Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL273988289M
Compliance #: HL273985480C

Date Concluded: January 18, 2023

Name, Address, and County of Licensee Investigated:
Ecumen Seasons at Maplewood
1670 Legacy Parkway E
Maplewood, MN
Ramsey County

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

Evaluator's Name: Deb Schillinger, RN
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 facility neglected the resident when cardiac (heart) medications were not administered to the resident as ordered which later required hospitalization.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although a medication error did occur, this was an isolated event. Several days later the resident required hospitalization, but the missed medication was unrelated.

The investigator conducted interviews with facility staff members, including administrative staff, and nursing staff. The investigator contacted family members. The investigation included review of facility policies and resident records. Also, the investigator observed a medication pass and interactions of staff and residents.

The resident resided in an assisted living facility. The resident's diagnoses included chronic ischemic heart disease (a weakening of the heart due to lack of blood flow), atrial fibrillation (an abnormal heart rhythm) and chronic obstructive pulmonary disease (COPD) (a lung condition that makes it hard to breathe). The resident's service plan included assistance with medication management and administration.

A facility incident report indicated a medication error occurred involving the resident, which included a cardiac medication prescribed to treat atrial fibrillation occurred one evening at bedtime. The same document indicate there was no adverse outcome at that time. A review of the resident's medical records did not identify any further medication errors.

Four days later the resident's progress notes indicated the resident complained of shortness of breath and she had a fast heart rate (greater than 140). The facility offered to contact emergency medical services, but the resident declined, however she did allow her family to take her to the hospital.

The hospital records indicated the resident had a pacemaker placed while in the hospital and returned to the facility afterwards.

During an interview, the nurse stated he was aware of the resident missing her prescribed medication on one occasion and completed a medication error report. The nurse stated he was not aware of any additional complaints made of resident not receiving medications on time.

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, declined interview.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
No action required.

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
	27398	A. BUILDING: _____ B. WING _____	C 11/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECUMEN SEASONS AT MAPLEWOOD	1670 LEGACY PARKWAY EAST MAPLEWOOD, MN 55109

(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 On November 7, 2023 , the Minnesota Department of Health initiated an investigation of complaint HL273985480C/HL273988289M . No correction orders are issued.	0 000		