

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL304343185M
Compliance #: HL304345170C

Date Concluded: February 28, 2023

Name, Address, and County of Licensee

Investigated:

Saint Ann's Residence
330 East 3rd Street
Duluth, MN 55805
St. Louis County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Barbara Axness, RN
Special Investigator

Finding: Inconclusive

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 they failed to ensure antibiotics were administered as ordered to treat a urinary tract infection (UTI). The resident died of sepsis in the hospital after several days in the intensive care unit.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was inconclusive. It is unable to be determined if the resident's death was a direct result of not receiving the prescribed dose(s) of the antibiotic and failure to obtain a follow-up urine culture. The resident had a history of septic urinary tract infections (UTI), and the cause of death was identified as sepsis due to *Corynebacterium bacteremia* (a bacterial infection) and *clostridium difficile* (a gastrointestinal infection). Due to conflicting information and documentation, it is unable to be determined if the resident received one dose of the prescribed antibiotic or if both scheduled doses were missed. In addition, there was a lack of information provided as facility staff were unable to recall the resident or the condition of the resident prior to her hospitalization.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted health care providers involved with the resident's care and law enforcement. The investigation included review of facility records including progress notes, assessments, medication administration records, and the service plan, along with hospital records, and the resident's death record.

The resident resided in an assisted living facility. The resident's diagnoses included hypertension (high blood pressure), congestive heart failure, and type two diabetes. The resident's service plan included assistance with medication administration and blood sugar and insulin management. The resident's assessment indicated the resident had previously been hospitalized for a septic UTI.

Hospital records indicated the resident returned to the facility after she was hospitalized following a fall. The resident was diagnosed with a UTI and returned to the facility with orders for an antibiotic to treat the UTI and a follow-up urine culture to be completed in ten days. One dose of the antibiotic had been administered in the hospital and the next two doses were to be administered by the facility. The order indicated the antibiotic was to be given every 72 hours.

The resident's medication administration record (MAR) indicated two doses of the antibiotic were scheduled to be given as ordered. However, both doses were marked as "not available and not given". The resident's record lacked documentation to demonstrate that the provider was updated on the medication not being available or that the resident did not get the remaining two doses of her three-dose antibiotic order. The resident's record also lacked evidence that the follow up urine culture was collected.

Hospital records indicated the resident was readmitted to the hospital 17 days after she had returned to the facility. The hospital records indicated the resident was admitted due to sepsis (an infection of the blood stream) and acute cystitis (urinary tract infection). The hospital admission history and physical indicated the resident arrived for evaluation of confusion, a reported 101-degree Fahrenheit fever, hyperglycemia (high blood sugar), and frequent moaning. The hospital physician wrote "The patient appears acutely ill and has possible severe sepsis...evidence of end organ damage due to severe sepsis." Hospital notes indicated the patient developed multisystem organ failure and was admitted to the intensive care unit for further management.

The resident's death record indicated the resident died after spending 17 days in the intensive care unit. The resident's cause of death was sepsis due to *Corynebacterium* bacteremia (a bacterial infection) and *Clostridium difficile* (a gastrointestinal infection). Other significant conditions contributing to death but not resulting in the underlying cause was listed as candida urinary tract infection, acute kidney injury.

During investigative interviews, multiple unlicensed personnel (ULP)s stated they could not remember any changes or events leading up to the resident being sent to the hospital. Multiple ULPs could not recall if the resident received her antibiotic.

During an interview, the health unit coordinator (HUC) stated the resident had returned from the hospital with a new order for an antibiotic. The resident received one dose in the hospital and the facility was to administer the two remaining doses. The HUC stated she was responsible for ordering the medication and when she tried to fill it, the pharmacy said insurance wouldn't cover it and they required a prior authorization from the doctor before they could release it. The HUC stated it took a couple of days for the pharmacy to get the necessary authorizations back from the doctor and she notified the nurse about the trouble filling the medication and that they were not able to get it as expected. The HUC stated the nurse would be the one responsible for updating the doctor on the medication not being able to get filled, as that would not be within the scope of her job duties. The HUC stated she personally picked up the antibiotics seven days after the resident was supposed to get her first dose at the facility. The HUC stated she witnessed the resident receive one dose but was not sure about the second dose. The HUC confirmed nothing was put in the MAR and there was no documentation to show the resident received the antibiotics. The HUC stated she was not sure how staff knew when or how to give the medication, but the medication was on the cart and there were directions on the box.

During an interview, the facility registered nurse (RN) stated she could not recall specific details regarding the resident's care since "she's [the resident] been gone for so long." The RN stated around the time the resident got the antibiotic order and was admitted to the hospital, "I was working at the time very short handed; I was the only RN in the building." The RN stated that "in hindsight, I have some concerns. I wish we all would have done a better job with documentation to see what went on there, there were gaps." The RN confirmed there were gaps in documentation and stated, "I really can't give an answer as to why, other than we usually do a better job." The RN stated the physician would have been aware the resident wasn't getting her antibiotic as ordered since the pharmacy would have contacted them to obtain a prior authorization. The RN stated she was not sure why there was no documentation of the antibiotic being given once it was obtained from the pharmacy. The RN stated she contacted the pharmacy after the investigation was initiated to find out why they didn't get the antibiotic right away. The RN stated she was told the antibiotic was ready for pick up the day it was supposed to be administered, but the pharmacy didn't have an automated system to tell people when medications are ready for pick up. The RN confirmed she did not follow up with the pharmacy because she thought they were still working on getting prior authorization and she would be updated when it was ready. The RN confirmed a follow up urine culture was not completed by the facility and it's likely they overlooked the order on the resident's hospital discharge orders. The RN stated it was possible they did not get all the paperwork as they relied on the resident to give them all their paperwork when returning from appointments or the hospital.

During an interview, the resident's family member stated the night the resident went to the hospital, her brother had called the resident and was concerned about how she sounded on the phone. The family member stated she called the facility and asked if someone could go check on her and when she didn't hear anything back, she went to the facility. The family member stated she ran in to a ULP in the hallway who worked with the resident and asked her how the resident was doing. The family member stated the ULP replied by saying "I'm busy and [the resident] doesn't want to go to the hospital." The family member stated when she got to the resident's room, she noticed she was rocking back and forth and moaning. The family member stated she went back down to the front desk and called the ambulance. The family member stated she was not sure if the nurse had been made aware of anything that night, but she felt like if she hadn't come in, the resident would not have been sent into the hospital. The family member stated she never got any calls or communication to say her antibiotic was not started right away and was not updated on any changes in condition. The family member stated, "I never got a call, no one called me, I don't know if she was like that all day, I just don't know. I was not happy with the fact I had to go and call 911...I don't know if she'd be stuck all night like that, the ULP said she doesn't want to go to the ER but she's also not hard to persuade."

During an interview, a medical doctor (MD) stated she had seen the resident in person the day after she returned from the hospital. The MD stated the resident was transitioning to be a patient under her care team but had not yet formally established care with them. The MD stated she had assumed the resident completed her antibiotic and that's the assumption she got from staff as well. The MD stated she would have expected the facility to contact the care team if there were issues with obtaining the antibiotics or if she didn't get them as prescribed. The MD could not locate any notes in the resident's records indicating they were notified of the inability to obtain the antibiotics or that they were unable to collect the urine culture as ordered. The MD stated it would be difficult to know if the antibiotic dose the resident did get was effective since there was no follow up culture completed. The MD stated since there were several different strains of bacteria noted in the resident just before her death, she could not definitively say if receiving the full course of the prescribed antibiotic would have made a difference or not.

In conclusion, the Minnesota Department of Health determined neglect was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.

"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17

"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.

(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Vulnerable Adult interviewed: No, deceased.

Family/Responsible Party interviewed: Yes

Alleged Perpetrator interviewed: Yes

Action taken by facility:

No action taken.

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 651-201-4890 to receive a copy via mail or email

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.

cc:

The Office of Ombudsman for Long Term Care

The Office of Ombudsman for Mental Health and Developmental Disabilities

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30434	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 02/08/2023
NAME OF PROVIDER OR SUPPLIER SAINT ANN'S HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 330 EAST 3RD STREET DULUTH, MN 55805		
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0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING 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: #HL304343185M/HL304345170C #HL304343204M/HL304345295C On January 30, 2023 to February 8, 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 89 residents receiving services under the provider's Assisted Living license. The following correction orders are issued for HL304343185M/HL304345170C, tag identification 0620, 1760, 2310, and 3000. No correction orders are issued for #HL304343204M/HL304345295C.	0 000	Assisted Living Provider 144G. Minnesota Department of Health is documenting the State Licensing 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	

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 000	Continued From page 1	0 000	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) Compliance with requirements for reporting ma (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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to timely submit a report to the Minnesota Adult Abuse Reporting Center (MAARC) for one of one resident (R1) with a medication error. 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: The licensee failed to immediately report to the provider difficulties in obtaining a prescribed antibiotic for R1, resulting in the resident not receiving the medication as ordered to treat an	0 620		

Minnesota Department of Health

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0 620	Continued From page 2 infection. The resident was later admitted to the hospital and died of sepsis (an infection of the blood stream). The facility registered nurse/clinical nurse supervisor (CNS)-B, failed to follow up with the provider after the order was not able to be filled and failed to document actions taken by the facility after the antibiotic was not able to be given as ordered. R1's diagnoses included hypertension (high blood pressure), congestive heart failure, and type two diabetes. R1's service plan, dated November 30, 2020, indicated the resident received services including medication administration, insulin and blood sugar management, and assistance with compression stockings. R1's most recent assessment was completed remotely by registered nurse (RN)-C on August 4, 2022, after she readmitted to the facility from the hospital. The assessment indicated the resident had a history of urinary tract infections (UTI), most recently in June 2022 when she was hospitalized with a septic UTI. Hospital records indicated R1 returned to the facility after a hospitalization on August 8, 2022, with a new order for Fosfomycin tromethamine, an antibiotic to treat a UTI. R1 was admitted to the hospital after a fall and was diagnosed with a UTI during the admission. The August 8, 2022, discharge summary from the hospital indicated the resident was to have a follow up urine culture in 10 days. R1's record contained an order dated August 8, 2022, for Fosfomycin 3 grams (g), take 3 g by mouth every 72 hours for two doses for infection.	0 620			

Minnesota Department of Health

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0 620	Continued From page 3 The order indicated R1 got the first dose while in the hospital on August 7, 2022, and the next two doses were to be given August 10 and August 13, 2022. R1's August 2022 medication administration record (MAR) included the following order: Fosfomycin tromethamine 3 g, take 1 packet by mouth W [wednesday] and Sat [saturday]. The antibiotic was scheduled to be given on August 10 and August 13, 2022. Medication administration notes on the MAR indicated both doses were out of stock and not given. R1's progress notes lacked any documentation to show the resident had been hospitalized or eventually passed away at the hospital. R1's progress notes lacked documentation of the antibiotic not being filled or the provider being updated that the medication was not available. R1's record lacked evidence that a follow up urine culture was collected as ordered. R1's record contained a discharge summary completed remotely by RN-C on September 14, 2022. The discharge summary indicated the resident was deceased and had died of natural causes at the hospital. The discharge reason was listed as "on 8/29/22, [R1's] daughter came in to check on her mother after her brother called saying he thought something was wrong with [R1]. When she arrived, [R1] was rocking in here (sic) chair and acting like she had when she was hospitalized earlier this year. She called 911 to have her mother transferred to the ER where she was admitted for sepsis." Hospital records indicated that R1 was admitted to the hospital on August 25, 2022, due to sepsis	0 620			

Minnesota Department of Health

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0 620	Continued From page 4 and acute cystitis (urinary tract infection). R1's hospital admission history and physical indicated the resident arrived for evaluation of confusion, a reported 101 degree Fahrenheit fever, hyperglycemia (high blood sugar), and frequent moaning. The hospital physician wrote "The patient appears acutely ill and has possible severe sepsis...evidence of end organ damage due to severe sepsis." Hospital notes indicated the patient developed multisystem organ failure and was admitted to the intensive care unit for further management. R1 died 17 days later on September 11, 2022. R1's death record indicated she died on September 11, 2022, and the cause of death was sepsis due to corynebacterium bacteremia (a bacterial infection) and clostridium difficile (a gastrointestinal infection). Other significant conditions contributing to death but not resulting in the underlying cause was listed as candida urinary tract infection, acute kidney injury. On February 7, 2023, at 11:05 a.m., assistant director (AD)-A confirmed a MAARC report was not completed since there were no concerns noted at the time R1 died and no investigation was completed. AD-A stated given what is known about the event now, it would meet their criteria to file a MAARC report. AD-A stated the facility would have a meeting with nursing once a week to review things that had happened that week and upon reviewing her notes from August and September 2022, she did not see anything indicating there were concerns around R1's death. AD-A stated she was not aware R1 had not gotten her antibiotics as ordered and had only heard the resident died of natural causes in the hospital.	0 620			

Minnesota Department of Health

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0 620	Continued From page 5 On February 7, 2023, at 1:30 p.m., CNS-B confirmed there were gaps in documentation and stated, "I really can't give an answer as to why, other than we usually do a better job." CNS-B confirmed an investigation or root cause analysis was not completed after R1 passed away and they had not identified any concerns regarding the resident not getting the antibiotic as ordered at that time. CNS-B confirmed they had not considered filing a MAARC report. The licensee's Vulnerable Adult Maltreatment Prevention & Reporting policy, last updated August 1, 2021, indicated neglect including the failure or omission by a caregiver to supply care or services, such as food, clothing, shelter, health care, or supervision, which is not the result of an accident or therapeutic conduct and which is reasonable and is necessary to maintain the VA's physical or mental health or safety would be reported immediately and an internal investigation would be conducted. The policy listed an example of neglect as home care staff person fails to give a resident the prescribed medications or treatments as specified on the client's service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620			
01760 SS=G	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who	01760			

Minnesota Department of Health

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01760	Continued From page 6 administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure medications were administered as prescribed for one of one resident (R1) with records reviewed. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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 diagnoses included hypertension (high blood pressure), congestive heart failure, and type two diabetes. R1's service plan, dated November 30, 2020, indicated the resident received services including medication administration, insulin and blood sugar management, and assistance with compression stockings.	01760			

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01760	Continued From page 7 R1's most recent assessment was completed remotely by registered nurse (RN)-C on August 4, 2022, after she readmitted to the facility. The assessment indicated the resident had a history of urinary tract infections (UTI), most recently in June 2022 when she was hospitalized with a septic UTI. Hospital records indicated R1 returned to the facility after a hospitalization on August 8, 2022, with a new order for Fosfomycin tromethamine, an antibiotic to treat a UTI. R1 was admitted to the hospital after a fall and was diagnosed with a UTI during the admission. R1's record did not contain any documentation regarding the resident's August 6 through August 8, 2022 hospitalization. R1's progress notes contained the following entries: -August 8, 2022, at 4:03 p.m. RN-C wrote received the following orders from [hospital physician] fosfomycin 3 gram packet, take one packet W (Wednesday) and Sa (Saturday) for UTI (urinary tract infection). -August 8, 2022, at 4:31 p.m., CNS-B wrote "...started on an antibiotic Fosfomycin 3 gms every three days for a total of 3 doses..." R1's record contained an order dated August 8, 2022, for Fosfomycin 3 grams (g), take 3 g by mouth every 72 hours for two doses for infection. The order indicated R1 received the first dose while in the hospital on August 7, 2022, and the next two doses were to be given August 10 and August 13, 2022. R1's August 2022 medication administration	01760			

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01760	Continued From page 8 record (MAR) included the following order: Fosfomycin tromethamine 3 g, take 1 packet by mouth W and Sat The antibiotic was scheduled in the MAR to be given on August 10 and August 13, 2022. Medication administration notes on the MAR indicated both doses were out of stock and not given. R1's record lacked documentation of the antibiotic not being filled or the provider being updated of the medication not being available. Hospital records indicated that R1 was admitted to the hospital on August 25, 2022, due to sepsis (an infection of the blood stream) and acute cystitis (urinary tract infection). R1's hospital admission history and physical indicated the resident arrived for evaluation of confusion, a reported 101 degree Farenheit fever, hyperglycemia (high blood sugar), and frequent moaning. The hospital physician wrote "The patient appears acutely ill and has possible severe sepsis...evidence of end organ damage due to severe sepsis." Hospital notes indicated the patient developed multisystem organ failure and was admitted to the intensive care unit for further management. R1 died 17 days later on September 11, 2022. R1's record contained a discharge summary completed remotely by RN-C on September 14, 2022. The discharge summary indicated the resident was deceased and had died of natural causes at the hospital. The discharge reason was listed as "on 8/29/22, [R1's] daughter came in to check on her mother after her brother called saying he thought something was wrong with [R1]. When she arrived, [R1] was rocking in here	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30434	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 02/08/2023
NAME OF PROVIDER OR SUPPLIER SAINT ANN'S HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 330 EAST 3RD STREET DULUTH, MN 55805		
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01760	Continued From page 9 (sic) chair and acting like she had when she was hospitalized earlier this year. She called 911 to have her mother transferred to the ER where she was admitted for sepsis." R1's death record indicated she died on September 11, 2022, and the cause of death was sepsis due to corynebacterium bacteremia (a bacterial infection) and clostridium difficile (a gastrointestinal infection). Other significant conditions contributing to death but not resulting in the underlying cause was listed as candida urinary tract infection and acute kidney injury. On February 2, 2023, at 1:15 p.m, clinical nurse supervisor (CNS)-B stated she could not recall exactly what the circumstances of R1's admission to the hospital were as "she (the resident) has been gone for so long." CNS-B stated around the time R1 got the antibiotic order and was later admitted to the hospital in August 2022, "I was working at the time, very short handed, I was the only RN in the building." CNS-B stated she was not sure if the provider had been updated about the delay in starting the antibiotic. On February 2, 2023, at 1:45 p.m., RN-C stated she did not work in the facility, completed all her assessments remotely, and relied on information from staff and her past knowledge of residents to complete her assessments. RN-C stated it would be the responsibility of the nurse at the facility to ensure the antibiotic was filled and given since she was not onsite. RN-C stated she had entered the order in the MAR and assumed it had been given as ordered. On February 6, 2023, at 9:15 a.m., unlicensed personnel (ULP)-I stated she had worked with R1 the week she was admitted the the hospital but	01760			

Minnesota Department of Health

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01760	Continued From page 10 could not recall any changes or concerns with the resident or issues with her medications. On February 6, 2023, at 10:20 a.m., ULP-H stated she probably did work with the resident before she was hospitalized but she didn't recognize her name or remember any changes with the resident or issues with her medications. On February 7, 2023, at 9:40 a.m., ULP-L stated she had noticed the resident wasn't her normal self after returning from her most recent hospitalization but had been doing ok after getting some extra help and services. ULP-L was not sure if she had received her antibiotics. On February 7, 2023, at 11:35 a.m., health unit coordinator (HUC)-J stated R1 had returned from the hospital on August 4, 2022, with a new order for an antibiotic. HUC-J stated R1 got one dose in the hospital and the facility was to give the two remaining doses. HUC-J stated she was responsible for ordering the medication and when she tried to fill it, the pharmacy said insurance wouldn't cover it and they would need a prior authorization from the doctor before they could release it. HUC-J stated it took a couple of days for the pharmacy to get the necessary authorizations back from the doctor. HUC-J stated she notified CNS-B about the trouble filling the medication and that they were not able to get it as expected. HUC-J stated the nurse would be the one responsible for updating the doctor on the medication not being able to get filled and that would not be within her scope of job duties to do so. HUC-J stated she personally picked up the antibiotics on August 17, 2022, and she witnessed the resident receive one dose but was not sure about the second dose. HUC-J confirmed nothing was put in the MAR and there	01760			

Minnesota Department of Health

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01760	Continued From page 11 was no documentation to show the resident received the antibiotics. HUC-J stated she was not sure how staff knew when or how to give the medication but it was on the cart and there were directions on the box. On February 7, 2023, at 1:30 p.m., CNS-B confirmed there were gaps in documentation and stated, "I really can't give an answer as to why, other than we usually do a better job." CNS-B confirmed an investigation or root cause analysis was not completed after R1 passed away and they had not identified any concerns regarding the resident getting the antibiotic as ordered at that time. CNS-B stated they haven't been doing root cause analyses "with everything the way its been, we were COVID central for a long time, our staffing and census has been an issue, I was the only nurse in the facility for over a year and a half...we don't do a root cause analysis like in the hospital, we have our weekly administrative meeting every Monday to talk about things and then do more of a root cause discussion at our nursing meeting. I don't recall exactly what was discussed but I probably would have reported R1 was in the hospital and had sepsis but we aren't in the habit of doing what you consider a root cause. It would be nice to do that but we just haven't had the wherewithal to do it. CNS-B stated that "in hindsight, I have some concerns. I wish we all would have done a better job with documentation to see what went on there, there were gaps." CNS-B stated at the time, she didn't consider it a medication error. On February 9, 2023, at 11:30 a.m., CNS-B stated she had just followed up with the pharmacy to try find out why they didn't get the antibiotic right away. CNS-B stated the pharmacy told her they had the medication ready to pick up	01760			

Minnesota Department of Health

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01760	Continued From page 12 on August 10, 2022, but they were not notified as the pharmacy doesn't have an automated system to tell people when medications are ready for pickup. CNS-B confirmed she did not follow up with the pharmacy because she thought they were still working on prior authorizations and she would get updated by the pharmacy when it was ready. CNS-B confirmed a follow up urine culture was not completed. CNS-B stated generally when a resident returns from the hospital, discharge orders are sent back with the resident and they rely on the resident providing them with all the paperwork. CNS-B stated that while they had a page of the discharge orders that contained the order for the antibiotic, she does not recall seeing the order for a follow up urine culture that was on the prior page. CNS-B stated that "generally if we see this is page 3 of 17, we would have contacted the hospital for more information and usually we send it all to [RN-C] so it's curious to me why we didn't send the whole thing to [RN-C] so I am guessing we didn't have it. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by:	02310			

Minnesota Department of Health

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02310	Continued From page 13 Based on interview and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards, for one of one resident (R1) with a medication error. In addition, the facility failed to follow up on a urine culture as ordered. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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 diagnoses included hypertension (high blood pressure), congestive heart failure, and type two diabetes. R1's service plan, dated November 30, 2020, indicated the resident received services including medication administration, insulin and blood sugar management, and assistance with compression stockings. R1's most recent assessment was completed remotely by registered nurse (RN)-C on August 4, 2022, after she readmitted to the facility. The assessment indicated the resident had a history of urinary tract infections (UTI), most recently in June 2022, when she was hospitalized with a septic UTI. Hospital records indicated R1 returned to the facility after a hospitalization on August 8, 2022, with a new order for Fosfomycin tromethamine,	02310		

Minnesota Department of Health

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02310	Continued From page 14 an antibiotic to treat a UTI. R1 was admitted to the hospital after a fall and was diagnosed with a UTI during the admission. The August 8, 2022, discharge summary from the hospital indicated the resident was to have a follow up urine culture in 10 days. R1's record did not contain any documentation regarding the resident's August 6 through August 8, 2022 hospitalization. The nurse failed to reassess R1 after returning from the hospital on August 8, 2022. R1's progress notes contained the following entries: -August 8, 2022, at 4:03 p.m. RN-C wrote received the following orders from [hospital physician] fosfomycin 3 gram packet, take one packet W (Wednesday) and Sa (Saturday) for UTI (urinary tract infection). -August 8, 2022, at 4:31 p.m., CNS-B wrote "...started on an antibiotic Fosphomycin 3 gms every three days for a total of 3 doses..." R1's record contained an order dated August 8, 2022, for Fosfomycin 3 grams (g), take 3 g by mouth every 72 hours for two doses for infection. The order indicated R1 got the first dose while in the hospital on August 7, 2022 and the next two doses were to be given August 10 and August 13, 2022. R1's August 2022 medication administration record (MAR) included the following order: Fosfomycin tromethamine 3 g, take 1 packet by mouth W [Wednesday] and Sat [Saturday] The antibiotic was scheduled in the MAR to be given on August 10 and August 13, 2022.	02310			

Minnesota Department of Health

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02310	Continued From page 15 Medication administration notes on the MAR indicated both doses were out of stock and not given. R1's record lacked documentation of the antibiotic not being filled or the provider being updated of the medication not being available. R1's record lacked evidence a follow up urine culture was collected as ordered. Hospital records indicated that R1 was admitted to the hospital on August 25, 2022, due to sepsis (an infection of the blood stream) and acute cystitis (urinary tract infection). R1's hospital admission history and physical indicated the resident arrived for evaluation of confusion, a reported 101 degree Farenheit fever, hyperglycemia (high blood sugar), and frequent moaning. The hospital physician wrote "The patient appears acutely ill and has possible severe sepsis...evidence of end organ damage due to severe sepsis." Hospital notes indicated the patient developed multisystem organ failure and was admitted to the intensive care unit for further management. R1 died 17 days later on September 11, 2022. R1's record contained a discharge summary completed remotely by RN-C on September 14, 2022. The discharge summary indicated the resident was deceased and had died of natural causes at the hospital. The discharge reason was listed as "on 8/29/22, [R1's] daughter came in to check on her mother after her brother called saying he thought something was wrong with [R1]. When she arrived, [R1] was rocking in here (sic) chair and acting like she had when she was hospitalized earlier this year. She called 911 to have her mother transferred to the ER where she was admitted for sepsis."	02310			

Minnesota Department of Health

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02310	Continued From page 16 R1's death record indicated she died on September 11, 2022, and the cause of death was sepsis due to corynebacterium bacteremia (a bacterial infection) and clostridium difficile (a gastrointestinal infection). Other significant conditions contributing to death but not resulting in the underlying cause was listed as candida urinary tract infection and acute kidney injury. On February 2, 2023, at 12:20 p.m., family member (FM)-E stated on the night R1 went to the hospital, her brother had called R1 and was concerned about how she sounded on the phone. FM-E stated she called the facility and asked if someone could go check on her and when she didn't hear anything back, she went to the facility. FM-E stated she ran in to an unlicensed personnel (ULP) in the hallway who worked with R1 and asked her how R1 was doing. FM-E stated the ULP replied by saying "I'm busy and [R1] doesn't want to go to the hospital." FM-E stated when she got to R1's room, she noticed she was rocking back and forth and moaning. FM-E stated she went back down to the front desk and called the ambulance. FM-E stated she was not sure if the nurse had been made aware of anything that night but she felt like if she hadn't come in, R1 would not have been sent in to the hospital. FM-E stated she never got any calls or communication to say her antibiotic was not started right away and was not updated on any changes in condition. FM-E stated, "I never got a call, no one called me, I don't know if she was like that all day, I just don't know. I was not happy with the fact I had to go and call 911...I don't know if she'd be stuck all night like that, the ULP said she doesn't want to go to the ER but she's also not hard to persuade."	02310			

Minnesota Department of Health

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02310	Continued From page 17 On February 2, 2023, at 1:15 p.m, clinical nurse supervisor (CNS)-B stated she could not recall exactly what the circumstances of R1's admission to the hospital were as "she (the resident) has been gone for so long." CNS-B stated around the time R1 got the antibiotic order and was later admitted to the hospital in August 2022, "I was working at the time very short handed, I was the only RN in the building." CNS-B stated she was not sure if the provider had been updated about the delay in starting the antibiotic. On February 2, 2023, at 1:45 p.m., RN-C stated she did not work in the facility and completed all her assessments remotely and relied on information from staff and her past knowledge of residents to complete her assessments. RN-C stated it would be the responsibility of the nurse at the facility to ensure the antibiotic was filled and given since she was not onsite. RN-C stated she had entered the order in the MAR and and assumed it had been given as ordered. On February 6, 2023, at 9:15 a.m., ULP-I stated she had worked with R1 the week she was admitted the the hospital but could not recall any changes or concerns with the resident or issues with her medications. On February 6, 2023, at 10:20 a.m., ULP-H stated she probably did work with the resident before she was hospitalized but she didn't recognize her name or remember any changes with the resident or issues with her medications. On February 7, 2023, at 9:40 a.m., ULP-L stated she had noticed the resident wasn't her normal self after returning from her most recent hospitalization but had been doing ok after getting some extra help and services. ULP-L was not	02310			

Minnesota Department of Health

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02310	Continued From page 18 sure if she had received her antibiotics. On February 7, 2023, at 11:35 a.m., health unit coordinator (HUC)-J stated R1 had returned from the hospital on August 4, 2022, with a new order for an antibiotic. HUC-J stated R1 got one dose in the hospital and the facility was to give the two remaining doses. HUC-J stated she was responsible for ordering the medication and when she tried to fill it, the pharmacy said insurance wouldn't cover it and they would need a prior authorization from the doctor before they could release it. HUC-J stated it took a couple of days for the pharmacy to get the necessary authorizations back from the doctor. HUC-J stated she notified CNS-B about the trouble filling the medication and that they were not able to get it as expected. HUC-J stated the nurse would be the one responsible for updating the doctor on the medication not being able to get filled and that would not be within her scope of job duties to do so. HUC-J stated she personally picked up the antibiotics on August 17, 2022, and she witnessed the resident receive one dose but was not sure about the second dose. HUC-J confirmed nothing was put in the MAR and there was no documentation to show the resident got the antibiotics. HUC-J stated she was not sure how staff knew when or how to give the medication but it was on the cart and there were directions on the box. On February 7, 2023, at 1:30 p.m., CNS-B confirmed there were gaps in documentation and stated, "I really can't give an answer as to why, other than we usually do a better job." CNS-B confirmed an investigation or root cause analysis was not completed after R1 passed away and they had not identified any concerns regarding the resident getting the antibiotic as ordered at	02310			

Minnesota Department of Health

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02310	Continued From page 19 that time. CNS-B stated they haven't been doing root cause analyses "with everything the way its been, we were COVID central for a long time, our staffing and census has been an issue, I was the only nurse in the facility for over a year and a half...we don't do a root cause analysis like in the hospital, we have our weekly administrative meeting every Monday to talk about things and then do more of a root cause discussion at our nursing meeting. I don't recall exactly what was discussed but I probably would have reported R1 was in the hospital and had sepsis but we aren't in the habit of doing what you consider a root cause. It would be nice to do that but we just haven't had the wherewithal to do it. CNS-B stated that "in hindsight, I have some concerns. I wish we all would have done a better job with documentation to see what went on there, there were gaps." On February 9, 2023, at 11:30 a.m., CNS-B stated she had just followed up with the pharmacy to try find out why they didn't get the antibiotic right away. CNS-B stated the pharmacy told her they had the medication ready to pick up on August 10, 2022, but they were not notified, as the pharmacy doesn't have an automated system to tell people when medications are ready for pickup. CNS-B confirmed she did not follow up with the pharmacy because she thought they were still working on prior authorizations and she would get updated by the pharmacy when it was ready. CNS-B confirmed a follow up urine culture was not completed. CNS-B stated generally when a resident returns from the hospital, discharge orders are sent back with the resident and they rely on the resident providing them with all the paperwork. CNS-B stated that while they had a page of the discharge orders that contained the order for the antibiotic, she does not recall seeing	02310			

Minnesota Department of Health

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02310	Continued From page 20 the order for a follow up urine culture that was on the prior page. CNS-B stated that "generally if we see this is page 3 of 17, we would have contacted the hospital for more information and usually we send it all to [RN-C] so it's curious to me why we didn't send the whole thing to [RN-C] so I am guessing we didn't have it. On February 10, 2023, at 4:25 p.m., medical doctor (MD)-K stated she saw the resident in person on August 9, 2022, the day after she returned from the hospital. MD-K stated the resident was transitioning to be a patient under her care team but had not yet formally established care with them. MD-K stated she had assumed the resident completed her antibiotic and that's the assumption she got from staff as well. MD-K stated she would have expected the facility to contact the care team if there were issues with obtaining the antibiotics or if she didn't get them as prescribed. MD-K could not locate any notes in the resident's records indicating they were notified of the inability to obtain the antibiotics or that they were unable to collect the urine culture as ordered. MD-K stated it would be difficult to know if the antibiotic dose the resident did get was effective since there was no follow up culture completed. MD-K stated since there were several different strains of bacteria noted in the resident just before her death, she could not definitively say if receiving the full course of the prescribed antibiotic would have made a difference or not. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

Minnesota Department of Health

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03000	Continued From page 21	03000			
03000 SS=D	626.557 Subd. 3 Timing of report (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. (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	03000			

Minnesota Department of Health

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03000	Continued From page 22 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 record review, the licensee failed to timely submit a report to the Minnesota Adult Abuse Reporting Center (MAARC) for one of one resident (R1) with a medication error. 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: The licensee failed to immediately report to the provider difficulties in obtaining a prescribed antibiotic for R1, resulting in the resident not receiving the medication as ordered to treat an infection. The resident was later admitted to the hospital and died of sepsis (an infection of the blood stream). The facility registered nurse, clinical nurse supervisor (CNS)-B, failed to follow	03000			

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03000	Continued From page 23 up with the provider after the order was not able to be filled and failed to document actions taken by the facility after the antibiotic was not able to be given as ordered. R1's diagnoses included hypertension (high blood pressure), congestive heart failure, and type two diabetes. R1's service plan, dated November 30, 2020, indicated the resident received services including medication administration, insulin and blood sugar management, and assistance with compression stockings. R1's most recent assessment was completed remotely by registered nurse (RN)-C on August 4, 2022, after she readmitted to the facility from the hospital. The assessment indicated the resident had a history of urinary tract infections (UTI), most recently in June 2022, when she was hospitalized with a septic UTI. Hospital records indicated R1 returned to the facility after a hospitalization on August 8, 2022, with a new order for Fosfomycin tromethamine, an antibiotic to treat a UTI. R1 was admitted to the hospital after a fall and was diagnosed with a UTI during the admission. The August 8, 2022, discharge summary from the hospital indicated the resident was to have a follow up urine culture in 10 days. R1's record contained an order dated August 8, 2022, for Fosfomycin 3 grams (g), take 3 g by mouth every 72 hours for two doses for infection. The order indicated R1 got the first dose while in the hospital on August 7, 2022 and the next two doses were to be given August 10 and August 13, 2022.	03000			

Minnesota Department of Health

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03000	Continued From page 24 R1's August 2022 medication administration record (MAR) included the following order: Fosfomycin tromethamine 3 g, take 1 packet by mouth W [Wednesday] and Sat [Saturday]. The antibiotic was scheduled to be given on August 10 and August 13, 2022. Medication administration notes on the MAR indicated both doses were out of stock and not given. R1's progress notes lacked any documentation to show the resident had been hospitalized or eventually passed away at the hospital. R1's progress notes lacked documentation of the antibiotic not being filled or the provider being updated the medication was not available. R1's record lacked evidence a follow up urine culture was collected as ordered. R1's record contained a discharge summary completed remotely by RN-C on September 14, 2022. The discharge summary indicated the resident was deceased and had died of natural causes at the hospital. The discharge reason was listed as "on 8/29/22, [R1's] daughter came in to check on her mother after her brother called saying he thought something was wrong with [R1]. When she arrived, [R1] was rocking in here (sic) chair and acting like she had when she was hospitalized earlier this year. She called 911 to have her mother transferred to the ER where she was admitted for sepsis." Hospital records indicate R1 was admitted to the hospital on August 25, 2022, due to sepsis and acute cystitis (urinary tract infection). R1's hospital admission history and physical indicated the resident arrived for evaluation of confusion, a reported 101 degree Fahrenheit fever,	03000			

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03000	Continued From page 25 hyperglycemia (high blood sugar), and frequent moaning. The hospital physician wrote "The patient appears acutely ill and has possible severe sepsis...evidence of end organ damage due to severe sepsis." Hospital notes indicated the patient developed multisystem organ failure and was admitted to the intensive care unit for further management. R1 died 17 days later on September 11, 2022. R1's death record indicated she died on September 11, 2022, and the cause of death was sepsis due to corynebacterium bacteremia (a bacterial infection) and clostridium difficile (a gastrointestinal infection). Other significant conditions contributing to death but not resulting in the underlying cause was listed as candida urinary tract infection, acute kidney injury. On February 7, 2023 at 11:05 a.m., assistant director (AD)-A confirmed a MAARC report was not completed since there were no concerns noted at the time R1 died and no investigation was completed. AD-A stated given what is known about the event now, it would meet their criteria to file a MAARC report. AD-A stated the facility would have a meeting with nursing once a week to review things that had happened that week and upon reviewing her notes from August and September 2022, she did not see anything indicating there were concerns around R1's death. AD-A stated she was not aware R1 had not gotten her antibiotics as ordered and had only heard the resident died of natural causes in the hospital. On February 7, 2023, at 1:30 p.m., CNS-B confirmed there were gaps in documentation and stated, "I really can't give an answer as to why, other than we usually do a better job." CNS-B	03000			

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03000	Continued From page 26 confirmed an investigation or root cause analysis was not completed after R1 passed away and they had not identified any concerns regarding the resident getting the antibiotic as ordered at that time. CNS-B confirmed they had not considered filing a MAARC report. The licensee's Vulnerable Adult Maltreatment Prevention & Reporting policy, last updated August 1, 2021, indicated neglect including the failure or omission by a caregiver to supply care or services, such as food, clothing, shelter, health care, or supervision, which is not the result of an accident or therapeutic conduct and which is reasonable and is necessary to maintain the VA's physical or mental health or safety would be reported immediately and an internal investigation would be conducted. The policy listed an example of neglect as home care staff person fails to give a resident the prescribed medications or treatments as specified on the client's service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	03000			