

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL312213007M
Compliance #: HL312215029C

Date Concluded: October 26, 2023

Name, Address, and County of Licensee

Investigated:

Carefree Cottages of MPLD Chateau
1801 Gervais Ave
Maplewood MN, 55109
Ramsey County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Lori Pokela, 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):

A facility staff member/alleged perpetrator (AP) neglected the resident when the AP failed to administer the correct dose of insulin causing the resident to have an increase in blood sugar levels, pneumonia, and cellulitis.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was inconclusive. Although a transcription error and medication error occurred, it was unable to be determined if the resident's high blood glucose levels and diagnoses of pneumonia and cellulitis were a direct result of the errors.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted the pharmacy representative and the resident's family. The investigation included review of facility and hospital medical records. The investigator reviewed facility internal investigations, staff education, trainings, and

facility policies and procedures. The investigator observed staff communication and medication and treatment administration at the time of the on-site visit.

The resident resided in an assisted living facility. The resident's diagnoses included diabetes mellitus type II, osteoarthritis, and a history of deep vein thrombosis (blood clots). The resident's service plan included assistance with activities of daily living such as dressing, grooming, bathing, and medication administration. The resident's assessment indicated the resident required staff assistance to obtain blood sugar level readings and apply anti-embolism stockings (compression stockings). The resident's medical records indicated the resident was independent with transfers and ambulation with the use of a wheeled walker.

The resident's medical records identified a history of high blood sugar readings and the resident's physician was updated on the high blood sugar levels approximately twenty-three days prior to the resident's hospitalization. However, the resident's medical record lacked documentation of follow-up to the update when no response was received by the physician.

Eight days prior to the resident's hospitalization, the resident was seen by the physician for a history of high blood sugar levels, edema (swelling) in the lower legs, and was diagnosed with a urinary tract infection (UTI). The physician ordered an antibiotic to treat the UTI. The resident's physician informed the resident that high blood sugar level data would be reviewed before any updates or changes were made to the existing insulin orders. Four days later, the physician made changes to the existing insulin orders by increasing the dosage and the orders were sent to the resident's pharmacy.

The pharmacy received the physician's orders and entered the orders into their electronic system. The orders were electronically sent to the facility. However, the electronic communication form generated by the pharmacy's record system included only one of the two updated insulin orders. The one insulin order sent to the facility was transcribed incorrectly by the facility nurse/alleged perpetrator (AP) when after entering the new order, the previous insulin dose was not discontinued. As a result, additional doses of insulin were administered to the resident.

Several days after the transcription error occurred, the resident woke up in the middle of the night, attempted to get out of bed, felt weak, and slid to the floor. Upon assessment of the resident, facility staff identified the resident's blood sugar level was 600. Staff contacted emergency medical services (EMS) and sent the resident to the hospital for an evaluation.

Hospital records indicated the resident appeared weak, had a cough, and complained of left ankle pain. The resident was diagnosed with high blood sugar levels, pneumonia, UTI, and a left ankle fracture.

Following the resident's admission to the hospital, facility staff reviewed the resident's medication list and spoke with the resident's physician. Facility nursing staff questioned the

resident's physician as to why insulin orders were not increased despite a history of high blood sugar readings. The resident's physician indicated both existing insulin orders were increased and sent to the resident's pharmacy four days prior to the resident's hospitalization.

During an interview, the facility's administrative nursing staff stated the facility investigation was not able to identify why or how the error occurred in the transmission of orders to the facility by the pharmacy.

During an interview, the resident's family stated they visited the resident the day she was sent to the hospital and noticed she wasn't feeling well. The family stated communication between facility nursing staff and the resident's physician was poor. The family indicated they were informed by facility staff that the poor communication was due to the resident not utilizing the facility's contracted physician.

During an interview, the facility's contracted pharmacist, confirmed both insulin dosages were increased by the resident's physician and sent to the pharmacy four days after the resident's physician visit. The facility's pharmacist stated one of the resident's updated insulin orders was successfully sent electronically to the facility on the date the order was prescribed. The other updated insulin order was not electronically sent on the date it was prescribed due to a software issue. The pharmacy software issue occurred because the pharmacy's electronic system showed the resident had enough of the insulin on-hand at the facility. Consequently, it was too early to refill the medication per the resident's insurance, so the order was not sent.

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: Yes

Alleged Perpetrator interviewed: AP declined to be interviewed.

Action taken by facility:

The facility initiated an internal investigation into the incident.

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31221	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/27/2023
NAME OF PROVIDER OR SUPPLIER CAREFREE COTTAGES OF MAPLEWOOD CHATEAU			STREET ADDRESS, CITY, STATE, ZIP CODE 1801 GERVAIS AVENUE LITTLE CANADA, MN 55109		
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0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER 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: #HL312215029C/#HL312213007M #HL312218355C/#HL312214883M On June 27, 2023, 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 80 residents receiving services under the provider's Assisted Living license. The following correction order is issued/orders are issued for #HL312215029C/ #HL312213007M, tag identification 0730.	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		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 000	Continued From page 1	0 000	ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 730 SS=E	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional;	0 730			

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0 730	Continued From page 2 (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the license failed to ensure documentation of an incident and actions taken to follow-up in response to an incident for one of one resident (R1) and failed to ensure R1's record contained all required content for one of six residents (R1) when there was a resident fall, report of a suspected medication error, and a discovered medication error. 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 was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: DOCUMENTATION OF SIGNIFICANT CHANGES IN STATUS, ACTION TAKEN, AND FOLLOW-UP:	0 730			

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0 730	Continued From page 3 R1's medical records were reviewed. R1's diagnoses included diabetes mellitus, osteoarthritis, history of arthroscopy for sepsis in left (L) ankle and deep vein thrombosis (a condition in which blood clots form in veins deep under the tissue). R1's service plan dated September 6, 2022, indicated R1 was to receive staff assistance with medication administration and obtaining blood glucose (sugar) level readings daily, along with staff assistance with dressing, grooming and showering. R1's daily blood sugar levels recorded for the month of September 2022, were between 291 mg/dL to 600 mg/dL and averaged approximately 328 mg/dL. R1's nurse's notes dated September 1, 2022, at 11:05 a.m., signed by registered nurse (RN)-D, indicated R1's physician would be notified of high blood sugar levels. R1's notes lacked documentation of the indicated update to the physician and lacked follow-up regarding the physician's response to the notification. R1's Medication Administration Record, (MAR) dated September 1, 2022 through September 19, 2022, indicated R1's insulin orders included the following: -Lantus 8 units given subcutaneously daily at bedtime. -Humalog 2 units given subcutaneously three times per day (TID). R1's physician provided a physician visit document dated September 15, 2023 at 11:10	0 730			

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0 730	Continued From page 4 a.m., which indicated R1 visited her physician's office regarding high blood sugar levels, dysuria (difficulty urinating) and bilateral leg edema. These same records indicated R1 was diagnosed with a urinary tract infection to which an antibiotic was ordered. The visit notes further indicated the physician would reach out to R1's pharmacy to obtain a history of the resident's blood sugar levels for review. R1's facility medical record lacked documentation, as well as follow-up, regarding R1's physician visit on September 15, 2022 at 11:10 a.m. R1's medication administration records (MAR) dated September 16, 2022, indicated R1 started an antibiotic, but did not identify why the antibiotic was prescribed. The licensee's pharmacy fax log dated September 19, 2022, indicated one of two of R1's insulin orders were increased: -Humalog insulin was increased from 2 units to 5 units three times per day, (TID). The September 19, 2022, pharmacy fax log also indicated registered nurse, (RN)-D, transcribed the insulin order but did not discontinue the existing insulin order on R1's MAR of: -Humalog 2 units subcutaneously TID. R1's MAR for September 21, 2022, indicated both Humalog 2 units and 5 units were given at 12:00 p.m. and 4:00 p.m. R1's MAR for September 22, 2022, indicated both Humalog 2 units and 5 units were given at 12:00 p.m. and 4:00 p.m.	0 730			

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0 730	Continued From page 5 R1's nurses notes dated September 23, 2022 at 8:55 a.m. indicated R1 was sent to the hospital and had a blood sugar level over 600. R1's medical records lacked documentation R1 fell, lacked evidence of an assessment of R1's condition, and failed to include the time of the incident and time that R1 was transported to the hospital or if R1's family was notified of the incident. R1's hospital medical records dated September 23, 2022, at 12:15 a.m., indicated R1 reported lowering herself to the floor after feeling weak at the facility. R1 also reported to hospital staff she had pain in her lower extremities, a sore throat, and a cough. R1's hospital medical records dated September 23, 2022, at 3:41 a.m., indicated R1 had an CT Scan which revealed R1 had pneumonia, and an x-ray revealed a fractured left ankle from the fall and labs revealed R1 continued to have a UTI. R1's facility nursing notes dated September 23, 2022 at 8:55 a.m., indicated registered nurse; (RN)-C complained to the R1's physician as to why R1's insulin orders were not increased prior to R1's hospitalization. R1's hospital medical records dated September 23, 2022 at 8:50 p.m. and signed by R1's primary care physician, indicated the physician verified to RN-C, R1's medications were both increased and sent to R1's pharmacy on September 19, 2022: -Lantus insulin was increased from 8 units to 12 units subcutaneously to be given daily at bedtime.	0 730			

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0 730	Continued From page 6 -Humalog insulin was increased from 2 units to 5 units subcutaneously to be given at mealtime, three times per day, (TID). R1's medical records lacked documentation of an incident report, medication errors, or facility investigation of the incidents. R1's medical records also lacked documentation of R1's surgery or discharge from the hospital to a transitional care unit (TCU). An email provided by registered nurse, (RN)-B on August 14, 2023 at 11:01 a.m., indicated after RN-B reviewed R1's September 21, 2022 and September 22, 2022 MAR, and clarified both staff signed off R1's MAR as giving two additional units of Humalog at 12:00 p.m. and 4:00 p.m. on both dates. RN-B indicated the nurses were not using the part of the licensee's MAR system that records the nurses check of medications against R1's MAR. The email further indicated RN-B tried to check pharmacy receipts, however, pharmacy receipts were only kept for a 6 month period and were then discarded. An email provided by RN-B on August 14, 2023 at 4:32 p.m., indicated RN-B reviewed licensee documents that indicated RN-D imported one of the two insulin orders and forgot to discontinue one of the two previous insulin orders which resulted in R1 receiving additional units of insulin on September 21, 2022 and September 22, 2022 at both 12:00 p.m. and 4:00 p.m. During an interview on August 8, 2023 at 2:06 p.m., the licensed assisted living director, (LALD)-A, stated all of R1's incidents were reported to him, including medication errors.	0 730			

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0 730	Continued From page 7 During this same interview, the LALD-A indicated they were aware R1 was hospitalized in September 2022, but could not recall if an incident report was made and stated he would send one if it could be found. No incident report was sent to the MDH investigator. During an interview on August 8, 2023 at 2:03 p.m., nursing administration/registered nurse, (RN)-B, stated in reference to R1's insulin's orders prior to the hospitalization on September 23, 2022: " The problem I am finding is, there should be an incident report and I cannot find one." RN-B also stated in reference to RN-C reviewing R1's insulin orders after R1's hospitalization: " I have no documentation of a medication error, so I do not know what had happened to R1's insulin orders." "There was also no documentation by RN-C or RN-D in R1's notes." RN-B stated R1 was transported to the hospital on September 23, 2023, and returned to the licensee in February 2023 after ankle surgery and a stay at a TCU to convalesce after the sugery. During an interview on August 10, 2023 at 1:48 p.m., registered nurse, (RN)-C, was asked if she completed an incident or fall report after R1 was sent to the hospital on September 23, 2022, RN-C stated: "the aides are supposed to do that." During an interview on August 14, 2023 at 2:47 p.m., with the licensee's contracted pharmacist (ADM)-I stated R1's physician orders included increases in insulin for the following on September 19, 2022: Lantus increased from 8 units to 12 units	0 730			

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0 730	Continued From page 8 subcutaneously daily at bedtime. Humalog increased from 2 units to 5 units subcutaneously TID. ADM-I stated the updated Humalog order was successfully sent electronically to the licensee on September 19, 2022. ADM-I stated the updated Lantus order was successfully sent electronically to the licensee at a later date due to a software issue. The software recognized the Lantus order as a refill because the pharmacy's system showed R1 to have Lantus in stock at the licensee. The licensee provided Incident Report Policy dated: August 1, 2021 indicated any incident involving a resident should be completed by utilizing an incident report and turned into the licensed assisted living director and supervisor. All incident reports will be kept in the resident's records. The licensee provided Falls Policy dated August 21, 2021, indicated the following: If a resident fall is suspected, the staff were to: 1. obtain vital signs 2. complete an incident report 3. incident reports will have follow-up by a registered nurse No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730			