Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL378682440M
Compliance #: HL378681477C

Date Concluded: August 25, 2024

Name, Address, and County of Licensee Investigated:
Living Hope Homes Audrey's Place
5641 Babcock Trail
Inver Grove Heights, MN 55077
Dakota County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:
Lisa Coil, RN, BSN, Special Investigator

Finding: Substantiated, facility responsibility

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 the facility failed to administer the resident's medications according to physician orders. The resident suffered from increased psychological symptoms, loss of appetite, weight loss, and increased weakness. The resident was taken to the emergency room for evaluation.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The resident did not receive an antipsychotic medication for 13 days. Multiple caregivers continued to document the medication was not available but did not notify the nurse or administrative staff so it could be ordered.

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 record, facility internal investigation, and related facility policy and procedures.

The resident resided in an assisted living facility. The resident's diagnoses included a mental health disorder and traumatic brain injury. The resident's service plan included assistance with medication management and behavior management.

The resident's assessment indicated he was usually understood, orientated but made poor decisions, and had visual and auditory hallucinations. The assessment indicated the registered nurse was to review medications weekly and order medications monthly or as necessary. The assessment indicated the resident had monthly lab draws for clozapine (an antipsychotic medication) dosing and a family member made the appointment and took the resident out for the blood draw.

An incident report indicated the resident had been sent to the hospital for evaluation following increased weakness and declining health. The report indicated the resident had not been eating or drinking well for a week or two and had lost 25 pounds in about four weeks.

A progress note, on the day the resident went to the hospital, indicated during investigation into the resident's medication chart a nurse identified the resident had not received clozapine for 13 days. With further follow up, it was determined the caregivers providing the resident's medications did not notify the nurse, or any other management staff the resident did not have clozapine available for administration.

The resident's medication administration record indicated in a 13-day period, clozapine was circled ten times indicating it was not given, signed off as given two times, and blank one time. At the bottom of the record, in a section labeled "Scheduled Med Notes," the ten days which were circled included notes stating, "med not here," "med not in," or "med not available." The two times the medication was signed off as given were in the middle of the times the medication was not available.

During an interview, the caregiver stated when a resident is out of a medication, staff members are to call the on-call nurse so they can put an order in for it. The caregiver stated the facility was without a house supervisor for a long time and the house supervisor was the one who made sure medications got put in the medication cart when they arrived from pharmacy. The caregiver stated in addition to charting "med not available" in the medication administration record, staff can put a note in the chart, such as "notified nurse." The caregiver did not recall if a note had been placed in the chart for this specific incident.

During an interview, the nurse stated on the day the resident went to the hospital, the hospital pharmacy called and asked when he took his last dose of clozapine. The nurse stated that was when she found the resident had not received the medication for 13-days. The nurse stated staff members had not notified her the medication was out of stock. When asked if she was

reviewing medication weekly and ordering monthly or as necessary according to the licensee policy, the nurse stated that task was delegated to the supervisor of the house. However, there was no supervisor during the time of incident. The nurse stated she did not review the resident's medications during the 13-days it was documented as not available. Further, the nurse stated an "Independent Home Support" person took the resident to a clinic for his lab work. The clinic would communicate the clozapine order to the pharmacy. The nurse stated she was not even aware the resident was not having his labs work done.

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

Vulnerable Adult interviewed: No, attempted but declined.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility investigated the incident and provided education to the staff members to reduce risk of recurrence and implement a correction.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

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.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Dakota County Attorney
Inver Grove Heights City Attorney
Inver Grove Heights Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37868	A. BUILDING: _____ B. WING _____	C 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING HOPE HOMES-AUDREY'S PLACE	4660 SLATER ROAD #230 EAGAN, MN 55122

(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 ******ATTENTION****** ASSISTED LIVING PROVIDER 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: #HL378681477C / #HL378682440M On July 11, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were four (4) residents receiving services under the provider ' s Assisted Living. The following correction order is issued for #HL378682440M, tag identification 2360.	0 000	Minnesota Department of Health is documenting the State 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 is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37868	A. BUILDING: _____ B. WING _____	C 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING HOPE HOMES-AUDREY'S PLACE	4660 SLATER ROAD #230 EAGAN, MN 55122

(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
02360	Continued From page 1 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 by: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		