Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL307806602M
Compliance #: HL307809901C

Date Concluded: March 11, 2025

Name, Address, and County of Licensee Investigated:
Minnehaha Senior Living
3733 23rd Avenue South
Minneapolis, MN 55407
Hennepin County

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

Evaluator's Name: James P. Larson, 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 they failed to administer scheduled medications as ordered.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility followed the care plan and nursing staff assessed and adjusted the care plan as needed. There was not a preponderance of evidence to support that the actions of the facility staff met the definition of neglect.

The investigator conducted interviews with facility staff members, including nursing staff. The investigation included review of the resident record, personnel files, employee training files, and facility policy and procedures. The investigator also toured the facility and observed staff interaction with residents.

The resident resided in an assisted living facility. The resident's diagnoses included asthma, hypertension (high blood pressure) and diabetes. The resident's service plan included assistance with all activities of daily living, routine safety checks, and medication administration. The resident's assessment indicated the resident was on a 28-day auto-refill cycle from her pharmacy. Oral medications were to be administered by facility staff and staff were to assist the resident as needed to self-administer the scheduled inhaler and nebulizer treatments.

A review of complaint documents and the resident's medical records indicated the resident had a history of exacerbations of asthma and recently experienced shortness of breath which required hospitalization and treatment including several medication adjustments.

During interviews, multiple staff members stated that since arriving at the facility, the resident has been involved with her own medication administration while working with the facility to try different approaches to administration to maintain independence safely.

During a discussion with the resident, she was able to identify her medication and administration times. The resident stated that staff assisted her with medication administration and had no concerns with the care and medication management provided at the facility.

During an interview, a family member stated that the resident has been able to administer medications with assistance, including nebulizers since her admission. Although recently they had been in contact with facility nursing staff concerning the resident's ability to self-administer medication even after receiving verbal ques and reminders from staff members. The family had concerns with care provided at the facility.

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, Unable
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: N/A

Action taken by facility:
The nursing staff continued to monitor the resident's ability to self-administer medication, as well as offering continued training to staff on proper data entry into the electronic health record.

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
	30780	A. BUILDING: _____ B. WING _____	C 02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNEHAHA SENIOR LIVING	3733 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(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 February 3, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL307809901C/#HL307806602M. No correction orders are issued.	0 000		