Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL319687307M
Compliance #: HL319683889C

Date Concluded: November 9, 2023

Name, Address, and County of Licensee Investigated:
Maple Hill Senior Living LLC
3030 Southlawn Drive
Maplewood MN 55109
Ramsey County

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

Evaluator's Name: Holly German, 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 a resident when she administered medication to the resident that was not ordered for the resident by the provider.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The AP administered insulin to the resident. The insulin was meant for another resident with a similar name. Although the wrong medication was given, the error was an isolated incident. The resident sustained nausea and vomiting, received increased monitoring, anti-nausea medication and returned to their baseline health condition.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, unlicensed staff, and a family member. The investigation included review of the resident's medical record, the medical provider's orders, facility incident report and personnel

files. Also, the investigator toured the facility and observed staff interactions with residents and medication administration.

The resident resided in an assisted living memory care unit. The resident's diagnoses included psychotic disorder with delusions and dementia with behavioral disturbance. The resident's service plan included assistance with bathing, toileting, and dressing. The resident's medication administration record (MAR) indicated she received assist with medication administration. The resident's assessment indicated she was oriented to person only and required stand by assist with walking.

The facility internal investigation indicated the AP took a syringe from the nurse, that was identified by the nurse as Trulicity (a diabetes medication) and administered it to the resident. The medication was ordered for a different resident with a similar name.

The resident's progress notes indicated the provider was notified of the error and of the resident developing increased anxiety and nausea with vomiting. The facility received orders from the provider for Ativan (a medication used to reduce anxiety) as needed and Zofran (an anti-nausea medication). Progress notes indicated the resident had returned to her baseline health status three days after the medication error was made.

The AP's personnel record indicated the AP received retraining after the incident and demonstrated competency with insulin administration.

During an interview, the AP stated she did not follow the five rights of medication administration (ensuring right medication, right resident, right time, right dose, right route) prior to giving the injection, because the nurse had already had the medication prepared and she thought the nurse had gone through all the steps already. The AP stated she should not have given the medication. The AP stated she had a feeling to double check the resident's MAR after giving her the insulin and found the medication was not listed on her MAR. The AP stated once the error was discovered, she called the provider, received new orders, and implemented them. The AP stated she called the family but did not get an answer at that time.

During an interview, the nurse stated she told the AP she did not feel comfortable giving the resident her insulin injection because she heard from other staff, she can be resistive at times. The AP stated she would do it and took the syringe from LPN-B. LPN-B followed the AP to the resident's room. The AP administered the medication. LPN-B stated later, while still doing the medication pass, another resident with a similar name notified LPN-B she needed her injection. At that time, LPN-B realized the medication error made. LPN-B and the AP went to the medication refrigerator where the medication was stored, and discovered the medication was given to the wrong resident.

During an interview, the licensed assisted living director (LALD) stated she was notified by the AP of the error the same day. The LALD later stated in an email communication to the

investigator that she was out of state when the error occurred and was notified of the error upon her return to the facility. The LALD stated the internal investigation concluded staff were going too fast during medication pass and both made assumptions the other made the safety checks already. The LALD stated LPN-B and the AP received retraining after the incident.

During an interview, a family member stated he was told by staff different versions of the incident. The family member stated he did not feel the resident was safe in 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.
(c) For purposes of this section, a vulnerable adult is not neglected for the sole reason that:
(5) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult that results in injury or harm, which reasonably requires the care of a physician, and:
(i) the necessary care is provided in a timely fashion as dictated by the condition of the vulnerable adult;
(ii) if after receiving care, the health status of the vulnerable adult can be reasonably expected, as determined by the attending physician, to be restored to the vulnerable adult's preexisting condition;
(iii) the error is not part of a pattern of errors by the individual;
(iv) if in a facility, the error is immediately reported as required under section 626.557, and recorded

Vulnerable Adult interviewed: No, due to cognitive deficits.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility immediately reported the incident to the provider and provided the follow up medical care as ordered by the provider. The facility provided retraining to staff.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31968	A. BUILDING: _____ B. WING _____	C 10/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HILL SENIOR LIVING LLC	3030 SOUTHLAWN DRIVE 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 ******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: #HL319683889C /# HL319687307M On October 30, 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 79 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL319683889C /#HL319687307M, tag identification 620, 1650.	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.	
0 620 SS=D	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma	0 620		

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0 620	Continued From page 1 (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.	0 620		

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0 620	Continued From page 2 (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review the licensee failed to report potential neglect to Minnesota Adult Abuse Reporting (MAARC) immediately, within 24 hours, as required for 1 of 1 residents (R1) reviewed. 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1's diagnosis includes psychotic disorder with	0 620	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.	

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0 620	Continued From page 3 delusions and dementia. R1's service plan dated September 29, 2023, indicated R1 received assistance with hygiene, toileting and behavior management. R1 was oriented to self. Incident report dated July 7, 2023, indicated a medication error occurred July 7, 2023 at 4:00 p.m. Licensed practical nurse (LPN)-B administered insulin medication to R1 in error when the insulin was intended for another resident with the same first name. Progress notes dated July 8, 2023 indicated R1 developed nausea with multiple episodes of vomiting. The facility received new physician orders to treat symptoms for anxiety, nausea and vomiting. The licensee reported the incident to MAARC on July 17, 2023. During an interview on November 3, 2023, at 09:03 a.m., LPN-B stated she asked the registered nurse (RN)-A if she needed to report and RN-A told her no, she was taking care of everything. LPN-B stated she was never talked to or asked to give a statement for the report. During an interview on November 3, 2023 at 10:30 a.m., licensed assisted living director (LALD)-C stated she was made aware of the medication error on July 7, 2023 by RN-A. LALD-C stated she asked RN-A if she needed her to do something, and RN-A stated no. LALD-C stated to RN-A that she could report it, and RN-A responded "OK." LALD-C stated she reported the incident on July 17, 2023, and did not recall a reason for why it was reported that date.	0 620	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.	

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0 620	Continued From page 4 In an email communication on November 6, 2023, at 3:15 p.m., LALD-C stated while looking at her calendar, she realized she was out of state when the incident occurred. When she returned to the facility and began an investigation, she realized it had not been reported. The licensee-provided policy titled "Vulnerable Adult Maltreatment-Prevention and Reporting" dated February 11, 2022 indicated the facility is to report suspicion of maltreatment no later than 24 hours after the maltreatment was first suspected. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
01650 SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including	01650		

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01650	Continued From page 5 identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to include medication services in the service plan, as required for 1 of 1 residents (R1) reviewed. 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1's diagnosis includes psychotic disorder with delusions and dementia. R1 was oriented to self. R1's service plan dated September 29, 2023, failed to include assistance with medication administration, with frequency, staff who provide the service and price of the service. R1's service delivery record dated July 2023, indicated staff provided medication assistance six times daily for the month of July. R1's service delivery record dated August 2023,	01650	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	

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01650	Continued From page 6 indicated staff provided medication assistance six times a day for August 1 through August 23, 2023. During an interview on November 7, 2023, at 1:59 p.m., family member (FM)-D stated the staff administer the medications to R1 as part of the services provided to her. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650	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.	