Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306296502M
Compliance #: HL306299741C

Date Concluded: December 9, 4024

Name, Address, and County of Licensee Investigated:
Walker Methodist
1 Thompson Ave
West St Paul MN 55118
Dakota County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:
Maggie Regnier
Special Investigator
Paul Spencer
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 it did not ensure her medications were administered according to medical provider orders.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. While two medications errors did occur, the facility continued to monitor the resident and when she had a change in her mental status, medical care was sought appropriately. One medication error was due to an error by an individual while the other was due to miscommunication between the medical provider, the pharmacy, and the facility. The possibility of a third medication error was raised but the investigation did not find evidence this occurred.

The investigator conducted interviews with facility staff members, including administrative staff, and nursing staff. The investigator contacted family member and the pharmacy. The investigation included review of facility records, resident records, pharmacy records, training records and facility policies. Also, the investigator observed staff interactions with other staff, residents and visitors.

The resident resided in an assisted living facility. The resident's diagnoses included brain cancer, stroke with right sided weakness, epilepsy, and generalized weakness. The resident's service plan included assistance with medication management, meals, mobility and grooming. The resident's assessment indicated the resident had a history of seizures.

The resident was hospitalized and about the same time the concern for potential medication errors arose. The three medications concerned included Aricept (a drug to treat Alzheimer's disease), Baclofen (a muscle relaxant), and phenytoin (an anti-seizure medication). While mediation errors did occur regarding Aricept and Baclofen, the investigation found no evidence of a medication error with phenytoin.

Aricept

An internal investigation indicated the resident's physician ordered Aricept. The order was written as give 5 milligram (mg) for 30 days, then increase to 10 mg. These orders were sent to the pharmacy by the physician's office.

The internal investigation document indicated the pharmacist on duty called the physician to clarify the order but no documentation whether pharmacist heard back from the office. The pharmacist pushed the order through the electronic medication administration record (EMAR) as take one 10mg tablet at bedtime with one 5mg tablet to equal 15 mg taken at bedtime.

The internal investigation indicated the facility nurse approved the medication order as entered by the pharmacist, without having the original order to compare it to which led to a medication error.

The resident's medication administration record shows the resident received this incorrect dose for 14 days.

The residents progress notes indicated on the 15th day of wrong dose of medication, the resident was seen by her neurologist who identified the wrong dose and called to pharmacy and facility to make them aware and correct the dose.

The resident's EMAR and progress notes indicated this medication error was identified and corrected on the 8th day of the month prior to the resident's hospitalization on the 11th.

Baclofen

The resident's EMAR indicated the resident initially had an order for Baclofen 15 mg three times a day. However, the medical provider wrote an additional order on the 8th day wrote for Baclofen 20 mg but did not discontinue the previous order.

The EMAR indicated the resident continued to receive Baclofen 15 mg three times a day. However, the EMAR also indicated the resident was to receive an additional Baclofen 20 mg three times a day, which was not administered every time it appeared in the EMAR.

The EMAR showed the resident received Baclofen 35 mg on four occasions: the evening of the 9th, the morning and evening of the 10th, and the morning of the 11th. For the afternoon dose on each of those days the resident received Baclofen 15 mg.

However, during the 11th the EMAR indicated the Baclofen order was clarified and changed to Baclofen 20 mg three times day, which was what the facility administered that evening at 8:15.

The internal investigation indicated the pharmacy had two active orders for Baclofen which totaled 35 mg three times a day [15 mg + 20 mg three times a day] because the medical provider had not discontinued the previous order. The same document indicated the medical provider's clinic said it did not discontinue the previous order because it had not been ordered by them. The internal investigation also indicated the nurse verified the EMAR as entered by the pharmacy matched the medical provider's orders and approved the orders.

Phenytoin

Initially, the resident's facility medical record indicated the resident had phenytoin ordered 100 mg every morning and phenytoin 200 mg every bedtime.

On the 9th day of the month the progress notes indicated the medical provider changed the order to 400 mg daily at bedtime. However, that same morning the facility clarified with the medical provider that the resident had already received the phenytoin 100 mg that morning. As a result, the medical provider gave a onetime order for phenytoin 300 mg that night at bedtime and to start phenytoin 400 mg at bedtime the next day.

The resident's EMAR indicated the facility administered the resident's phenytoin according to the medical provider's orders without the occurrence of a medication error or a missed dose through to the resident's hospitalization on the 11th.

Hospitalization

On the 11th the facility progress notes indicated the resident had a change in status at approximately 8:30 pm which included slowness to respond and emesis. The resident's caregivers contacted the on-call nurse who directed them to contact 911 and the resident was transported to the hospital. The same note indicated that prior to the resident's change she had been able to eat dinner and had taken her evening medications [which was consistent with the EMAR].

The hospital records indicated the resident admitted to with a diagnosis of encephalopathy [any brain disorder which affects brain function] and weakness. The hospital records indicated the resident missed a phenytoin dose prior to admission and missed a dose after admission to the hospital [however a review of the facility document indicated the resident did receive her prescribed phenytoin]. The same documents indicated medication adjustments and medication errors involving baclofen and Aricept were “further possible contributors” to “AMS” [altered mental status].

The hospital records indicated the resident discharged to a nursing home for transitional care after spending several days in the hospital.

Interviews

During an interview, a manager stated the process for medication reconciliation is that the pharmacy does the 1st medication order check, and the facility nurse does the 2nd check of the EMAR. The manager acknowledged the facility process to ensure correct medication orders was not followed and a medication error occurred regarding the Aricept. The manager stated at the time this occurred the facility was changing pharmacies and there were some difficulties with that transition.

During an interview, a pharmacist stated the Baclofen order should have triggered as a duplicate order and the pharmacist should have looked into it. The pharmacist working on it should have called the medical provider or the facility. Regarding Aricept, the pharmacist stated the records showed the pharmacist called the medical provider to clarify the order but did not document any follow-up. The pharmacist stated that since then they had identified that there was a start date included on the order in small print, so the information was there, but the pharmacist missed it. The pharmacist stated the employee who was involved is no longer working at the pharmacy.

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.
(d) For purposes of this section, a vulnerable adult is not neglected for the sole reason that:

(4) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult which does not result in injury or harm which reasonably requires medical or mental health care; or

(5) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult that results in injury or harm, which reasonably requires the care of a physician, and:
(i) the necessary care is provided in a timely fashion as dictated by the condition of the vulnerable adult;
(ii) if after receiving care, the health status of the vulnerable adult can be reasonably expected, as determined by the attending physician, to be restored to the vulnerable adult's preexisting condition;
(iii) the error is not part of a pattern of errors by the individual;
(iv) if in a facility, the error is immediately reported as required under section 626.557, and recorded internally in the facility;
(v) if in a facility, the facility identifies and takes corrective action and implements measures designed to reduce the risk of further occurrence of this error and similar errors; and
(vi) if in a facility, the actions required under items (iv) and (v) are sufficiently documented for review and evaluation by the facility and any applicable licensing, certification, and ombudsman agency.

Vulnerable Adult interviewed: No, not able to communicate reliably
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility conducted an internal investigation, communicated with the pharmacy involved in the errors, and provided re-education regarding processing medication orders to avoid errors.

Action taken by the Minnesota Department of Health:
No further action 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
	30629	A. BUILDING: _____ B. WING _____	C 11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER METHODIST WESTWOOD I	1 THOMPSON AVENUE WEST WEST SAINT PAUL, MN 55118

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** INITIAL COMMENTS: #HL306299741C/#HL306296502M On November 7, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL306299741C/#HL306296502M. No correction orders are issued.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	