Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL368498244M
Compliance #: HL368495390C

Date Concluded: January 12, 2024

Name, Address, and County of Licensee Investigated:
Personal Care Management LLC
525 Cutter Street
Anoka, MN 55303
Anoka County

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

Evaluator's Name: Brooke Anderson, 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 the resident did not receive her scheduled Metolazone (a medication used to treat high blood pressure and fluid retention) which resulted in hospitalization and fluid overload.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the resident's medication was not administered as prescribed, the error was an isolated incident. When a significant change in condition was observed, the resident's provider was updated, and the resident was transferred to the hospital for further evaluation.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident's medical record, hospital records, personnel files, and facility policies and procedures. At the time of the

onsite visit, the investigator toured the facility and observed interactions between staff and residents.

The resident resided in an assisted living facility. The resident's diagnoses included chronic heart failure (CHF), dementia, atrial fibrillation, and a history of edema (swelling). The resident's service plan included assistance with medication management and application of compression stockings.

The resident's physician's orders directed staff to administer Metolazone (a diuretic) 2.5 milligrams every Thursday and to weigh the resident every Monday, Wednesday, and Friday, for management of CHF.

Facility documentation indicated staff weighed the resident and reported the weight to the nurse, per physician's orders. One Friday, the resident's weight displayed an increase of 14 pounds and the nurse reported the change in weight to the resident's physician.

The following Monday, the resident's family member observed the resident's legs were swollen and the cardiologist was notified. The cardiologist ordered an additional dose of Metolazone to be administered on Tuesday, prior to the scheduled Thursday dose.

On Tuesday evening, nursing staff noticed the additional dose of Metolazone was not administered due to the medication being unavailable. The nurse contacted the pharmacy, re-ordered the medication, and the medication was delivered later that evening. When staff administered the medication the next morning, the resident reported additional symptoms of nausea, vomiting, and lower abdominal pain, and was transferred to the hospital for further evaluation.

Hospital records indicated the resident was admitted with shortness of breath and lower extremity edema (swelling). The resident was diagnosed with acute CHF and treated with intravenous (IV) diuretics. No changes were made to the resident's medications and the resident discharged back to the facility.

The facility completed an internal investigation of the medication error and determined the resident missed two doses of the scheduled Metolazone over a one-month period. Staff documented the Metolazone was out of supply but did not notify the nurse. The medication was not re-ordered from the pharmacy until nursing staff noticed the additional dose was not administered. Following identification of the error, nursing staff completed a medication audit and re-educated facility staff.

During an interview, the resident's family stated they were aware of the medication error and felt none of the overlooked items were intentional. The family stated the resident returned to her baseline health condition after the hospitalization and no further incidents have occurred.

The facility nurse employed at the time of the incident was interviewed but no longer worked at the facility and did not recall the incident.

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: Not Applicable

Action taken by facility:
The facility assessed the resident, updated the provider, and sent the resident to the hospital when additional symptoms were observed. The facility investigated and completed staff education following the incident.

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
	36849	A. BUILDING: _____ B. WING _____	C 11/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSONAL CARE MANAGEMENT LLC	525 CUTTER STREET ANOKA, MN 55303

(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 November 28, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL368498409C/HL368494867M, #HL368495390C/HL368498244M. No correction orders are issued.	0 000		