Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL368753463M
Compliance #: HL368755533C

Date Concluded: January 23, 2023

Name, Address, and County of Licensee Investigated:
T&R Homes
11409 Swallow St NW
Coon Rapids MN 55433
County: Anoka

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Maggie Regnier, RN BSN
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 the facility failed to give the resident one of his mood stabilizing medications leading to a worsening of his behavioral symptoms and subsequent emergency room visit.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility documented the resident was offered the mood-stabilizing medication but refused to take them.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's provider. The investigation included review of medical records from the facility, care providers and hospital records. Also, staff education and training, policies and procedures and facility incidents. Also,

the investigator observed interactions between the resident and staff, resident interactions with others and the residents' accommodations.

The resident resided in an assisted living facility for more than a year. The resident's diagnoses included bipolar disorder, schizoaffective disorder, and history of suicidal ideation. The resident's service plan indicated the resident required medication management and administration along with behavior management. The resident's medical record indicated the resident had been prescribed the mood-stabilizing medication for years.

In the days leading up to the resident's visit to the emergency room visit, the resident's progress notes indicated the resident had episodes of yelling. The same documents indicated the resident at times refused his medications including the mood-stabilizing medication.

On the day of the resident's emergency room visit, the resident's emergency room documents indicated the emergency room physician consulted with the resident's nurse practitioner and ordered medication changes. The same document indicated a newly-prescribed antidepressant medication may have been causing the resident's increased anxiety and behaviors.

The resident's medication administration record indicated the antidepressant medication mentioned in the emergency room was discontinued while the mood stabilizing medication was continued.

However, the resident's medical record indicated the resident required hospitalization and further medication adjustments in the following weeks to help stabilize the resident's moods and behaviors. The resident returned to the facility after further adjustments in his medication with improved mood and behaviors.

During an interview, the resident's medical provider stated it was likely the newly-prescribed antidepressant may have caused increased anxiety and so the antidepressant was discontinued.

During an interview, the resident stated he had been on the mood-stabilizing medication for many years.

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: No, resident is responsible for his own self
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility makes assessments appropriately when necessary and offers appointment scheduling and transportation when needed.

Action taken by the Minnesota Department of Health:
Insert appropriate action from standard language document

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
	36875	A. BUILDING: _____ B. WING _____	C 12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TR HOMES	11409 SWALLOW STREET NW COON RAPIDS, MN 55433

(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 December 13, 2022, the Minnesota Department of Health initiated an investigation of complaint #HL368755533C/#HL368753463M. No correction orders are issued.	0 000		