hospitalization with an order for oxygen as needed.

During an interview family member (FM) stated the resident has had multiple hospital stay related to low oxygen levels. FM stated one time the resident was admitted to the hospital for pneumonia and a blood infection but returned to the facility. FM stated a couple of days after returning to the facility the resident was admitted back to the hospital because the pneumonia was starting to come back. FM stated someone from the hospital called him the following day and said the resident did not receive her antibiotics which were ordered at discharge from the

prior hospitalization. FM stated someone at the facility acknowledged the mistake when FM talked to them, but they did not provide details.

During an interview, the nurse stated the resident returned from a hospital stay one day, went to the ED a few hours later, and was admitted to the hospital again that same day. The nurse stated the facilities electronic record indicated the resident had been out on a leave of absence (LOA) for two separate hospital stays but did not stay at the facility between the two hospital stays.

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 hospital.

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		