Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL319628642M
Compliance #: HL319626064C

Date Concluded: April 18, 2025

Name, Address, and County of Licensee Investigated:
Meadow Ridge Senior Living
7475 Country Club Drive
Golden Valley MN 55427
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 alleged perpetrator (AP) neglected the resident when they failed to administer medications as prescribed.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although a medication administration error occurred, it was an isolated incident. The resident was monitored and treated at a local hospital before returning to the facility at their baseline health status. 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 members interacting with residents.

The resident resided in an assisted living facility. The resident's diagnoses included epilepsy and osteoporosis. The resident's service plan included assistance with all activities of daily living, routine safety checks, and medication administration. The resident's assessment indicated nursing staff to provide medication setup and assist with medication administration. The resident has had a history of hospitalization for altered mental status related to seizures.

Documentation indicated that during morning medication administration the AP (facility staff member) took medication from a pill dispenser slated for the evening dose and included it in the morning dose preparations. This resulted in the resident being given a higher dose of medication than was ordered. A facility nurse doing a routine medication inventory discovered the error and reported it. The facility contacted the resident's provider and after observing a change in condition, the resident was transported to a local hospital for further observation. As a result of the incident, the facility changed the method of medication set-up and delivery for this resident. The resident returned to her baseline medical status and returned to the facility the next day.

During an interview, a nurse said that the resident returned to the facility days before the incident following a hospital stay and a new process for medication administration had been implemented prior to her return. The resident no longer used a weekly medication set up container and all medication was now being delivered and distributed from a pill pack card (a container holding pills in individual sealed compartments). This process was well established through out the facility and the AP had been trained in its use.

During an interview, a second nurse said on the morning of the incident as she was reviewing the morning medication inventory logs when she identified an error in where a medication prescribed to be given in the evening was documented as given that morning. Further investigation uncovered that the AP documented distributing both the morning and evening doses of a medication. When the nurse asked the AP about the error, the AP's explanation was that she got confused with the change in the medication process.

During an interview, the AP stated that prior to the incident, the resident had been receiving medication set up services by the facility nurse who placed all the required individual medication doses into a weekly planner for retrieval. Days prior to the incident, the resident's medication administration process had transitioned to being dispensed from individual medication cards, which held pills in a bubble pack for individual dispensing. The AP said she was familiar with this medication administration process and was previously trained in its use, as other residents in the facility required set up and some did not. The AP stated that in addition to the scheduled morning dose, she was confused with the medication names and similar doses, and it appeared that she also dispensed a medication scheduled for evening administration that same day.

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, attempts to contact were unsuccessful.
Family/Responsible Party interviewed: No, attempts to contact were unsuccessful.
Alleged Perpetrator interviewed: Yes

Action taken by facility:
Nursing staff monitored the resident for a change in health status and notified emergency medical services when needed. The facility conducted additional individual and facility wide training and reeducation on the medication administration process.

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
	31962	A. BUILDING: _____ B. WING _____	C 04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW RIDGE SENIOR LIVING	7475 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427

(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 April 3, 2025, the Minnesota Department of Health initiated an investigation of complaint # HL319627483C and #HL319626064C/#HL319628642M. No correction orders are issued.	0 000	Assisted Living Provider 144G. 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.	