DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL322164821M
Compliance #: HL322166291C

Date Concluded: November 27, 2024

Name, Address, and County of Licensee Investigated:
Walker Methodist Plaza Gardens
100 Monroe Street
Anoka, MN 55303
Anoka County

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

Evaluator's Name: Danyell Eccleston, RN
Special Investigator

Finding: Substantiated, facility responsibility

Nature of Investigation:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
The facility neglected the resident when the facility failed to administer blood thinner medication as prescribed. Approximately two weeks later the resident experienced a medical emergency and died.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to ensure the residents Eliquis (blood thinner used to prevent blood clots) was administered as ordered. The resident was experiencing throat pain and coughing up blood for approximately seven days prior to the resident's death at the facility. The resident's death record indicated the cause of death was pulmonary embolism.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a provider that cared for

the resident. The investigation included review of the resident's medical records, death record, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed staff administering resident medications.

The resident resided in an assisted living facility. The resident's diagnoses included blood clots of the lungs, chronic nerve cell break down disorder, and falls. The resident's service plan included assistance with medication management and safety checks. The resident's assessment indicated the resident had difficulty with communication and required patience with staff to allow slow, clear conversation and make needs known.

Review of the medication administration record indicated the resident was prescribed Eliquis twice per day. Per documentation during the time in question, the resident missed ten doses of blood thinner medication due to the medication not being available and awaiting medication delivery.

Written correspondence with facility leadership indicated four doses of blood thinner were documented in the resident's medication administration record as given after staff documented the resident had no Eliquis to administer and prior to when a new supply of Eliquis was available at the facility. Facility leadership could not confirm or deny if the four doses of Eliquis were administered or documented incorrectly.

Review of progress notes indicated a nurse attempted to reorder the residents Eliquis from the pharmacy five days after the Eliquis was first noted as not available.

Additional progress notes indicated eleven days later the resident began to experience throat pain and coughing up blood. Two additional days later, the resident had a medical event and died at the facility.

Review of emergency room records indicated seven days before the resident died, she went to the hospital due to chest pain and was checked for heart related issues. Emergency room notes also indicated the resident had a sore throat, difficulty swallowing, and fatigue. Notes indicated due to Huntington's disease; the resident's speech was somewhat difficult to interpret. Chest X-rays, lab tests, and heart rhythm check were completed, and the resident was discharged back to the facility later that day.

The Emergency room records contained no information related to the residents missed Eliquis.

The resident's facility medical record contained no information regarding the resident being sent to the emergency room.

During interview, a nurse stated she was on vacation when the facility transitioned pharmacy providers. The nurse stated when she returned to work and reviewed medication administration reports, many residents' medications were missed due to medication supply not being available. The nurse stated the resident missed ten doses of Eliquis over a five-day period. The nurse reordered the resident's medications and communicated the issue to leadership.

During interview, a leadership member stated while on the elevator, a nurse informed her a staff member called for assistance because the resident reported throat pain and blood was coming out of the resident's mouth. The leadership member stated she and the nurse went to the resident. The resident was slumped forward in her wheelchair and a pool of blood was on the floor. The resident was transferred to her bed, and 911 was called. The resident was deceased when paramedics arrived.

During interview, another nurse stated the day of the resident's medical event the resident could not stop vomiting brown colored liquid. The resident lost consciousness and died.

During interview, a medical provider indicated the resident was prescribed Eliquis due to a history of blood clots to the lungs.

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

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

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, resident is deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
Facility conducted an internal investigation of the incident and updated policies and procedures.

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 651-201-4200 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
Anoka County Attorney
Anoka City Attorney
Anoka Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32216	A. BUILDING: _____ B. WING _____	R-C 02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER METHODIST PLAZA GARDENS	**100 MONROE STREET ANOKA, MN 55303**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments On February 6, 2025, the Minnesota Department of Health conducted a licensing order follow-up related to correction orders issued for complaint #HL322166291C/#HL322164821M and #HL322167391C. Walker Methodist Plaza Gardens was found to be in compliance with state regulations.	{0 000}	No further action required.	