Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL357452022M
Compliance #: HL357453747C

Date Concluded: April 19, 2023

Name, Address, and County of Licensee Investigated:

Carepoint Homes Inc.
957 Prosperity Ave, unit 201,
St. Paul, MN 55106
Ramsey County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Brandon Martfeld, 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 when staff failed to check the resident's blood pressure, oxygen saturations, and provide medications according to the plan of care.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility attempted to check the resident's vital signs, but the resident would refuse to have vital signs checked.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member. The investigation included review of the resident's medical record, and facility policies and procedures. Also, the investigator observed the resident at the facility.

The resident resided in an assisted living facility. The resident's diagnoses included complex regional pain syndrome, anxiety, depression, and congestive heart failure. The resident's service plan included staff assistance with anxiety, depression management, vital signs, and inhalers. The resident's memory was moderately impaired, and the resident made poor decisions, requiring staff cues and supervision. The resident's vulnerabilities included poor judgement for her safety.

The resident's physician orders indicated the resident's blood pressure was to be taken two times a day and the resident's oxygen saturation was to be taken daily. The physician orders also indicated the resident was to be sent to the emergency room if the oxygen saturation was less than 88 percent. The same orders indicated the resident had an inhaler scheduled twice a day for shortness of breath and a different inhaler that was as needed for shortness of breath.

Review of one month of the resident's treatment administration record (TAR) indicated the resident's blood pressure was completed per physician orders. The resident declined monitoring of her oxygen saturation 16 of 31 days during a month. The resident also declined to go to the hospital when her oxygen saturation was below 88 percent in that month. The resident's progress notes indicated the resident was provided the as needed inhaler when the resident experienced shortness of breath. The resident's service delivery record indicated the resident received her scheduled inhaler twice a day.

During an interview, the resident stated last winter she went to the hospital because her oxygen level was too low. The resident stated she hated hospitals and begged the staff not to send her to the hospital.

During an interview, the registered nurse (RN) stated staff monitored the resident's blood pressure and oxygen levels as the resident allowed. The RN stated the resident often refused staff to monitor her oxygen saturation levels because she knew if the level was too low, she would be sent to the hospital. Because of the resident's dislike for hospitals, the resident's anxiety would increase when staff attempted to check her oxygen levels.

During an interview, the family member stated staff contact her when the resident refuses to have her vital signs check. The family member also stated the resident hated the hospital and was aware if her vital signs were not good, she would have to go to the hospital.

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:
Facility staff made attempts to check the resident’s vital signs. The facility also attempted to complete the vital signs more frequently than the physician orders. When the resident presented with breathing distress, the facility sent the resident to the hospital for further evaluation.

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
	35745	A. BUILDING: _____ B. WING _____	C 04/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREPOINT HOME INC	957 PROSPERITY AVE #201 SAINT PAUL, MN 55106

(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 10, 2023, the Minnesota Department of Health initiated an investigation of complaint HL357452022M/HL357453747C. No correction orders are issued.	0 000		