Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL350171403M
Compliance #: HL350179042C

Date Concluded: May 29, 2024

Name, Address, and County of Licensee Investigated:
Heritage of Edina, Inc
3450 Heritage Drive
Edina, MN 55435
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:
Maerin Renee, RN, Special Investigator

Finding: Substantiated, facility responsibility

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):
It is alleged the alleged perpetrator (AP) neglected a resident when the resident did not receive medication according to physician orders. The resident experienced a hypertensive crisis that required hospitalization.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The resident ran out of olanzapine (a psychotropic medication) and the medication nurse failed to notify the AP to follow up and order more medication, nor did the nurse attempt to order more of the residents Olanzapine. Although the resident had no Olanzapine, the medication nurse continued to document in the resident's medication administration record the resident was receiving the olanzapine. The resident did not receive Olanzapine for 12 days. The resident had a hypertensive crisis and was hospitalized.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family members, providers, and caregivers. The investigation included review of the resident records, hospital records, pharmacy records, clinic records, the facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed medication administration and resident interactions with staff.

The resident resided in an assisted living facility The resident's diagnoses included schizophrenia, anxiety, and high blood pressure. The resident's service plan included assistance with morning and evening cares, bathing, meals, housekeeping, laundry, and medication management. The resident's assessment indicated the resident required orientation and redirection as needed by staff due to cognitive impairment.

The facility's internal investigation indicated the resident went without her olanzapine for a total of 12 days. The medication nurse sent a refill request to the pharmacy, and the pharmacy contacted the prescriber multiple times to request a new prescription. The prescriber denied the refill requests, but the facility did not receive this information. The medication nurse contacted the pharmacy but did not notify the AP for further follow up, per protocol. The nurse continued to sign off the olanzapine when setting up the resident's weekly medication set up. However, the olanzapine was out of stock and not in the resident's weekly medication setup.

The resident's progress notes indicated she then experienced a blood pressure spike and was sent to the hospital for further evaluation.

The resident's care sheets indicated unlicensed personnel (ULP) staff were instructed to administer the resident's medications in the morning and evening. The care sheets provided no further direction to staff regarding the resident's medications, such as the names, dosages, methods, and routes of administration. The ULP staff initialed and signed the care sheets, but there was no indication ULP staff knew what medications they were signing off as having administered.

The resident's hospital records indicated a diagnosis of hypertensive urgency with a history of hypertension, and delirium, hypoactive type. The resident's family expressed concerns they discovered the resident had not been receiving olanzapine for 12 days. Upon receiving olanzapine in the hospital, the resident improved. Psychiatry recommended continuing the resident's current medication management without any changes. At discharge, the resident's diagnoses were altered mental status, unclear cause, and hypertensive emergency, improved. The resident's condition at discharge was documented as stable.

After hospitalization, the resident's psychiatric clinic visit note indicated the resident experienced withdrawn behavior, psychosis, and cognitive changes. The resident was at a higher risk of falls and had not returned to baseline.

When interviewed, the AP stated the medication nurse had not notified her that the resident was out of olanzapine. The AP was unaware she needed to follow up about the olanzapine with the pharmacy and provider. The AP was unaware of why the med nurse continued to document that she set up the resident's olanzapine when it was out of stock, and the AP did not discover the missing olanzapine until after the resident returned from the hospital. The AP said ULP staff who administered medications to the residents would have had no way to double-check the med set up because the sign off sheets only note the medication times, and not what medications are being administered.

When interviewed, leadership staff stated she discovered the medication nurse continued to sign off that the resident's olanzapine had been included in her medication set up, although the medication had been out of stock for 12 days. The medication nurse contacted the pharmacy with a refill request; however, the AP was unaware and did not follow up on the prescription refill. The pharmacy contacted the prescriber multiple times with refill requests, and the prescriber denied the requests. The prescriber wanted the resident's mental health provider to start prescribing the olanzapine. The facility did not receive this information.

When interviewed, the med set up nurse said when the resident's olanzapine was running low, she sent a refill request to the pharmacy. She said she also notified the AP, although there was no documentation of that until the resident had been out of olanzapine for six days. There was no indication of follow-up to that notification. The medication nurse stated she continued to document she was setting up olanzapine for the resident, which was "a mistake."

When interviewed, the resident's mental health provider said the resident had pre-existing health issues the pre-disposed her to developing a hypertensive crisis in response to the abrupt discontinuation of olanzapine. In addition to the increased blood pressure, the resident developed a worsening of her psychosis. The mental health provider said the resident experienced significant clinical changes after she missed the olanzapine and did not return to her baseline status.

When interviewed, family members said they were concerned the resident was not getting some of her medications. In response, family members contacted the dispensing pharmacy. The family discovered the resident had been without her olanzapine for almost two weeks, as the prescription had not been refilled. The family notified the facility and coordinated with the resident's mental health provider to obtain an updated prescription. Family members said the resident never returned to a baseline level of functioning.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

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, due to cognitive limitations.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility identified the error, took corrective action, and implemented new measures designed to reduce the risk of further occurrence of this or similar errors. The facility trained staff in the new procedure for medication administration.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

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.
You may also call 651-201-4200 to receive a copy via mail or email.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Hennepin County Attorney
Edina City Attorney
Edina Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35017	A. BUILDING: _____ B. WING _____	C 04/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE OF EDINA INC	3450 HERITAGE DRIVE EDINA, MN 55435

(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: #HL350179042C/#HL350171403M On April 16, 2024, 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 85 residents receiving services under the provider's Assisted Living license. The following correction order is issued for #HL350179042C/#HL350171403M, tag identification 2360.	0 000	Minnesota Department of Health is documenting 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 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 evaluators' 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 SUBDIVISION 1-3.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

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02360	Continued From page 1 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 the facility 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 is required for this tag.	