Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL351958544M
Compliance #: HL351955922C

Date Concluded: April 29, 2024

Name, Address, and County of Licensee Investigated:
Riley Crossing Senior Living
620 Aldrich Drive
Chanhassen, MN 55317
Carver County

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

Evaluator's Name: Lena Gangestad, RN
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 by failing to administer his gabapentin for six days, resulting in increased pain.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the gabapentin was missed for six day the facility used other medications the resident had available to treat his pain. The occurrence was isolated.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident's records, internal investigation documentation, incident reports, personnel files, staff schedules, policies, and procedures.

The resident resided in an assisted living secured memory care building. The resident's

diagnoses include dementia and chronic pain. The resident's service plan included assistance with all activities of daily living, medications, meals, and housekeeping.

One day the manager visited the memory care unit when the resident expressed pain to her. She instructed the unlicensed caregiver to administer pain medication to the resident. At that time, the unlicensed caregiver informed her that the resident was out of gabapentin and had been for six days.

During an interview, the manager, who was a nurse, stated the resident had been without his gabapentin for six days while in hospice care. Initially, the resident received all his medications from one outside pharmacy, however it became necessary to change to a new pharmacy and the hospice pharmacy which led to confusion and the resident ran out of gabapentin. Despite the medication oversight, the resident did not require hospitalization. However, he experienced increasing pain so in response the facility caregivers gave him provided alternative "as needed" medications like Tylenol, Dilaudid, a lidocaine patch, and tramadol which helped to address his pain. The manager stated the resident reported suicidal thoughts, prompting nursing staff to send him to the hospital for evaluation, but he was discharged back to the facility on the same day. To address medication management issues, the manager initiated a refill medications binder system. This involved a pharmacy refill page, where the unlicensed caregiver would place stickers, which the nursing staff checked daily and submitted to the pharmacy. The nurses also conducted weekly cart checks.

During an interview, the registered nurse stated he no longer worked at the facility and did not remember anything about the incident. However, when he worked at facility, he said that he used to audit the entire medication cart every Wednesday to ensure that medications were filled. He stated that the unlicensed caregiver would often call him on his work cell to request medication refills. Alternatively, they would return the old card to him and inform him to reorder medications. Typically, he would reorder medications if the supply was less than 7 days.

During an interview, unlicensed caregiver #1 stated she could not remember the incident. However, she said there was a medication refill log, which the nurse checked daily. In instances where the nurse was unavailable, unlicensed caregivers would inform the triage. She also noted that the nurse frequently audited the medication cart.

During an interview, unlicensed caregiver #2 said she remembered the incident. She said at the time, the resident was receiving medications from the outside pharmacy and caregivers would contact the pharmacy three days prior to the resident's supply running low, but there was a delay in filling the prescription. She also stated when medication levels were low, she informed the nurses to reorder. Unlicensed caregiver #2 stated following the incident the facility implemented a binder system with refill pages. When medications reached five days or less, unlicensed caregivers were instructed to remove the label and place it in the binder or write it down. Nurses were responsible for checking the binder daily to refill medications.

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. The resident was deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
Staff promptly ordered medication to arrive right away from the pharmacy to address the situation. A medication error was processed, and an action plan was created. The manager reviewed the medication dashboard daily and followed up with support nurses regarding the status of all missed medications. Additionally, the nurse conducted daily checks with medication passers to obtain verbal reports on medications running low. Education was provided to unlicensed caregivers on completing re-order forms for the pharmacy and creating a binder for them to submit refill requests, ensuring medications could be ordered in a timely manner.

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
	35195	A. BUILDING: _____ B. WING _____	C 04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RILEY CROSSING SENIOR LIVING	620 ALDRICH DR CHANHASSEN, MN 55317

(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 April 3rd 2024, the Minnesota Department of Health initiated an investigation of complaints #HL351958826M/HL351956424C and #HL351958544M/HL351955922C. No correction orders are issued.	0 000		