Minnesota
Department of Health

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:			Report Number:	Date of Visit:
Haven Homes of Maple Plain			H5497012	January 3, 2017
Facility Address:			**Time of Visit:**	**Date Concluded:**
1520 Wyman Avenue			8:45 a.m. to 5:30 p.m.	August 3, 2017
Facility City:			**Investigator's Name and Title:**	
Maple Plain			Arthur Biah, RN, Special Investigator	
State:	**ZIP:**	**County:**		
Minnesota	55359	Hennepin		

☒ **Nursing Home**

Allegation(s):

It is alleged that a resident was neglected when a medication (omeprazole) was discontinued without a physician order.

☒ Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)

☒ State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)

☒ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)

☒ State Statutes Chapters 144 and 144A

Conclusion:

Base on preponderance of evidence, neglect occurred when the facility failed to ensure the resident's medication was administered as prescribed by the physician. The resident did not receive the prescribed medication for two weeks and was subsequently hospitalized for a week.

The resident was admitted with diagnoses of gastric ulcer, gastro-esophageal reflux disease , constipation, nausea, and dementia. The resident was recently hospitalized with gastric ulcer prior to this admission. The resident was discharged from the hospital with a prescription of omeprazole, 20 milligrams (mg) capsule twice daily, to treat his/her gastric ulcer. The physician's order for the omeprazole did not have a stop date. The resident needed staff's assistance with medication management and administration.

About a month after admission to the facility, the resident experienced fever and weakness. The physician was notified and the resident was re-admitted to the hospital. The hospital's medication reconciliation indicated the facility's medication administration record sent to the hospital did not include omeprazole.

The hospital record review indicated the resident was admitted with fever, bloating and abdominal pain. A computed tomography scan indicated the resident had perforated gastric ulcer. Perforated gastric ulcer is a condition where an untreated ulcer can burn through the wall of the stomach or other areas of the gastrointestinal tract, allowing stomach acid and food to leach into the abdominal cavity. According to the hospital records, the perforation of gastric ulcer was likely due to the stoppage of the resident's omeprazole without a physician order. The resident was hospitalized for seven days and discharged on high-dose

medication to manage his/her perforated gastric ulcer.

Review of the medication administration record (MAR) indicated the resident received the prescribed dose of omeprazole up to the end of the month. At the beginning of the next month, the facility switched from paper MAR to electronic medication administration record (eMAR). After the switch from the paper MAR to eMAR, the facility's MAR showed no evidence that the resident received the prescribed omeprazole for the two weeks.

During an interview, the director of nursing (DON) stated the facility switched from paper MAR to electronic MAR.. The DON stated the facility's review indicated the staff did not administer the resident's omeprazole order for 14 days. The DON stated the facility's verification process did not detect the missing medication and the facility's licensed staff were not aware of the resident missing the omeprazole since beginning of the month.

The resident's primary care physician was interviewed and stated the resident's diagnosis at re-admission was perforated gastric ulcer. The physician stated the resident's readmission to the hospital was attributable to the facility's staff's failure to administer his/her omeprazole as ordered.

After the error was discovered, the facility conducted an audit of medication administration.

Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557)

Under the Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557):

☐ Abuse ☒ Neglect ☐ Financial Exploitation

☒ Substantiated ☐ Not Substantiated ☐ Inconclusive based on the following information:

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ☐ Individual(s) and/or ☒ Facility is responsible for the

☐ Abuse ☒ Neglect ☐ Financial Exploitation. This determination was based on the following:

The facility failed to ensure that policies on medication discontinuation and review were implemented. The facility did not have a monitoring process to ensure accurate month-to-month medication administration records.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

Compliance:

Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B) - Compliance Not Met
The requirements under the Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B), were not met.

Deficiencies are issued on form 2567: ☒ Yes ☐ No

(The 2567 will be available on the MDH website.)

State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) - Compliance Not Met
The requirements under State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) - Compliance Not Met
The requirements under State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

State Statutes Chapters 144 & 144A – Compliance Not Met - Compliance Not Met
The requirements under State Statues for Chapters 144 &144A were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

Compliance Notes:

Facility Corrective Action:
The facility took the following corrective action(s):

Definitions:

Minnesota Statutes, section 626.5572, subdivision 17 - Neglect
"Neglect" means:

(a) 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.

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

The Investigation included the following:

Document Review: The following records were reviewed during the investigation:

- [x] Medical Records
- [x] Care Guide
- [x] Medication Administration Records
- [x] Nurses Notes
- [x] Physician Orders
- [x] Physician Progress Notes
- [x] Care Plan Records
- [x] Facility Incident Reports
- [x] Laboratory and X-ray Reports

Other pertinent medical records:

- [x] Hospital Records

Additional facility records:

- [x] Resident/Family Council Minutes
- [x] Staff Time Sheets, Schedules, etc.
- [x] Facility Internal Investigation Reports
- [x] Personnel Records/Background Check, etc.
- [x] Facility Policies and Procedures

Number of additional resident(s) reviewed: Three

Were residents selected based on the allegation(s)? (●) Yes ( ) No ( ) N/A

Specify:

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

(●) Yes ( ) No ( ) N/A

Specify:

Interviews: The following interviews were conducted during the investigation:

Interview with complainant(s) (●) Yes ( ) No ( ) N/A

Specify:

If unable to contact complainant, attempts were made on:

Date:	Time:	Date:	Time:	Date:	Time:

Interview with family: (●) Yes ( ) No ( ) N/A Specify:

Did you interview the resident(s) identified in allegation:

(●) Yes ( ) No ( ) N/A Specify: Unable to answer questions.

Did you interview additional residents? (●) Yes ( ) No

Total number of resident interviews:Six

Interview with staff: (●) Yes ( ) No ( ) N/A Specify:

Tennessen Warnings

Tennessen Warning given as required: (●) Yes ( ) No

Total number of staff interviews: Six

Physician Interviewed: (●) Yes ( ) No

Nurse Practitioner Interviewed: ( ) Yes (●) No

Physician Assistant Interviewed: ( ) Yes (●) No

Interview with Alleged Perpetrator(s): ( ) Yes (●) No ( ) N/A Specify:

Attempts to contact:

Date:	Time:	Date:	Time:	Date:	Time:

If unable to contact was subpoena issued: ( ) Yes, date subpoena was issued ( ) No

Were contacts made with any of the following:

☐ Emergency Personnel ☐ Police Officers ☐ Medical Examiner ☐ Other: Specify

Observations were conducted related to:

- [x] Call Light
- [x] Medication Pass
- [x] Dignity/Privacy Issues
- [x] Safety Issues
- [x] Facility Tour

Was any involved equipment inspected: ○ Yes ◉ No ○ N/A
Was equipment being operated in safe manner: ○ Yes ○ No ◉ N/A
Were photographs taken: ○ Yes ◉ No Specify: ______________________

cc:

Health Regulation Division - Licensing & Certification

Minnesota Board of Examiners for Nursing Home Administrators

Minnesota Board of Nursing

The Office of Ombudsman for Long-Term Care

West Hennepin Public Safety

Hennepin County Attorney

Maple Plain City Attorney

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 30, 2017

Mr. Garrett Bothun, Administrator
Haven Homes Of Maple Plain
1520 Wyman Avenue
Maple Plain, MN 55359

Re: Reinspection Results - Complaint Number H5497012

Dear Mr. Bothun:

On September 15, 2017 an investigator from the Minnesota Department of Health, Office of Health Facility Complaints, completed a reinspection of your facility, to determine correction of licensing orders found during the investigation completed on June 26, 2017. At this time these correction orders were found corrected.

Regarding the results of the Federal deficiency (F333) cited during the investigation completed on June 26, 2017. Please refer to the Centers for Medicare and Medicaid Services (CMS) letter date November 21, 2017 for additional information.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the president of your facility's governing body.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245497	A. BUILDING ______ B. WING ______	R-C **09/15/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	**1520 WYMAN AVENUE MAPLE PLAIN, MN 55359**

(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) COMPLETION DATE
{F 000}	INITIAL COMMENTS A Post Certification revisit was conducted on September 15, 2017, to follow up on deficiencies issued relate to complaint H5497012. Haven Homes of Maple Plain is in compliance with 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00950	A. BUILDING: ______ B. WING ______	R-C **09/15/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	**1520 WYMAN AVENUE MAPLE PLAIN, MN 55359**

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{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: A licensing order follow-up was completed to follow up on correction orders issued related to complaint H5497012. Haven Homes of Maple Plain was found in compliance with state regulations. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first	{2 000}		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Electronically Signed

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00950	A. BUILDING: ______ B. WING ______	R-C **09/15/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	**1520 WYMAN AVENUE MAPLE PLAIN, MN 55359**

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{2 000}	Continued From page 1 page of the State form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	{2 000}		