Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL370713446M
Compliance #: HL370715568C

Date Concluded: January 6, 2023

Name, Address, and County of Licensee Investigated:
Boulder Ponds Senior Living
192 Jade Trail North
Lake Elmo, MN 55042
Washington County

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

Evaluator's Name:
Katie Germann, RN, Special Investigator

Finding: Substantiated, facility responsibility and 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 a resident when staff did not answer his call light for over two hours, resulting in the resident calling emergency services to assist with his cares. In addition, the resident was abused when he was found to have bruising of unknown origin on his left thigh.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The resident was unable to move in bed or independently complete cares without staff assistance. After waiting for staff assistance for almost two hours with no response, the resident called 911. The paramedics assisted the resident with cares.

The Minnesota Department of Health determined abuse was not substantiated. Although the resident did have four small circular bruises on his left thigh, the resident denied anyone

harmed him, and it could not be determined how the bruises occurred. There was no correlating documentation or staff concerns regarding the residents bruising.

The investigator conducted interviews with facility staff members, including administrative, licensed, and unlicensed staff. The investigation included review of medical records, facility policies and procedures, incident reports, call light records, and employee records. In addition, the investigator observed staff completing cares.

The resident resided in an assisted living facility with diagnoses including post-polio syndrome, absence of right leg, weakness, and stage 2 pressure sore on buttocks. The resident had no cognitive impairment and was able to make his needs known. The resident's service plan indicated the resident required staff assistance with activities of daily living, bathing, meals, and housekeeping. The resident had functional vulnerabilities and required assistance of two staff with toileting and transfers.

A facility investigation indicated the resident put his call light on to request assistance with morning cares. The resident was incontinent of stool and urine and needed assistance with changing and getting out of bed. The resident was unable to move in bed without assistance. The resident waited in his bed for an hour and a half with no response from facility staff. The resident began screaming for help, and nobody responded to his call light or his cries for help. The resident called 911 to request assistance. When the paramedics arrived, it had been over 2 hours since the resident put his call light to request staff assistance. The paramedics assisted the resident with cleaning up and changing into a clean brief prior to leaving the facility.

The residents progress notes written by a nurse regarding the incident indicated 911 was called due to the facility being short staffed and unable to help the resident, however, the resident was on the list (for staff to assist with cares), when the paramedics were called. The nurse was assisted by the paramedic and completed peri-care on the resident. The resident was having loose stools at the time.

The paramedic reported the resident stated he was placed into bed the evening prior and activated his call light for staff assistance with repositioning and toilet use approximately 2 ½ hours prior to the paramedic's arrival. The resident was bed ridden due to being an amputee and a recent leg fracture. The paramedic reported the resident had an open pressure ulcer on his buttocks and the resident stated the lack of repositioning caused him pain. When the paramedics arrived, the resident was lying in bed with no clothing and stool underneath him. The paramedics located facility staff and verified the residents call light was functioning properly. The staff stated they were unable to answer the residents call light because they were short staffed. The resident was cleaned and repositioned by the paramedic and a staff person prior to the paramedic leaving the facility. The resident declined transport to the hospital but expressed concerns regarding getting the cares and assistance he needed. The paramedic reported they had concerns over the resident's welfare.

The residents progress notes the day after the incident indicated the resident had complaints, he had not received a bath for 3 weeks and he was, “not happy about that.”

During an interview, the resident stated the morning of the incident he was calling for staff assistance and waiting in bed for an hour and a half screaming for help. The resident stated he gets very sore after lying in one place for a long period of time and he was unable to move himself in bed. The resident also stated he was incontinent of stool and urine and was lying in soiled clothing. The resident stated he finally called 911 when nobody was responding to his cries for help. The resident stated after this incident he called 911 on another occasion after waiting too long for assistance. However, prior to the ambulance arriving staff came to assist him and staff called to cancel the 911 call. The resident stated he had a wound on his left buttocks that got worse when he didn’t receive assistance with repositioning and/ or toileting.

In conclusion, the Minnesota Department of Health determined neglect was substantiated and abuse was not 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.

“Not Substantiated” means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and

(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: No, resident is his own responsible party
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility developed a plan to increase staffing coverage.

Action taken by the Minnesota Department of Health:

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
The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37071	A. BUILDING: _____ B. WING _____	C 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOULDER PONDS SENIOR LIVING	192 JADE TRAIL NORTH LAKE ELMO, MN 55042

(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 Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING 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: #HL370712791C/#HL370711403M #HL370713446M/ #HL370715568C On November 22, 2022, 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 67 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL370713446M/ #HL370715568C, tag identification 1690 and 2360.	0 000	The Minnesota Department of Health documents the State Licensing 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 ' 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 correction order. A copy of the provider ' s records documenting those actions may be requested for follow-up surveys. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider ' s Plan of Correction." The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144G.31, Subd. 2 and 3.	
01690 SS=F	144G.71 Subdivision 1 Medication management services	01690		

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01690	Continued From page 1 (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement current written medication management policies and procedures when one of one residents (R1) did not receive medication for 3 months. This had the potential to	01690		

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01690	Continued From page 2 affect all residents receiving medication services from the licensee. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1's face sheet dated November 22, 2022, indicated R1's diagnoses include chronic obstructive pulmonary disorder, interstitial lung disease, pulmonary fibrosis, and Alzheimer's disease. R1's service plan dated March 1, 2022, indicated the facility was responsible for the residents medication management assist and administration, which included ordering all necessary medications. R1's physician orders dated September 2, 2021, included an order for Esbriet, 860 mg three times per day, a medication to help the ease of the resident's breathing and slow the progression of pulmonary fibrosis. R1's medication administration record (MAR) for November and December of 2021, and January of 2022, indicated staff were directed to administer Esbriet, 860 mg three times a day. R1's MAR for November, and December,of 2021 and January of 2022 indicated all administration times were initialed by staff with a circle around	01690		

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01690	Continued From page 3 their initials, which indicated the medication was not given. However, there was no follow up documentation why R1 didn't receive the Esbriet or what the facility was doing to ensure the resident received the medication as prescribed. During interview on November 22, 2022, R1's family member stated they reported to the facility nurse on January 5, 2022, R1 was not receiving Esbriet since admission to the facility on September 2, 2022. The nurse then reported to the doctor and asked for new orders for the Esbriet. It took several phone calls back and forth to clarify orders and obtain the medication. The resident resumed taking the medication on January 21, 2022. Review of the facility's medication administration policy dated March 2021, indicated the registered nurse was responsible for assuring medication orders were implemented within 24 hours of receiving the order. The registered nurse will review the task (medication administration) was completed accurately by the unlicensed personnel. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	01690		
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	02360		

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02360	Continued From page 4 by: Based on interviews and document review, the facility failed to ensure 1 of 1 resident, R1, was free from maltreatment. The resident was neglected. Findings include: On November 22, 2022, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility was responsible for the maltreatment, in connection with incidents, which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	