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 #: H54093283M **Date Concluded:** July 20, 2023

Name, Address, and County of Licensee Investigated:
Edenbrook of Rochester
1875 19th Street NW
Rochester, MN 55901
Olmsted County

Facility Type: Nursing Home

Evaluator's Name:
Lisa Coil, RN Special Investigator

Finding: Substantiated

Nature of Visit:
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 neglected the resident when the alleged perpetrator did not call for emergency medical service in a timely manner while the resident's respirations became labored, and the resident went unresponsive.

The facility neglected the resident when staff failed to flush the resident's tube feedings appropriately or provide the resident enough water. The inappropriate flushing or lack of water caused the residents sodium lab to rise to a level greater than 170 milliequivalents per liter (mEq/L; normal sodium levels are 136-145 mEq/L) causing severe dehydration, which contributed to the resident's death.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated, however, the alleged perpetrator was not responsible for the maltreatment. When the alleged perpetrator was notified of the resident's low oxygen level, he assessed the resident, applied oxygen, and called 911. Preceding this, there was miscommunication between the registered dietician and nursing department regarding the amount of water the resident was receiving per day; the

registered dietician based her calculations on nursing staff administering water flushes with every medication while the nursing staff administered fewer water flushes (once per entire medication pass). The resident experienced significant dehydration, which contributed to her death.

The investigator conducted interviews with facility staff members, including medical staff, registered dietician, nursing staff, and unlicensed staff. The investigator conducted an interview with the resident's family member and contacted law enforcement. The investigator also made attempts to contact two of the emergency department providers. The investigation included review of the resident's facility record, ambulance record, emergency department record, death record, and autopsy report. The investigation also included review of the facility's policies and procedures.

The resident resided in a nursing home. The resident's diagnoses include severe protein-calorie malnutrition, dysphagia (difficulty with swallowing), hydrocephalus (fluid around the brain) with the placement of a shunt (a tube for draining the fluid), and intellectual disabilities. The resident's care plan indicated the resident had limited physical mobility and was dependent upon staff for all cares, including her nutritional intake. The care plan indicated the resident required nutritional feeding through a percutaneous endoscopic gastrostomy (PEG; a surgically placed feeding tube through the abdomen into the stomach) tube for inadequate oral intake because of severe dysphagia (difficulty with swallowing). The care plan also indicated the resident had minimal to no verbal communication, yelled out at times, and required staff to check on her frequently.

Review of the orders indicated the resident received nutritional tube feedings through her PEG tube three times a day, could have honey-thick textures delivered by spoon, limited to 3-5 spoonful's up to five times a day, but could have nothing else by mouth. The orders indicated diets, supplements, hydration program, and nutritional tube feedings were delegated to the registered (certified) dietitian. The orders further indicated the amount of formula and water provided every eight hours and a total intake every 24 hours were to be documented along with signs of dehydration, nausea, vomiting, diarrhea, and breath sounds.

Review of the Enteral Nutrition Detailed Written Orders from the date of admit indicated the resident was to receive 500 milliliters (mL) of tube feeding formula in the morning, 500 mL in the afternoon, and 250 mL in the evening. The same document indicated the resident was to receive 100 mL water flush before and after each feeding and 20-30 mL water before and after medication administration.

Review of the electronic medication administration record indicated the resident's medications were crushed and administered through the PEG tube. The document included the 20-30 mL of water flush order before and after every administration of medication pass but did not indicate the specific amount of mL used each time a medication pass was completed.

Approximately four weeks prior to the resident's death, the progress notes indicated the nurse manager notified the provider team of frequent vomiting after tube feedings and requested recommendations to address this concern. During this same time, the resident's sodium level was found to be 144 mEq/L.

Approximately three weeks prior to the resident's death, the medical record indicated the registered dietician decreased water flushes before and after each feeding, which was three times a day, from 250 mL to 100 mL because the resident had emesis at times. The note indicated the resident was still receiving over 1300 mL of fluid per day to meet her fluid needs yet allow for increased gastrointestinal tolerance. During the same week, the progress notes indicated the registered dietician increased the nutritional tube feeding from four cans per day to five cans per day for additional calories.

Ten days prior to the resident's death, the provider's progress notes indicated the physician was at the facility one day when the registered nurse asked her to see the resident for a fever and tachycardia (rapid heart rate) after receiving Tylenol. The note indicated the resident had chills, was minimally responsive, and tachycardic (fast heart rate). The note indicated the resident was not cooperative with the exam, so the physician requested the resident be sent to the emergency department for evaluation. In the emergency department, the resident was diagnosed with a urinary tract infection and returned to the facility with an order for a five-day course of antibiotics. The emergency department lab values indicated the resident's sodium level was 146 mEq/L.

Two days prior to the resident's death, the progress notes indicated the resident was having convulsions/spasms to the upper body and had significant diaphoresis (sweating), however her vital signs were normal. The notes indicated the resident typically had moderate diaphoresis and muscle spasms daily. The note further indicated the nurse practitioner ordered Ativan (a medication used for anxiety and seizures) and to have the resident see her regular medical provider within the next few days.

On the day of the resident's death, the progress notes indicated the resident had been diaphoretic and had a drastic change of condition. The note indicated staff were unable to get an accurate blood pressure reading, oxygen saturation was 70%, oxygen was applied at four liters per minute, the on-call provider was notified, and the resident was transferred to the emergency department.

Review of the ambulance record indicated emergency medical services were dispatched to the facility for an individual with low oxygen levels and clammy skin. The report indicated when ambulance arrived, the resident was lying on her back in bed, having difficulty breathing, was unresponsive, and had pale, clammy skin. The report indicated facility staff had checked the resident oxygen saturation level and it was in the 70s so staff started oxygen at four liters per minute using a nasal tube. Emergency medical service changed the nasal tube to a mask and turned the oxygen up to 15 liters per minute and transported the resident to the hospital

emergency department. The report further indicated the resident's respirations became shallower and weaker during transport and the resident required manual ventilation.

Review of the emergency department record indicated the resident arrived unresponsive and in respiratory distress. The record indicated the resident's airway was compromised by emesis (vomit); however, no complications were indicated with intubation. The resident went into cardiac arrest and died in the emergency department. The record indicated the resident's sodium level was greater than 170 mEq/L.

Review of the death record indicated the resident's cause of death was complications of severe dehydration due to improper nutritional care of a dependent adult with a history of brain injury.

Review of facility policy addressing administering medications for tube feedings indicated each medication should be administered separately and the tube should be flushed between each individual medication. The document further indicated if a resident were able to receive medications as a bolus (several medications together), an order and documentation would be kept in the resident's chart.

A review of the resident's medical record did not identify a physician's order authorizing administering medications through the resident's tube feeding as a bolus.

During an interview, the alleged perpetrator, a nurse, stated he was taking care of the resident on the day she died. The alleged perpetrator stated the resident was declining the week before and the medical provider was notified. The medical provider ordered Ativan for seizure-like activity and indicated the resident could be seen on Monday when the doctor would be at the facility. The alleged perpetrator stated the unlicensed personnel informed him the resident had a low oxygen saturation level. The alleged perpetrator stated he went to the resident's room, checked her oxygen saturation level, applied oxygen, notified the provider, and called 911. The alleged perpetrator stated the ambulance arrived and transferred the resident to the emergency department. The alleged perpetrator stated he provided the resident with her tube feedings and medications as ordered that day, including crushed medications. The alleged perpetrator denied missing any orders, denied administering oral medications, and stated the resident had no emesis following her tube feedings.

During an interview, the registered dietician stated the nurse's notes indicated the resident had occasional vomiting following her tube feedings and she felt the amount of water flushes before and after the tube feedings was too much for the resident to tolerate. The registered dietician stated she spent a significant amount of time reviewing how best to meet the resident's nutritional needs along with her being able to tolerate the amount of mL's per feeding. The registered dietician stated following her assessment, she wrote an order to decrease the water flushes before and after tube feedings. The registered dietician stated the following day she increased the resident's bolus feeding by one can per day. The registered dietician stated although this change could have affected the resident's sodium lab level, it was not a big

concern to her because the resident was still receiving oral pleasure feedings and water flushes with medication administrations. The registered dietician stated she understood the medication flush order to read 20-30 mL flush before and after each medication and according to the number of medications the resident was ordered, the medication flushes would have provided 760-1140 mL per day. The registered dietician stated with the new orders she wrote and the medication flush order, the resident's total intake would have met her fluid and nutritional needs. The registered dietician stated she had no reason to believe nursing staff were not administering tube feedings as ordered.

During an interview, the nurse stated it was normal for the resident to have tremors, rigidity, and diaphoresis. The nurse stated because of the resident's difficulties with communication it was hard to determine cognition changes, which could have assisted in assessing a change in sodium levels. The nurse stated there was no documentation of how often pleasure feedings were given. The nurse stated it was her understanding the resident received 20-30 mL water flushes before and after each medication pass, meaning the medication due at the same time were mixed together and given at one time. The nurse stated she had no reason to believe the resident was not receiving her tube feedings and water flushes as ordered.

During an interview, the physician stated she completed the resident's admission assessment to the facility following two prolonged hospitalizations and considered the resident medically complex. The physician stated the resident spent two months in the hospital while providers tried to figure out why the resident had a functional decline. During her hospitalization, she developed aspiration pneumonia and dysphagia which resulted in a PEG tube placement and artificial nutritional feedings. The physician stated the dietician was the one who wrote orders regarding diet orders, supplements, and hydration and would let the provider team know if she had any concerns the providers needed to follow up on. The physician stated a decrease in water flushes could lead to dehydration but not to severe dehydration alone, because the resident was still receiving hydration. The physician stated "no" when asked if she had any reason to believe the nursing staff was not administering tube feedings and water as ordered. The physician stated it would be hard to tell if the resident were exhibiting signs of dehydration because the information in the nurse's notes was conflicting and the residents blood pressure was stable.

The resident's autopsy report listed the resident's sodium level as 180 mEq/L indicating severe dehydration. The same report indicated the resident died as a result of complications of severe dehydration due to improper nutritional care of a person with a history of brain injury.

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. The resident was deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility investigated the incident and sent the resident to the hospital.

Action taken by the Minnesota Department of Health:
MDH previously investigated the issue during a standard abbreviated survey under 42 CFR 483, Subpart B, Requirement for Long Term Care Facilities, 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

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.

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
Olmsted County Attorney
Rochester City Attorney
Rochester Law Enforcement
Olmstead County Medical Examiner & Coroner

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00916	A. BUILDING: ____ B. WING ____	C 06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	**1875 19TH STREET NORTHWEST ROCHESTER, MN 55901**

(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 #H54093283M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. The following correction order is issued for	2 000	The Minnesota Department of Health documents the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes. The assigned tag number appears in the	

Minnesota Department of Health

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2 000	Continued From page 1 #H54093283M, tag identification 1850. The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "reviewed" in the box available for text. Then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000	far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule number out of compliance are listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings, which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." 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/RULES.	
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a	21850		

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21850	Continued From page 2 resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details. No plan of correction is required for this tag.	21850	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	