Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL378271481M
Compliance #: HL378278965C

Date Concluded: July 12, 2024

Name, Address, and County of Licensee Investigated:
Avian Care LLC
1465 Danforth Street North
St. Paul, MN 55114
Ramsey County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Holly German, RN
Special Investigator

Finding: Inconclusive

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 they failed to follow the medical providers orders for the resident's medications. The resident experienced side effects related to the medication errors.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. The investigation lacked evidence the facility made medication errors or the resident experienced medication side effects due to alleged errors. The investigation revealed provider medication orders given did not always match the hospital after visit summaries, which contributed to the confusion of the multiple providers involved in the resident's care on what medications the resident took. Multitude of providers, hospital stays, medication order changes, and lack of pharmacy records proved difficulty in determining exact medication orders during given timelines.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's psychiatrist. The investigation included review of the resident record, hospital records, personnel files, staff schedules, pharmacy records, and related facility policy and procedures. Also, during the onsite visit, the investigator observed medication administration.

The resident resided in an assisted living facility. The resident's diagnoses included depression, anxiety, and borderline personality disorder. The resident's service plan included assistance with medication administration. The resident's assessment indicated the resident was independent with activities of daily living.

The resident received psychotropic medications for her mental health diagnosis. During the reviewed time frame of concern, staff noted a decrease in the residents mental and physical health stability, resulting in four hospitalizations in which providers ordered medication changes during each hospitalization. Additionally, the resident attended other various scheduled appointments with providers, who made medication changes. The resident also called her psychiatric provider with various medication change demands and received new orders. The providers notes did not always match with the order changes made, creating confusion in the continuity of care between providers. As psychiatric clinic staff noted potential order discrepancies, the facility nurse and psychiatric care clinic nurse spoke to clarify orders and ensure medication lists were accurate to both providers.

The pharmacy record indicated discontinue and start dates for medications, but lacked documentation on what provider gave the order or by what method the pharmacy received the order.

The resident's medication administration record (MAR) indicated staff administered medications to the resident per the order on record. The residents MAR orders matched the medication orders received by the facility.

During an interview, an administrative staff member stated there had not been any medication errors involving the resident. The staff member stated when there were new orders, the nurse put them in to the electronic tasks system, which then automatically sent the orders to the pharmacy. The pharmacy delivered the medication the next day or two. The staff member stated there were times the provider did not communicate orders to the facility, but instead directly to the pharmacy, so they were not always aware until the medication arrived, and the nurse would then confirm the orders and place them in MAR for staff to see the orders and administer the medication.

During an interview, the nurse denied having issues or concerns with the resident's medications. The nurse stated there were times it took longer to get new medications than the resident preferred due to a communication issue between the provider and the pharmacy, which increased the resident's anxiety and exacerbated her mental health issues. The nurse

stated there was a time the resident went away on vacation and staff sent the medications with her. The nurse stated she discovered the staff did not know how to document the medications sent with the resident in the electronic record, so it appeared the resident had not received her medications. The nurse stated this documentation error caused confusion to the resident's psychiatric provider when they reviewed the resident's MAR. Subsequently, the nurse trained the staff how to document medications sent with a resident properly on the MAR when a resident leaves with medications.

During an interview, the psychiatric provider stated the resident's mental health had declined and she saw her monthly in person in attempt to find medications that gave her benefit but didn't cause side effects. The provider stated the resident received high risk medications that required close monitoring and laboratory tests the resident did not complete. The provider stated there were medications abruptly stopped, and other medications staff administered double the ordered dosage. Upon review of the medication orders and administration record, the provider acknowledged the orders prescribed during a hospital visit did not match the after-visit summary notes, which she followed. The provider subsequently acknowledged the facility did administer the medications correctly based off the prescribed orders, and it was the after-visit summary notes that did not correctly state the orders.

During an interview, the resident denied ever running out of any of her medications or given an incorrect dose. The resident stated the staff monitor her for any side effects, and she has never had concerns about her care. The resident stated she had itching as a side effect of her medications, and the staff updated her provider who worked on getting the itching resolved.

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

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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: Not applicable, the resident was her own responsible party.

Alleged Perpetrator interviewed: Not applicable.

Action taken by facility:
The facility administered medication and updated received orders.

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
	37827	A. BUILDING: _____ B. WING _____	C 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIAN CARE LLC	1465 DANFORTH STREET SAINT PAUL, MN 55117

(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 May 17, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL378278965C/#HL378271481M. No correction orders are issued.	0 000		