Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL347126003M
Compliance #: HL347121281C

Date Concluded: July 6, 2023

Name, Address, and County of Licensee Investigated:
Miller's Landing
155 South 5th Street
Minneapolis, MN 55401
Hennepin County

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

Evaluator's Name: Peggy Boeck, RN
Special Investigator

Finding: Inconclusive

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 alleged perpetrator (AP) (unknown facility staff) neglected a resident when the AP gave the resident a peer's medications. The facility did not investigate the incident or retrain the AP. The facility also neglected to check on the resident and ensure the resident was eating/drinking.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. The resident experienced altered mental status and the facility sent the resident to the hospital. The hospital reported to the facility the resident had a medication in his system that was not prescribed to him. The facility investigation determined medication counts were accurate and could not find evidence of a medication error. The Minnesota Department of Health investigation could not determine why/ how the unprescribed medication was in the resident's system.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the hospital and reached out to a

family member. The investigation included review of medical records, incident reports, policies and procedures related to medication administration, medication errors, and maltreatment of vulnerable adults. Also, the investigator observed the facility medication administration process.

The resident lived in the assisted living with diagnoses including mild cognitive impairment and Parkinson's disease. The resident's service plan included assistance with medication administration, reminders for meals, and safety checks three times per day.

A progress note indicated a staff entered the resident's apartment one evening to give him his bedtime medications and found the resident on the floor. The note indicated the resident attempted to speak but made no sense and had difficulty keeping his eyes open. The staff called 911 and the resident went to the hospital.

Hospital records indicated the resident was evaluated and had a low likelihood of seizure or stroke. The resident experienced hallucinations while at the hospital and was admitted for further testing. The resident's record indicated a toxicology screen identified a medication in the resident's system that was not prescribed to the resident. The hospital could not determine a level or when it had been administered. Additionally, the record indicated a lack of one prescribed medication in the resident's system. The two medications had similar sounding/spelled names. A pharmacist called the director of nursing and requested the facility physically verify all the resident's medications. The pharmacist told the director of nursing it was possible the pharmacy had packaged an incorrect medication.

During an interview the director of nursing stated she looked at and identified all the resident's medications one by one using pill identification information. The director of nursing stated the resident had one card of medications that had just been completed, so it was empty, but all others were verified as prescribed.

During an interview, the resident stated he did not recall the day of the incident. He stated he understood his hallucinations were due to a flare up of Parkinson's. The resident stated they never found out why his bloodwork showed he had a medication in his system that he did not take. The resident stated he did not know his medications by looking at them but did know how many pills he received. The resident stated he was pleased with the care he received at the facility.

In conclusion, neglect is inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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: No, attempted but did not reach
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility retrained staff on medication administration and verified all the resident’s medications.

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
	34712	A. BUILDING: _____ B. WING _____	C 06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLERS LANDING SENIOR LIVING	155 5TH AVENUE SOUTH MINNEAPOLIS, MN 55401

(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 ******ATTENTION****** ASSISTED LIVING PROVIDER 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: #HL347125082C/#HL347123087M and #HL347121281C/#HL347126003M On June 8, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were 57 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL347125082C/#HL347123087M, tag identification 2360. .	0 000	The Minnesota Department of Health documents the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the Surveyors and/or Investigators ' findings is the Time Period for Correction. Per Minnesota Statute §144G.30, Subd. 5 (c), the assisted living facilities must document any action taken to comply with the state correction order. A copy of the provider ' s records documenting those actions may be requested for follow-up surveys and/or complaint investigations. 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.	

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0 000	Continued From page 1	0 000	THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPY AND LEVEL ISSUED PURSUANT TO THE MINN. STAT. § 144G.31, SUBDIVISION 2 and 3.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	