Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL313362503M
Compliance #: HL313364300C

Date Concluded: March 14, 2023

Name, Address, and County of Licensee Investigated:
Caring Nurses LLC
7700 Shingle Creek Drive
Brooklyn Center, MN 55443
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:
Maerin Renee, Special Investigator

Finding: Not Substantiated

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 alleged perpetrator (AP), facility staff, neglected the resident when the AP failed to assess the resident's health status after he was found unresponsive. The resident subsequently died.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The AP checked on the resident multiple times the morning of the incident. When the resident's mental status was not improving despite staff interventions the resident was sent to the hospital.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family, law enforcement, and a primary care provider. The investigation included review of the resident's medical record, facility grievances, vulnerable adult reports, and policies and procedures. Also, the investigator observed resident interactions with staff.

The resident resided in an assisted living facility with diagnoses including bipolar disorder, alcohol-related liver cirrhosis, post-traumatic stress disorder (PTSD), and diabetes. The resident's service plan included assistance with behavior management, medication administration, skin/wound care, bathing, and housekeeping. The resident's assessment indicated the resident had anxiety and behaviors triggered by past trauma which triggered overuse of alcohol.

During an interview, the AP stated when she entered the resident's room on the morning of the incident, the resident was in bed sleeping. The AP stated the resident was minimally responsive, which was not outside of the resident's past behaviors. The AP left the resident's room and returned approximately one hour later. When the AP returned, the resident was sitting in his wheelchair sleeping. The AP continued to check on the resident for the next hour and a half, and the resident continued to sleep and was minimally responsive. The AP stated when the resident refused cares or had similar behaviors in the past, staff were directed to call the resident's family member to speak with the resident. The AP stated when the resident was not responding to the family member, 911 was called, and the resident was transported to the hospital.

The resident' hospital record indicated the resident's diagnoses included severe hyperkalemia (high blood potassium levels) leading to acidosis (high acid levels) with elevated lactate level (caused by tissues not getting enough oxygen) causing septic shock, markedly elevated liver function tests (LFT)s and an elevated "blood alcohol of 197." The resident's septic shock did not improve despite maximal medical support. The hospital record indicated the resident was "recently on an alcohol bender." A skin assessment of the resident noted multiple lesions, but "none with definite infection." A previous hospitalization indicated the resident's diagnoses included acute kidney injury (AKI) and severe acidosis, which was felt to be related to drinking hand sanitizer. It was noted the resident continued to actively drink alcohol and he was not interested in stopping.

During an interview, the resident's family member stated she had ongoing concerns with the lack of cares the facility provided to the resident. The family member stated she couldn't understand why the facility contacted her instead of contacting 911 the morning of the incident.

The resident's death certificate indicated the resident's immediate cause of death was acute respiratory failure, due to septic shock, alcoholic hepatitis, and end-stage liver disease.

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: No, deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
No action taken.

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

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
	31336	A. BUILDING: _____ B. WING _____	C 01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING NURSES LLC	7700 SHINGLE CREEK DRIVE BROOKLYN CENTER, MN 55443

(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 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: #HL313364300C/#HL313362503M On January 31, 2023, 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 six residents receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL313364300C/#HL313362503M, tag identification 0650 and 1760.	0 000	Minnesota Department of Health is documenting 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 t 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	
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual	0 650		

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0 650	Continued From page 1 contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records contained the required orientation and annual training content for three of three staff members, registered nurse (RN)-B, unlicensed personnel (ULP)-E, and ULP-F, with employee records reviewed. This had the potential to affect all residents in the facility. 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 was issued at a widespread scope (when problems are pervasive or represent a systemic	0 650		

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0 650	Continued From page 2 failure that has affected or has potential to affect a large portion or all of the residents). Findings include: RN-B was hired on January 30, 2008, under the facility's comprehensive home care license. RN-B began providing assisted living services to the facility's residents on August 1, 2021. RN-B's employee record lacked evidence of orientation to assisted living regulations to include the following components: -Review of provider's policies and procedures -Reporting maltreatment of vulnerable adults or minors -Home care/Assisted Living bill of rights -Handling of resident/clients' complaints, reporting of complaints, where to report -Consumer advocacy services -Review of types of Home Care/Assisted Living services the employee will provide and provider's scope of license -Principles of person-centered planning/service delivery RN-B's employee file also lacked evidence of annual training in accordance with assisted living statutes, with the following components missing: -Review of the assisted living bill of rights -Effective approaches for working with challenging behaviors -Review of the facility's policies and procedures -Review of person-centered planning and service delivery ULP-E was hired on June 11, 2018, under the facility's comprehensive home care license.	0 650		

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0 650	Continued From page 3 ULP-E began providing assisted living services to the facility's residents on August 1, 2021. ULP-E's employee record lacked evidence of orientation to assisted living regulations to include the following components: -Overview of Home Care/Assisted Living statutes -Review of provider's policies and procedures -Home care/Assisted Living bill of rights -Handling of resident/clients' complaints, reporting of complaints, where to report -Consumer advocacy services -Review of types of Home Care/Assisted Living services the employee will provide and provider's scope of license -Principles of person-centered planning/service delivery ULP-E's employee file also lacked evidence of annual training in accordance with assisted living statutes, with the following components missing: -Training on reporting maltreatment of vulnerable adults -Review of the assisted living bill of rights -Review of infection control techniques -Effective approaches for working with challenging behaviors -Review of the facility's policies and procedures -Review of person-centered planning and service delivery In addition, ULP-E's file lacked evidence of competency evaluations for the following tasks: -documentation requirements for all services provided; -reports of changes in the resident's condition to the supervisor designated by the facility;	0 650		

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0 650	Continued From page 4 -basic infection control, including blood-borne pathogens; -maintenance of a clean and safe environment; -appropriate and safe techniques in personal hygiene and grooming, including -training on the prevention of falls -standby assistance techniques and how to perform them; -medication, exercise, and treatment reminders; -basic nutrition, meal preparation, food safety, and assistance with eating; -preparation of modified diets as ordered by a licensed health professional; -communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; -awareness of confidentiality and privacy; -understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and -awareness of commonly used health technology equipment and assistive devices. ULP-F was hired on October 1, 2018, under the facility's comprehensive home care license. ULP-F began providing assisted living services to the facility's residents on August 1, 2021. ULP-F's employee record lacked evidence of orientation to assisted living regulations to include the following components: -Overview of Home Care/Assisted Living statutes -Review of the facility's policies and procedures -Reporting maltreatment of vulnerable adults or minors -Handling of resident/clients' complaints, reporting of complaints, where to report	0 650		

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0 650	Continued From page 5 -Consumer advocacy services -Review of types of Home Care/Assisted Living services the employee will provide and provider's scope of license -Principles of person-centered planning/service delivery ULP-F's employee file also lacked evidence of annual training in accordance with assisted living statutes, with the following components missing: -Review of infection control techniques -Review of the facility's policies and procedures -Principles of person-centered planning/service delivery In addition, ULP-F's file lacked evidence of competency evaluations for the following tasks: -documentation requirements for all services provided; -reports of changes in the resident's condition to the supervisor designated by the facility; -basic infection control, including blood-borne pathogens; -maintenance of a clean and safe environment; -appropriate and safe techniques in personal hygiene and grooming, including -training on the prevention of falls -standby assistance techniques and how to perform them; -medication, exercise, and treatment reminders; -basic nutrition, meal preparation, food safety, and assistance with eating; -preparation of modified diets as ordered by a licensed health professional; -communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family;	0 650		

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0 650	Continued From page 6 -awareness of confidentiality and privacy; -understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and -awareness of commonly used health technology equipment and assistive devices. On January 31, 2023, at 2:45 p.m., RN-B stated staff received training in 144G assisted living statutes, but the training records were not complete in the employee files. The facility's undated policy titled Personnel Records indicated records related to training would be kept in each employee's personnel file. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	0 650		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.	01760		

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01760	Continued From page 7 This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure administered medication was documented in the residents record for one of one resident, R1, reviewed for medications. The facility failed to ensure as needed (PRN) medication was documented for effectiveness, failed to ensure each medication administered was documented in the medical record, and failed to ensure documentation and follow up when a medication was not provided to R1 according to physican orders. 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 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted to the facility on July 21, 2020, with diagnoses including bipolar disorder, diabetes, and alcohol related liver cirrhosis. R1's service plan dated June 16, 2022, indicated R1 received services including medication management, assistance with activities of daily living (ADLs), housekeeping, laundry, behavior management, and wound care. R1's medication administration record (MAR) indicated R1 had a prescription for PRN hydromorphone 2mg tablet with the following	01760		

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01760	Continued From page 8 instructions: Take 1 tablet (2mg) by mouth every two hours as needed for severe pain. R1's administration dates included August 1, 2, 3, 4, 5, and 6, 2022. Date, time, dose, reason/comment, nurse notified, and PCA/caregiver sections were completed. No follow-up to evaluate the effectiveness of the PRN medication was documented. R1's MAR indicated R1 was prescribed medications including Lantus Solostar 100U/ml subcutaneous injection every morning, Aspercreme lidocaine 4% patch 2 patches on skin every 24 hours, Novolog Flexpen 100u/ml injection 12 units three times a day, Advair HFA 115/21 inhale 2 puffs by mouth twice a day, augmented betamethasone 0.05% ointment apply twice a day, calcipotriene 0.005% cream apply twice a day, clotrimazole 1% cream apply twice a day, fluocinonide 0.05% solution massage into scalp twice a day, Nystatin 100000 powder apply twice a day, Breo Ellipta 100-25 inhale one dose daily. There were no staff initials to indicate these medications were administered. Rather, each of these medications had a notation in the MAR instructing the reader to "see ULP book." Review of the unlicensed personnel (ULP) care sheets, titled Resident Services Delivery Record, the only indication of medications administered was a row on the sheet titled "Meds" where each ULP would initial AM Administration, PM Administration, or NOC Administration, and PRN administration. From this, it was impossible to determine what medications were, or were not, administered. Many of the dated columns were left blank, with no initials, and some had initials that were circled, indicating medications were not administered. However, there were no notations indicating which medications were not	01760		

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01760	Continued From page 9 administered or if it was all of the medications or only some of them. On January 31, 2023, at 2:45 p.m., RN-B stated records provided were complete. The facility's undated policy titled Documentation of Medication, Treatment and Therapy Management Services stated documentation will follow professional standards for documentation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01760		