Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL381642943M
Compliance #: HL381644849C

Date Concluded: November 30, 2023

Name, Address, and County of Licensee Investigated:
Second Horizon Living
7609 Modern Rd
Brooklyn Park, MN 55428
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Yolanda Dawson, RN
Special Investigator
Jill Hagen, RN, 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 a resident when staff failed to provide the resident with adequate hydration, timely transfers, and incontinence care. As a result, the resident required emergency medical services. The resident passed away.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. Staff members did not follow provider orders for the administration of water through the resident's gastrotomy tube (placed through the abdominal wall for liquids) and as a result the resident did not receive a significant amount of water over a two-month period. Facility staff provided care for the resident according to the resident's care plan and as the resident allowed.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of employee and resident records, policies and procedures related to training and documentation, provider orders, hospitalization summary, and the resident's death certificate.

The resident resided in an assisted living facility for approximately 10 weeks. The resident's diagnoses included stroke, dysphagia (difficulty swallowing), dysarthria (slurred speech), hemiparesis (partial paralysis), weakness, gastrostomy with gastrointestinal appliance and device (feeding tube), and moderate protein-calorie malnutrition. The resident only received liquids and nutrition through the gastrostomy tube.

The resident's service delivery record indicated staff assisted the resident with incontinence care every four hours, assisted with tube feedings, medication management, and transfer assistance. The resident did not ambulate and used a wheelchair for mobility. The resident used facial gestures and nodding of the head to communicate to staff.

The resident's admission and provider orders indicated the resident was to receive 180 milliliters (ml) water flushes every 4-hours and tube feedings at 55 ml per hour for 20 hours a day through the gastrostomy tube.

The facility tube feeding instructions directed staff to flush the resident's gastrostomy tube every four hours with 30 ml of water (not 180 ml every four hours according to the provider's order.) The direction to staff limited the resident of a significant amount of water during the resident's 10 weeks at the facility.

Staff documentation indicated the resident received scheduled tube feedings and was repositioned or out of bed throughout the day when the resident allowed. Documentation did not show the resident received scheduled water or flushes.

Review of a progress note indicated one day the resident's family requested the resident be evaluated at a hospital for a change in condition.

The resident's hospital summary indicated the resident had multiple health issues at the time of hospitalization including respiratory failure (when the respiratory system was not able to provide enough oxygen) and septic shock (severe response to an infection) with multi-system failure.

During the investigation, review of the resident's medication administration record indicated in the second month after admission, staff failed to administer several doses of medications indicating the medications were not available. The medication administration record indicated the medications missed included eight days of Aspirin 81 milligrams (mg) one tablet every day (prevention blood clots), 21 days of Coreg 3.125 mg twice a day (anti-hypertensive), four days of

Lisinopril 20 mg once day (anti-hypertensive), 14 days of Atorvastatin 80 mg at bedtime (for lowering cholesterol), and 27 days of Lansoprazole 30 mg every day (to reduce stomach acid.)

During an interview, unlicensed personnel (ULP) stated she did not receive training on tube feeding administration. The ULP stated management assumed she was trained because she was a certified nursing assistant. The ULP stated staff members were flushing the gastrostomy tube when feedings were started and stopped, and after medication administration. The ULP stated no other water was administered to the resident. The ULP stated the resident was slowly declining and was not staying in her chair for long periods of time.

During an interview, another ULP stated the nurse provided tube feeding administration training. The ULP stated other than using water to flush the tube, no additional water was given to the resident. The ULP stated the resident was being moved every few hours when they changed her or got her up in a chair. The ULP stated she did not notice a significant decline in the resident in the days preceding hospitalization.

During an interview, a nurse stated all staff were trained on the administration of tube feedings and to flush the tube with 20 ml of water every four hours (not 30 ml or 180 ml according to the provider order.) The nurse stated she did not see a decline in the resident's condition and staff did not report any changes in the resident's condition prior to hospitalization. The nurse stated there was miscommunication among staff and nursing and the resident did not receive the ordered 180 ml of water every four hours. The nurse stated the previous nurse did not put in the order for water and the two current nurses did not catch this error. The nurse stated the resident's medications were available however, the staff did not recognize the generic name of the medications and therefore, did not administer the medications. The nurse stated staff did not report the medications missed by the resident until the nurse completed a monthly audit of the medication administration record.

During an interview, a family member stated when visiting, the resident was often still in bed late in the afternoon. The family member stated she questioned staff members about the amount of water the resident was getting, and she was told they were only flushing the tube in-between feedings and medications. In the days leading up to the residents hospitalization the family reported to staff members the resident did not look well and was not responding appropriately. The family member stated they requested the resident be sent to the hospital.

The resident's death certificate indicated the resident's primary cause of death included Escherichia coli (E coli) bacteria pneumonia, E coli urinary tract infection, and E coli sepsis (a body's extreme reaction to an infection.)

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, VA was deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not applicable.

Action taken by facility:
Nursing started a weekly audit on medication administration records.

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
Hennepin County Attorney
Brooklyn Park City Attorney
Brooklyn Park Police Department
Minnesota Department of Human Services - Licensing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38164	A. BUILDING: _____ B. WING _____	C 08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SECOND HORIZON LIVING LLC	7609 MODERN ROAD BROOKLYN PARK, MN 55428

(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: HL381644849C/#HL381642943M On August 10, 2023 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 three residents receiving services under the provider's Assisted Living license. The following correction order is issued/orders are issued for HL381644849C/#HL381642943M, 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		

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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 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	No plan of correction is required for this tag.	