Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306464281M
Compliance #: HL306465087C

Date Concluded: July 25, 2024

Name, Address, and County of Licensee Investigated:
River Pointe of Moorhead
2401 11th Street South
Moorhead, MN 56560
Clay County

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

Evaluator's Name: Barbara Axness, 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 alleged perpetrator (AP), a facility unlicensed personnel (ULP), neglected the resident when he failed to administer scheduled insulin as prescribed. As a result, the resident was hospitalized with high blood sugar.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the resident was hospitalized after the AP failed to administer insulin, the error was an isolated incident. The resident was treated for high blood sugar and returned to their baseline health condition.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident records, hospital records, facility internal investigation documentation, facility incident reports,

personnel files, staff schedules, and related facility policies and procedures. Also, the investigator observed medication administration at the facility.

The resident resided in an assisted living facility. The resident's diagnoses included diabetes and chronic kidney disease. The resident's service plan included assistance with blood sugar management and medication administration. The resident's assessment indicated the resident was diabetic but did not follow a diabetic diet. The resident liked to keep ice cream in his apartment and tried to replace meals with ice cream, causing high blood sugar levels. The resident required assistance with insulin administration and blood sugar checks.

The resident's medication administration record (MAR) from the day of the incident, indicated the 8:00 a.m. blood sugar check was not completed due to resident refusal. The MAR indicated the resident also refused his Humalog (a fast-acting insulin) and Lantus (a long-acting insulin) administration.

The facility's internal investigation indicated the AP did not administer the resident's 8:00 a.m. medications, including insulin, or check the resident's blood sugar, and failed to notify the RN. The medication error was not identified until the resident's blood sugar was checked later that morning, and the monitor read that it was too high to be measured. The AP called the RN at 12:05 p.m. to report the high reading and was instructed by the RN to check it again and call back. The AP called back at 12:12 p.m. and stated the reading was still high. The RN directed the AP to use a different blood sugar machine and call back with the result. The resident's blood sugar reading remained high. The resident reported feeling sick, was lightly sweating, and was sent to the emergency room. After emergency room staff called the facility to verify medication administration, it was discovered that the resident's 8:00 a.m. medications, insulin, and blood sugar check were marked as refused. The internal investigation indicated administrative staff interviewed the AP who reported that he didn't get to his 7:00 a.m. shift until 7:45 a.m. and was already behind and so he did not pass the morning medications.

The resident's medical record indicated that the day of the incident, the resident had a large bowl of ice cream for breakfast.

Administrative staff members stated that after the error occurred, they reviewed what systems could have led to the staff member feeling too rushed to complete medication administration. This included review of camera footage to see what the AP was doing during the shift, analyzed service schedules, and interview with other staff who worked that day. The internal investigation indicated the AP was asked by several coworkers to help with nonurgent tasks. The AP wasn't comfortable saying no and overextended himself trying to help everyone before completing his time sensitive tasks.

During an interview, the AP stated the morning of the medication error, he was running behind on his assigned tasks. The AP stated one resident had increased anxiety and took up a lot of his time. He was not able to calm the resident down and he was also asked to help with other tasks

throughout the facility. The AP stated he was familiar with diabetes but didn't realize the resident was a type-one diabetic and thought he would be ok to administer the insulin a little later than scheduled while he worked to catch up on his tasks. The AP stated the resident ate a large bowl of ice cream for breakfast, but he wasn't aware of that until after he obtained the high blood sugar level reading.

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: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility reported the incident, suspended the AP, and completed an internal investigation. The AP was retrained on medication administration and time management.

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
	30646	A. BUILDING: _____ B. WING _____	C 07/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER POINTE OF MOORHEAD	2401 11TH STREET SOUTH MOORHEAD, MN 56560

(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 July 1, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL306464281M/ #HL306465087C. No correction orders are issued.	0 000	Minnesota Department of Health is documenting the State 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.	