Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H54147805M **Date Concluded:** December 1, 2023

Name, Address, and County of Licensee Investigated:
Viewcrest Health Center
3111 Church Street
Duluth, Minnesota 55811
Saint Louis County

Facility Type: Nursing Home **Evaluator's Name:** Nicole Myslicki, 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 the AP failed to verify the resident's identity and administered insulin meant for another resident.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although, the AP made a medication error, the facility failed to properly train the AP and orient her to the residents prior to providing nursing care. The facility received a licensing order.

The investigator conducted interviews with facility staff members, including administrative staff and nursing staff. The investigator contacted family. The investigation included review of the resident's medical record, the AP's personnel record, the internal investigation, and policies including medication errors, medication administration, and training.

The resident resided in a skilled nursing facility. The resident's diagnoses included dementia. The resident did not have a diagnosis of diabetes. The resident's care plan included assistance with medication administration.

An incident report indicated the AP, an agency nurse on her first shift of training on the unit, incorrectly identified the resident and gave six units of insulin meant for another resident. Vital signs were taken, and at that time, the resident had a blood sugar level of 220 milligrams per deciliter (mg/dL). A facility registered nurse (RN) spoke with the on-call doctor who ordered blood sugar checks every hour for eight hours, and if blood glucose dropped to less than 60 mg/dL, call back. Staff attempted to get the resident to eat or drink, but the resident declined. Approximately four hours after the medication error, the resident's blood sugar level dropped below 60 mg/dL, so the RN called to inform the doctor. The doctor ordered glucagon 1 gram intramuscularly, then check the blood sugar again in 30 minutes and if less than 80 mg/dL, call back again. The RN administered the glucagon as ordered, and the blood sugar level raised up to 80 mg/dL at the next check. The RN completed blood sugar checks multiple times throughout the night, and the blood sugar continued to rise.

A medical provider saw the resident the day after the incident. The provider's visit note did not identify the medication error as an area of concern.

The resident's medical record indicated the resident's blood sugar level dropped from 220 mg/mL to 44 mg/mL over the course of four hours. The resident's blood sugar reached 80 mg/dL approximately an hour later. The facility continued to monitor her blood sugar which remained above 80 mg/dL for the following few days.

During an interview, the RN stated she spoke with the resident about the medication error, but the resident did not remember it happening. The resident's medical provider rounded on her the next day and ordered labs. Nothing came back abnormal, and the provider did not identify any concerns. The RN completed an internal investigation and re-educated the nurses and trained medication aides (TMA) on medication administration. The AP put in her notice the day after the incident and declined to complete her contract at the facility.

During an interview, the RN stated for about the last year or so, the facility had to use agency nurses, particularly on the overnight shift. Agency nurses only received one shift of training, while facility nurses received 10 shifts. Some days, brand new agency nurses would be put on the schedule to work a regular shift instead of even receiving the one training shift. The day of the incident, herself, the AP, and a TMA were scheduled. Because the AP did not have a nurse assigned to train her, the RN rearranged the schedule so she would be on the same floor to help the AP, and they each took a medication cart. The AP misidentified the resident and gave her another resident's insulin. The AP tried to give her this other resident's medications too, but the resident did not take them. When the AP came and told the RN the resident would not take her medications, the RN found it strange because the correct resident always took her medications. The RN asked the AP to show her which resident received the insulin and identified the resident

as the wrong resident. The RN called the on-call doctor and checked the resident's blood sugar. The RN also gave the correct resident her medications and insulin. Throughout the evening, they were in contact with the on-call doctor and monitored her and her blood sugar. When it dropped, they gave the resident glucagon IM because she did not want to take anything by mouth. After the glucagon injection, the resident's blood sugar started to improve. During the incident, the resident never seemed lethargic or out of it.

During an interview, the AP stated she received no formal training from the facility prior to working on the unit. A nurse called in, so instead of shadowing, the AP had a medication cart to herself. Additionally, the AP did not receive orientation to the residents prior to providing nursing care. The AP stated she thought she gave the correct resident the insulin, but when she attempted to give the resident medication by mouth, the resident refused. The AP informed the RN who told the AP the medications and insulin were for a different resident. After they discovered the error, she and the RN notified the doctor who ordered them to monitor the residents blood sugar. The resident's blood sugar started dropping, so the doctor ordered them to give glucose. The AP and the RN continued to monitor her until she stabilized. About the situation, the AP stated she should have said no to accepting the assignment that day knowing the facility wanted to put her on a medication cart by herself.

During an interview, a family member stated she did not think the facility took the incident very seriously. Staff kept telling the family member it was a very low dose and only happened once. The family member did not think the facility told her everything going on, and she had to be the one to call for updates on the resident.

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. The resident is deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility completed an internal investigation and retrained nurses and trained medication aides (TMA).

Action taken by the Minnesota Department of Health:
The facility was issued a federal deficiency and/or a state correction order for noncompliance with licensing requirements. For a copy of the Statement of Deficiencies, please call 651-201-4890.

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
	00602	A. BUILDING: _____ B. WING _____	C 11/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIEWCREST HEALTH CENTER	3111 CHURCH STREET DULUTH, MN 55811

(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
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: The Minnesota Department of Health investigated an allegation of maltreatment, complaint #H54147805M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. No correction orders are issued.	2 000		

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2 000	Continued From page 1 The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	2 000		