Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL35793003M **Date Concluded:** August 11, 2022
Compliance #: HL35793004C

Name, Address, and County of Licensee Investigated:
Grace Assisted Living LLC
2566 112th avenue NW
Coon Rapids, MN 55433
Anoka County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Erin Johnson-Crosby, 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 the resident when the facility failed to assess and provide interventions to prevent a suicide attempt.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was inconclusive. It is unable to be determined how the resident obtained the medication as conflicting accounts were provided of the resident's ability to access the medication. Upon learning of the resident's overdose attempt, the facility immediately contacted emergency services (EMS) and the resident was sent to the hospital for evaluation and treatment.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of resident, hospital, and police records. The investigator also observed staff interaction with residents.

The resident resided in an assisted living facility. The resident's diagnoses included borderline personally disorder, depression, and a history of self-injurious behavior. The resident's service plan indicated the resident required assistance with medication administration and was independent with other activities of daily living (ADLs).

The resident's comprehensive admission assessment indicated the resident was alert and orientated and did not abuse or misuse prescription medications. The same assessment indicated the resident never exhibited unsafe behaviors and was not a danger to self or others. The assessment further indicated the resident was able to partially self-administer medications safely, but prescription medications should be locked in a medication cart as the resident had a history of medication overdose.

The resident's individual abuse prevention plan completed prior to the incident, indicated the resident was at risk for self-abuse. Staff were to monitor and report any incidents of self-abuse to the nurse.

The resident's medication administration record (MAR) included a physician's order for an anti-psychotic medication Zyprexa (olanzapine) 10 milligrams (mg) to be taken as needed.

The day the incident occurred, progress notes indicated the resident took her evening medication and went to her room for 25 minutes. The resident came out of her room and told another resident she overdosed on pills. The other resident informed staff who contacted emergency medical services (EMS).

Hospital records indicated the resident took 100 tablets of Zyprexa. The resident was intubated for three days and hospitalized for 10 days before returning to the facility.

During an interview, the unlicensed personnel (ULP) stated another resident informed him the resident had taken too many medications. He immediately contacted EMS who brought the resident to the hospital. The resident stated she bought the medications from a friend. The ULP indicated he was unaware the resident had medications in her possession and the resident was never left unattended with medications.

During an interview, another ULP stated several of the resident's as needed medications were kept in a zip lock bag. The ULP stated the resident was able to go through the zip lock bag to pick out what medications she needed. Staff were directed to monitor and document the medications administered to the resident.

During an interview, the registered nurse (RN) stated the resident was not allowed to self-administer medications due to the resident's history of overdosing. The RN stated the only way the resident would have obtained a prescription bottle is if the resident took it without the staff's knowledge. The RN stated all the resident's medications were locked in the medication cart.

During an interview, the resident stated the day of the incident she took 100 pills of Zyprexa and informed another resident of her actions. The resident stated the ULP left a zip lock bag full of as needed medications in front of her while the ULP assisted another resident. The resident took the bottle of Zyprexa back to her room and took all the pills in the bottle. The resident initially said the pills were from a friend so the facility would not get in trouble. The resident further stated she had the bottle of Zyprexa she brought to her room that day and sent a picture to the investigator.

Review of the picture the resident provided identified a bottle of medication prescribed to the resident with directions that read: Olanzapine 10 mg tab; take one half-tab by mouth as needed. The pharmacy filled this medication approximately three months prior to the incident.

Pharmacy records indicated a courier delivered the olanzapine 10 mg medication to the facility and the resident signed as received. This medication bottle date included the same date as the picture provided by the resident.

The resident discharged from the facility prior to the time of the onsite visit. The surveyor was not able observe or determine how the facility stored the resident's medications or if facility staff left the resident's medications unattended for the resident to access.

In conclusion, it was inconclusive whether neglect occurred.

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:
(a) 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.
(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

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

Action taken by facility:
No action taken

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
	35793	A. BUILDING: _____ B. WING _____	C 06/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE ASSISTED LIVING LLC	2566 112TH AVENUE NW COON RAPIDS, MN 55433

(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 On June 23, 2022, the Minnesota Department of Health initiated an investigation of complaint #HL35793004C/#HL35793003M and #HL35793006C/#HL35793005M. No correction orders are issued.	0 000		