Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H53475545M
Compliance #: H53478208C

Date Concluded: August 23., 2023

Name, Address, and County of Licensee Investigated:
Lyngblomsten Care Center
1415 Almond Avenue
Saint Paul, MN 55108
Ramsey County

Facility Type: Nursing Home

Evaluator's Name: Jennifer Segal RN, BSN
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 alleged perpetrator (AP) neglected a resident when the AP administered incorrect medication to the resident.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although there was a medication error, the error was an isolated incident and there was no indication the resident experienced any negative outcome related to the medication error.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included a review of the resident's medical record, the facility investigation, the AP's personnel file, and the previous related federal survey.

The resident’s diagnoses included dementia and congestive heart failure. The resident was admitted to the skilled nursing facility one day earlier for general decline in health and safety.

The facility contracted with a local pharmacy that managed an automated medication system that dispensed individualized medications in real-time.

The resident’s medication administration record (MAR) and physician orders included allopurinol (medication for gout) daily at 8:30 a.m., and metoprolol (medication for blood pressure), daily at 4:30 p.m. both medications were round, white and began with the same number on the inscription of the medication.

One morning the AP obtained the resident's medications from the dispenser, verified each medication, and discovered a discrepancy. The nurse confirmed the AP's findings that metoprolol was incorrectly dispensed from the machine at 8:30 a.m. although prescribed for 4:30 p.m. The pharmacy and nurse worked together to correct the dispense time and the AP returned a white round medication to the nurse. The day nurse planned to return the metoprolol to the dispenser for reconciliation.

Staff monitored the resident's blood pressure and heart rate twice during the shift, and both were within normal range.

The same evening the resident received her 4: 30 p.m. medications including metoprolol. Following a nurse returned the 8:30 a.m. medication to the dispenser and the dispenser detected the medication returned was allopurinol, not metoprolol.

A facility investigation confirmed the AP identified an error when the pharmacy initially dispensed the resident's metoprolol in the morning instead of the evening. When the AP was instructed to return the metoprolol to the envelope the AP incidentally returned the allopurinol, and it was discovered the resident received metoprolol at 8:30 a.m. and again at 4:30 p.m.

During an interview, the nurse manager stated that the AP had a long work history and consistently exceeded expectations. The nurse manager stated following the investigation, the facility worked with the pharmacy to prevent recurrence, and staff were coached on cross-checking medications.

During an interview, the AP stated when she reconciled the resident’s 8:30 a.m. medications and discovered the error “I couldn't tell you what happened from there because it makes no sense”. The AP stated she must have put the metoprolol in the cup and administered it to the resident and returned the allopurinol to the envelope. The AP stated it was an "aberration" and stated the negative outcome was her pride in making the error. The AP did not have a pattern of medication errors or any performance concerns.

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.

Vulnerable Adult interviewed: No, deceased.
Family/Responsible Party interviewed: No, did not respond to interview attempts.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility led an internal investigation, notified the resident’s family, on call provider and the facilities medical director. The facility coordinated with the pharmacy to ensure the residents medication was prepacked at the correct time. The facility monitored the resident’s vital signs and assessed for potential side effects.

Action taken by the Minnesota Department of Health:
MDH previously investigated the issue during a complaint survey under federal regulations, and substantiated facility 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.

You may also call 651-201-4200 to receive a copy via mail or email.

The purpose of this investigation was to determine any individual responsibility for alleged maltreatment under Minn. Stat. 626.557, the Maltreatment of Vulnerable Adults Act.

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
	00501	A. BUILDING: _____ B. WING _____	C 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNGBLOMSTEN CARE CENTER	1415 ALMOND AVENUE SAINT PAUL, MN 55108

(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	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: The Minnesota Department of Health investigated an allegation of maltreatment, complaint #H53475545M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. No correction orders are issued.	2 000		

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2 000	Continued From page 1 The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	2 000		