



Protecting, Maintaining and Improving the Health of Minnesotans

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility:

Crest View Lutheran Home
4444 Reservoir Blvd NE
Columbia Heights, MN 55421
Anoka County

Report #: H5018098

Date: September 23, 2013

Date of Visit: August 2, 2013
Time of Visit: 10:30 a.m.

By: Deborah Neuberger, R.N., Special Investigator

- Type of Facility:**
- Nursing Home
 - SLF
 - Hospital
 - HHA
 - ICF/IID
 - Other: _____
 - Home Care Provider/Assisted Living
 - Home Care

- Facility Self Report
- Complaint

Allegation(s): It is alleged that a neglect of care occurred when a resident did not receive antipsychotic medication for one month causing hallucinations and suicidal thoughts.

An unannounced visit was made at this facility and an investigation was conducted under:

- Federal Regulations for Hospital Conditions of Participation (42 CFR, Part 482)
- Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
- Federal Regulations for ICF/IID (42 CFR Part 483, subpart I)
- Federal Regulations for HHA (Home Health Agencies) (42 CFR, Part 484)
- Federal Regulations for CAH (Critical Access Hospital) (42 CFR, Part 485)
- Federal Regulations for EMTALA (42 CFR Part 489)
- State Licensing Rules for Boarding Care Homes (MN Rules Chapter 4655)
- State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)
- State Licensing Rules for Supervised Living Facilities (MN Rules Chapter 4665)
- State Licensing Rules for Home Care (MN Rules Chapter 4668)

- State Statutes for Maltreatment of Minors (MN Statutes, section 626.556)
- State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
- State Statutes Chapters 144 and 144A

Conclusion:

Minnesota Vulnerable Adults Act (MN 626.557)

Under the Minnesota Vulnerable Adults Act (MN. 626.557):

Abuse Neglect Financial Exploitation was:

Substantiated Not Substantiated Inconclusive based on the following information:

Based on a preponderance of evidence neglect occurred when a significant medication error occurred and continued for a period of approximately 3 weeks. After the initiation of the electronic medication administration record (MAR), the resident's ordered antipsychotic was omitted from the electronic MAR. A pattern of medication errors developed when several staff members failed to give the resident the ordered antipsychotic medication. The resident developed suicidal thoughts while off the antipsychotic medication.

The resident was a long time resident of the facility with diagnoses that included schizophrenia and anxiety. The resident's medications included long term use of the antipsychotic medication Risperidone. The resident experienced periods of anxiety, often related to his/her physical condition, but was not known to experience suicidal thoughts.

The facility initiated an electronic medication administration record (MAR). During the process of initiating the electronic system, the resident records were entered by the pharmacy according to pharmacy records. After the pharmacy records were entered facility nursing staff checked each resident's MAR in an effort to eliminate the possibility of errors. Although this process took place, the resident's antipsychotic medication, Risperidone, did not get placed on the new electronic MAR and the resident did not receive regularly scheduled antipsychotic medication for a period of 3 weeks. During this time the resident's family observed a decline in condition evidenced by verbalizations of suicidal thoughts. When the family alerted the facility to the declining condition, the family and facility staff identified the medication error. Facility staff contacted the resident's Nurse Practitioner (NP), who restarted the medication. The resident was placed on increased monitoring. The resident was responding to the medication but later died at the facility.

The resident's family member was interviewed and stated s/he spoke with the resident on the phone and noticed the resident was experiencing suicidal thoughts. The family member called the facility to discuss how much antipsychotic the resident was on and realized the resident had not been getting any antipsychotic medication, although one was ordered for him. Another family member was interviewed and stated the resident had expressed suicidal thoughts to him/her and it alarmed him/her so s/he notified facility staff of the concern.

The resident's NP stated the facility notified him/her of the transcription error and s/he initiated the antipsychotic immediately. The NP stated s/he evaluated the resident and found the resident mildly distressed, articulating suicidal thoughts, but without a plan. The NP stated s/he monitored the resident and the resident was responding to the medication change and the resident's suicide ideation was resolving after the medication was restarted. The NP stated the facility asked him/her to review all resident medication orders as soon as

possible to ensure accurate medication administration. S/he found other minor errors which were resolved. The NP stated s/he did not believe the resident's death was related to the medication omission.

The resident's death certificate was reviewed and revealed the immediate cause of death to be probable acute on chronic aspiration pneumonia.

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 initiated the electronic MAR and took steps to ensure accuracy. Despite those steps, the resident's medication was not placed on the new MAR. A pattern of errors developed when numerous staff responsible for medication administration repeatedly omitted the ordered antipsychotic. The resident did not receive the ordered Risperidone for a period of approximately 3 weeks. The resident developed thoughts of suicide.

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 Met**

The facility was found to be in compliance with Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B). No deficiencies were issued.

State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) – Compliance Met

The facility was found to be in compliance with State Licensing Rules for Nursing Homes (MN Rules Chapter 4658). No state orders were issued.

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) – Compliance Met

The facility was found to be in compliance with State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557). No state licensing orders were issued.

Facility Corrective Action:

The facility took the following corrective action(s):

Although a significant medication error occurred, when the facility staff was made aware of the error, they notified the resident's medical provider, initiated the medication, and monitored the resident's condition, which initially was improving. Prior to the investigation facility staff reviewed all other resident's electronic MAR's for accuracy. Facility staff rechecked all significant medication orders and all the resident's electronic MAR records were printed and sent to each resident's physician to be reviewed to ensure all medications ordered were correctly transcribed on the electronic MAR. During this process other medication errors were noted and resolved by the facility. Documentation of this process was reviewed. During the investigation a sample of resident medication orders were reviewed and compared with physician orders and found to be accurate.

Definitions:**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.

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.

(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.

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

(1) the vulnerable adult or a person with authority to make health care decisions for the vulnerable adult under sections 144.651, 144A.44, chapter 145B, 145C, or 252A, or sections 253B.03 or 524.5-101 to 524.5-502, refuses consent or withdraws consent, consistent with that authority and within the boundary of reasonable medical practice, to any therapeutic conduct, including any care, service, or procedure to diagnose, maintain, or treat the physical or mental condition of the vulnerable adult, or, where permitted under law, to provide nutrition and hydration parenterally or through intubation; this paragraph does not enlarge or diminish rights otherwise held under law by:

(i) a vulnerable adult or a person acting on behalf of a vulnerable adult, including an involved family member, to consent to or refuse consent for therapeutic conduct; or

(ii) a caregiver to offer or provide or refuse to offer or provide therapeutic conduct; or

(2) the vulnerable adult, a person with authority to make health care decisions for the vulnerable adult, or a caregiver in good faith selects and depends upon spiritual means or prayer for treatment or care of disease or remedial care of the vulnerable adult in lieu of medical care, provided that this is consistent with the prior practice or belief of the vulnerable adult or with the expressed intentions of the vulnerable adult;

(3) the vulnerable adult, who is not impaired in judgment or capacity by mental or emotional dysfunction or undue influence, engages in consensual sexual contact with:

(i) a person including a facility staff person when a consensual sexual personal relationship existed prior to the caregiving relationship; or

(ii) a personal care attendant, regardless of whether the consensual sexual personal relationship existed prior to the caregiving relationship; or

(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.

(d) Nothing in this definition requires a caregiver, if regulated, to provide services in excess of those required by the caregiver's license, certification, registration, or other regulation.

(e) If the findings of an investigation by a lead agency result in a determination of substantiated maltreatment for the sole reason that the actions required of a facility under paragraph (c), clause (5), item (iv), (v), or (vi), were not taken, then the facility is subject to a correction order. An individual will not be found to have neglected or maltreated the vulnerable adult based solely on the facility's not having taken the actions required under paragraph (c), clause (5), item (iv), (v), or (vi). This must not alter the lead agency's determination of mitigating factors under section 626.557, subdivision 9c, paragraph (c).

Click here to enter text.

The Investigation included the following:**Document Review: The following records were reviewed during the investigation:**

- | | |
|---|--|
| <input checked="" type="checkbox"/> Medical Records | <input checked="" type="checkbox"/> Care Guide |
| <input checked="" type="checkbox"/> Medication Administration Records | <input checked="" type="checkbox"/> Treatment Sheets |
| <input checked="" type="checkbox"/> Facility Incident Reports | <input checked="" type="checkbox"/> Physician Progress Notes |
| <input type="checkbox"/> ADL (Activities of Daily Living) Flow Sheets | <input type="checkbox"/> Laboratory and X-ray Reports |
| <input checked="" type="checkbox"/> Physician Orders | <input type="checkbox"/> Social Service Notes |
| <input checked="" type="checkbox"/> Nurses Notes | <input type="checkbox"/> Meal Intake Records |
| <input type="checkbox"/> Activities Reports | <input type="checkbox"/> Weight Records |
| <input type="checkbox"/> Therapy and/or Ancillary Services Records | <input checked="" type="checkbox"/> Assessments |
| <input type="checkbox"/> Skin Assessments | <input checked="" type="checkbox"/> Care Plan Records |

Other pertinent medical records:

- Hospital Records Ambulance/Paramedics Medical Examiner Records Death Certificate
- Police Report

Additional facility records:

- | | |
|---|--|
| <input checked="" type="checkbox"/> Resident/Family Council Minutes | <input type="checkbox"/> Personnel Records/Background Check, etc. |
| <input checked="" type="checkbox"/> Staff Time Sheets, Schedules, etc. | <input checked="" type="checkbox"/> Facility In-service Records |
| <input checked="" type="checkbox"/> Facility Internal Investigation Reports | <input checked="" type="checkbox"/> Facility Policies and Procedures |

Call Light Audits

Other, specify: Medication error reports.

Number of additional resident(s) reviewed: 4

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: Resident was deceased.

Did you interview additional residents: Yes No

Total number of resident interviews: 3

Interview with staff: Yes No N/A Specify: _____

Tennessee Warning given as required: Yes No

Total number of staff interviews: 11

Physician interviewed: Yes No

Nurse Practitioner interviewed: Yes No

Interview with Alleged Perpetrator(s): Yes No N/A Specify: None identified.

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:

- Wound Care
- Medication Pass
- Meals
- Personal Care
- Dignity/Privacy Issues
- Restorative Care
- Nursing Services
- Safety Issues
- Facility Tour
- Infection Control
- Cleanliness
- Injury
- Use of Equipment
- Transfers
- Incontinence
- Call Light
- Other: Use of electronic MAR.

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: _____

xc: Division of Compliance Monitoring - Licensing & Certification
 Minnesota Board of Examiners for Nursing Home Administrators
 Minnesota Board of Nursing
 Minnesota Board of Pharmacy
 Anoka County Attorney
 Columbia Heights City Attorney

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

PRINTED: 11/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245018	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/05/2013
NAME OF PROVIDER OR SUPPLIER CREST VIEW LUTHERAN HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421		
(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 An abbreviated standard survey was conducted to investigate case #H5018098. Crest View Lutheran Homes. is in compliance with 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities.	F 000			

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

TITLE

(X6) DATE

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: 00005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/05/2013
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CREST VIEW LUTHERAN HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

2 000	<p>Initial Comments</p> <p style="text-align: center;">*****ATTENTION*****</p> <p style="text-align: center;">NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS: A complaint investigation was conducted to investigate complaint #H5018098. No correction orders are issued.</p>	2 000		
-------	--	-------	--	--

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