DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL31761005M
Compliance #: HL31761006C

Date Concluded: January 5, 2023

Name, Address, and County of Licensee Investigated:
Lino Lakes Gracewood
675 Market Place Drive
Lino Lakes, MN 55014
Anoka County

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

Evaluator's Name: James Larson, RN
Special Investigator

Finding: Inconclusive

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 failed to administer scheduled medications as ordered by the resident's physician.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. It is unable to be determined if the error caused additional medical complications for the resident. Although a medication error occurred, blood glucose readings obtained following the error remained within acceptable parameters provided by the resident's physician. When a high blood glucose reading was obtained the following evening, staff immediately reported the reading to the nurse, contacted emergency medical services (EMS) and the resident was transferred to the hospital for further evaluation and treatment.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement and

reviewed a police report. The investigation included review of the resident's medical record, nursing assessments, service plans, care plans, progress notes, and facility policies and procedures. In addition, the investigator observed medication administration to multiple residents during the onsite visit.

The resident resided in an assisted living facility. The resident's diagnoses included congestive heart failure, type 2 diabetes mellitus with hyperglycemia and acute respiratory failure. The resident's service plan included assistance with activities of daily living, and medication management including insulin administration. The resident also had blood glucose checks scheduled four times per day with orders to notify the nurse if blood glucose readings were less than 100 or greater than 300. The resident's assessment indicated a history of urinary tract infections (UTI). The resident was able to independently communicate her needs.

The facility experienced a failure with the computer system utilized for staff's documentation of medication administration. As a result, the facility was forced to use back-up resources, which meant a physical paper copy of the medication record was printed off for each resident. During the transition from electronic to paper documentation an oversight occurred, resulting in a medication error. Staff responsible for medication administration that evening indicated the paper medication record for this resident was not available and the resident did not receive her scheduled 5:00 p.m. or 8:00 p.m. doses of insulin.

Review of the resident record and facility documentation indicated no side effects or change in condition were reported throughout the remainder of the evening or night shifts. The resident received all medications, including insulin and blood glucose checks as prescribed the next day. The resident's blood glucose levels remained within the accepted range of blood glucose parameters identified in the resident's medical record. During a scheduled blood glucose check the following evening, staff obtained a high blood glucose reading and the resident reported symptoms associated with high blood glucose levels. Staff immediately contacted the nurse who directed staff to contact emergency medical services (EMS) and the resident was transferred to the hospital for further evaluation and treatment.

During an interview with an unlicensed staff person (ULP), who worked the evening the medication error occurred, they confirmed they were trained on the use of paper documentation in the event computer records were not available. According to the ULP, the medication error occurred because the resident's paper record was unavailable that evening. The ULP denied neglecting the resident.

The resident's family was interviewed and confirmed they were aware of the medication error and had concerns with the care provided at the facility, as well as concerns with call light response times. The family member stated the resident did not return to the facility. The resident was hospitalized and later admitted to a different care facility.

A police report was filed following the incident. The police report indicated there was no evidence to support staff intentionally missed giving the resident's medication and concluded no intentional neglect was committed by facility staff. The case was closed, and no charges were filed.

During an interview, facility nursing administration indicated they reviewed the incident. The ULP responsible for the resident's medication that evening also administered medication to several other residents and no further medication or documentation errors occurred. To mitigate further occurrence of errors, facility nursing administration retrained staff involved and contacted the software company to review and update their documentation system and computer equipment.

Licensing orders were issued related to this incident.

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: No, unavailable for interview (deceased)
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility worked with the software vendor to correct the issue and obtained new computer equipment. Staff members involved were re-trained and counseled on facility policies and procedures.

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
	31761	A. BUILDING: _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINO LAKES GRACEWOOD	675 MARKET PLACE DRIVE LINO LAKES, MN 55014

(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: #HL31761006C/#HL31761005M On November 21, 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 34 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for #HL31761006C/#HL31761005M, tag identification 1760.	0 000	Assisted Living Provider 144G. 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 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.	

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01760	Continued From page 1	01760		
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. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were administered as ordered for one of three residents (R1) with records reviewed. 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's medications were not administered as prescribed on March 30, 2022 at two separate times.	01760		

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01760	Continued From page 2 R1's diagnoses included congestive heart failure, type 2 diabetes mellitus with hyperglycemia, acute respiratory failure. R1's signed Service Plan dated March 29, 2022, included medication administration four times a day. R1's medication administration record (MAR) dated March 2022, included but not was limited to the following medications and treatments: Insulin Aspart injection flexpen (Novolog flexpen) 8:00 a.m. and 5:00 p.m. -Inject 8 units (U) subcutaneously 2 times daily before breakfast & dinner hold for blood glucose (BG) <100 or patient does not eat. -Prime with 2 units prior to administration. Insulin Aspart injection flexpen (Novolog flexpen) 12:00 p.m. -Inject 4 units (U) subcutaneously before lunch *hold for blood glucose (BG) <100 or patient does not eat. -Prime with 2 units prior to administration. Lantus injection 100/ML unit (U)/milliliter (ml) (insulin) 8:00 p.m. -Inject 28u subcutaneously at bedtime -Prime with 2 units prior to administration. Blood Glucose (BG) testing at 8:00 a.m., 12:00 p.m., 5:00 p.m., and 8:00 p.m. -Check blood glucose four times daily. -Notify registered nurse (RN) if blood glucose less than 100 or greater than 300. R1's insulin and blood glucose summary from March 29, 2022, through March 31, 2022, failed	01760		

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01760	Continued From page 3 to include blood glucose testing or the prescribed units of insulin administered. The residents MAR identified that on March 30, 2022 the residents's scheduled 5:00 p.m. insulin Aspart injection flexpen (Novolog flexpen) was not administered. In addition, the resident was not administered their scheduled March 30, 2022 8:00 p.m. Lantus injection. R1's medical record did not indicate R1 experienced any negative side effects immediately following the medication error. Blood glucose levels the following morning were within range according to blood glucose parameters identified in the resident's physician orders. The resident recieved all medication as ordered the following day and later that evening R1 had a high blood glucose reading and was sent to the hospital for further evaluation. On November 21, 2022, at 3:30 p.m. registered nurse (RN)-A confirmed R1's medication was not administered on the evening medication passes at 5:00 p.m. and was also not given at 8:00 p.m. RN-A went on to explain there was a failure of the computer system, resulting in paper MARs being used. RN-A stated ULP-B failed to follow the prescribed dosage as indicated on the MAR and the medication packaging. During an interview on December 06, 2022 at 9:09 a.m. ULP-B verified R1's medication was not administered as ordered. ULP-B confirmed he worked at the time the medication error occurred and when interviewed indicated their was no paper MAR available for R1 so he was unaware R1 had any scheduled evening doses of medication.	01760		

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01760	Continued From page 4 The licensee's Medication and Treatment administration policy, dated August 1, 2021, indicated medications are to be administered according to the physician's order. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		