Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL370711403M
Compliance #: HL370712791C

Date Concluded: January 6, 2023

Name, Address, and County of Licensee Investigated:
Boulder Ponds Senior Living
192 Jade Trail North
Lake Elmo, MN 55042-4496
Washington County

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

Evaluator's Name:
Katie Germann, 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 the resident's medication was not administered according to physician orders. The resident passed away.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. Although the facility did not provide the resident a medication, Esbriet (used to treat lung conditions and ease breathing) according to physician orders for approximately four months, it could not be determined if the missed medication contributed to the resident's decline and/ or death.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of medical records, facility policies and procedures, facility medication system, and staff training records. Observations of staff providing cares and the facility medication system were completed.

The resident resided in an assisted living memory care unit with diagnoses including chronic obstructive pulmonary disease, interstitial pulmonary disease, idiopathic pulmonary fibrosis, and Alzheimer's disease. The resident's service plan included assistance with activities of daily living, bathing, meals, laundry, medication management, and housekeeping.

A review of facility and provider documentation indicated the family notified the facility the resident had not been receiving Esbriet since admission, approximately three months prior. The facility nurse attempted to order the medication from the resident's pulmonologist. After several phone calls back and forth, the facility began administering the residents Esbriet three weeks after being notified the resident was not receiving the medication as prescribed.

The resident passed away around approximately two months after resuming use of Esbriet.

During interview, the resident's family member stated they were told by the nurse during admission the facility would manage the resident's medications. The family member stated it was several months after the resident moved in when they found the resident had not taken the Esbriet since admission. The family member stated they had several meetings with the facility in the weeks following regarding the residents missed Esbriet and they were assured the medication would be administered. The family member stated the pulmonologist office informed the family of difficulties getting in touch with the facility regarding the resident's medication.

When interviewed, the resident's physician stated the resident had end stage lung disease and the cause of death was not related to the resident not receiving his Esbriet.

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, deceased.

Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility updated policy and procedures regarding transcribing medication orders and auditing to ensure residents are receiving medications as prescribed.

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
	37071	A. BUILDING: _____ B. WING _____	C 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOULDER PONDS SENIOR LIVING	192 JADE TRAIL NORTH LAKE ELMO, MN 55042

(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: #HL370712791C/#HL370711403M #HL370713446M/ #HL370715568C On November 22, 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 67 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL370713446M/ #HL370715568C, tag identification 1690 and 2360.	0 000	The Minnesota Department of Health documents 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors ' findings is the Time Period for Correction. Per Minnesota Statute §144G.30, Subd. 5 (c), the assisted living facilities must document any action taken to comply with the correction order. A copy of the provider ' s records documenting those actions may be requested for follow-up surveys. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider ' s Plan of Correction." The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144G.31, Subd. 2 and 3.	
01690 SS=F	144G.71 Subdivision 1 Medication management services	01690		

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01690	Continued From page 1 (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement current written medication management policies and procedures when one of one residents (R1) did not receive medication for 3 months. This had the potential to	01690		

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01690	Continued From page 2 affect all residents receiving medication 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, but was not likely to cause serious injury, impairment, or death), and is 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 of the residents). The findings include: R1's face sheet dated November 22, 2022, indicated R1's diagnoses include chronic obstructive pulmonary disorder, interstitial lung disease, pulmonary fibrosis, and Alzheimer's disease. R1's service plan dated March 1, 2022, indicated the facility was responsible for the residents medication management assist and administration, which included ordering all necessary medications. R1's physician orders dated September 2, 2021, included an order for Esbriet, 860 mg three times per day, a medication to help the ease of the resident's breathing and slow the progression of pulmonary fibrosis. R1's medication administration record (MAR) for November and December of 2021, and January of 2022, indicated staff were directed to administer Esbriet, 860 mg three times a day. R1's MAR for November, and December,of 2021 and January of 2022 indicated all administration times were initialed by staff with a circle around	01690		

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01690	Continued From page 3 their initials, which indicated the medication was not given. However, there was no follow up documentation why R1 didn't receive the Esbriet or what the facility was doing to ensure the resident received the medication as prescribed. During interview on November 22, 2022, R1's family member stated they reported to the facility nurse on January 5, 2022, R1 was not receiving Esbriet since admission to the facility on September 2, 2022. The nurse then reported to the doctor and asked for new orders for the Esbriet. It took several phone calls back and forth to clarify orders and obtain the medication. The resident resumed taking the medication on January 21, 2022. Review of the facility's medication administration policy dated March 2021, indicated the registered nurse was responsible for assuring medication orders were implemented within 24 hours of receiving the order. The registered nurse will review the task (medication administration) was completed accurately by the unlicensed personnel. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	01690		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, 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	02360		

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02360	Continued From page 4 by: Based on interviews and document review, the facility failed to ensure 1 of 1 resident, R1, was free from maltreatment. The resident was neglected. Findings include: On November 22, 2022, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility was responsible for the maltreatment, in connection with incidents, which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	