Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL360112381M
Compliance #: HL360114148C

Date Concluded: December 16, 2022

Name, Address, and County of Licensee Investigated:
Gabby Care Homes LLC Faith's
1513 Pennsylvania Ave
Champlin, MN 55070
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:
Maerin Renee, 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 disregarded medication changes and continued to administer medications to the resident that had been discontinued. The resident's mental health decompensated, leading to a threat of suicide and subsequent hospitalization.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. Review of documentation indicated the resident received one tablet of as needed anti-anxiety medication after the medication was noted to be discontinued by the prescriber. However, there was no provider order signed or dated to discontinue the resident's medication.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's guardian and the resident. The investigation included review of the resident's chart, including medication

administration records, incident reports, and staff training records. Also, the investigator toured the facility and observed interactions between staff and residents.

The resident resided in an assisted living facility. The resident's diagnoses included major depressive disorder, generalized anxiety disorder, and autistic disorder. The resident's service plan included assistance with behavior management, meals, and medication management. The resident's assessment indicated independence with most activities of daily living, while requiring reminders for others (such as meals and showering).

During an interview, a nurse stated the pharmacy automatically filled and delivered new resident medications. Any medication changes were automatically logged by the pharmacy into the facility's electronic medication administration system. If a medication was discontinued, the nurse would manually indicate the discontinuation. The nurse stated direct communication with the resident's prescriber could be a challenge as they often communicated with the resident's guardian instead of the facility. The nurse stated there would be a lag time between the prescriber changing a medication because the prescriber would discuss any changes with the resident's guardian, and the guardian would need to approve any changes before implementation. Then the prescriber would send the order to the pharmacy, which would then log changes into the facility's electronic medication administration system. The nurse stated any changes would be verified with the resident's after-visit summary provided by the prescriber.

When interviewed, the resident state he moved to a different facility because he did not receive much mental health support at the facility. The resident stated he needed to supplement his care with mental health services outside the facility. The resident stated he did not remember much about his medications while at the facility but did not recall staff ever reviewing his medications with him.

The resident's medication administration record (MAR) indicated staff administered one tablet of as needed anti-anxiety medication to the resident 19 days after the prescriber noted it was to be discontinued. However, since the medication documentation had not been signed or dated by the prescriber, the medication was not discontinued. There was no corresponding medication error report. The medication was no longer on the resident's MAR the following month.

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: Yes.
Family/Responsible Party interviewed: No, declined interview.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility audited staff administering resident medications for compliance.

Action taken by the Minnesota Department of Health:
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
	36011	A. BUILDING: _____ B. WING _____	C 11/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GABBY CARE HOMES LLC - FAITH'S	1513 PENNSYLVANIA AVENUE NORTH CHAMPLIN, MN 55316

(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: #HL360114148C/#HL360112381M On November 30, 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 3 residents receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL360114148C/#HL360112381M, tag identification 1450 and 1480.	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 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.	
01450 SS=F	144G.62 Subd. 5 Documentation	01450		

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01450	Continued From page 1 A facility must retain documentation of supervision activities in the personnel records. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure documentation of direct supervision of staff performing delegated tasks for two of two unlicensed personnel (ULP-C and ULP-D) with records reviewed. This had the potential to affect all residents receiving services from the licensee. 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: ULP-C was hired on September 14, 2021, under the facility's assisted living license. ULP-D was hired on September 24, 2021, under the facility's assisted living license. Both employee training records lacked evidence of documentation of a registered nurse (RN) supervising ULP-C and ULP-D performing delegated tasks in accordance with assisted living statutes beginning August 1, 2021. On November 30, 2022, at 9:10 a.m., registered nurse (RN)-A stated staff had been trained according to 144G assisted living statutes.	01450		

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01450	Continued From page 2 The facility undated policy titled Competency Training Evaluations, indicated staff providing delegated services will demonstrate competency to the training nurse. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01450		
01480 SS=F	144G.63 Subd. 3 Orientation to resident Staff providing assisted living services must be oriented specifically to each individual resident and the services to be provided. This orientation may be provided in person, orally, in writing, or electronically. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff providing assisted living services were oriented specifically to each individual resident and the services to be provided to individual residents two of two unlicensed personnel (ULP-C and ULP-D) with records reviewed. This had the potential to affect all residents receiving services. 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include:	01480		

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01480	Continued From page 3 ULP-C was hired on September 14, 2021, under the facility's assisted living license. ULP-D was hired on September 24, 2021, under the facility's assisted living license. Both employee records lacked documentation of orientation to each individual resident and the resident's needs prior to staff providing services to residents at the facility, in accordance with 144G statutes. On November 30, 2022, at 9:10 a.m., registered nurse (RN)-A stated staff had been trained according to 144G assisted living statutes. The undated facility policy titled Orientation of Staff and Supervisors & Content indicated staff would be specifically oriented to each resident and the services provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01480		