DEPARTMENT OF HEALTH

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:			Report Number:	Date of Visit:
Three Links Care Center			H5450032	March 2, 2018
Facility Address:			**Time of Visit:**	**Date Concluded:**
815 Forest Avenue			6:45 a.m. - 12:15 p.m.	August 2, 2018
Facility City:			**Investigator's Name and Title:**	
Northfield			Debora Palmer, RN, Special Investigator	
State:	**ZIP:**	**County:**		
Minnesota	55057	Rice		

☒ **Nursing Home**

Allegation(s):

It is alleged that a resident (R1) was neglected when an employee, the Alleged Perpetrator (AP), administered the wrong medications, resulting in R1's emergent hospitalization.

☒ Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)

☒ State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)

☒ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)

☒ State Statutes Chapters 144 and 144A

Based on a preponderance of evidence, neglect was substantiated when the AP incorrectly administered all eight of another resident's morning medications to R1, which included three cardiac medications. Within 45 minutes of receiving the wrong medications, R1's blood pressure dropped dangerously low, necessitating R1's emergent transfer to the hospital. R1 was admitted to the Intensive Care Unit (ICU) with bradycardia and then transferred to another hospital for permanent pacemaker implantation (PPM).

The resident was weak and admitted to the facility for rehabilitation following a hospital stay. The resident was alert and orientated, and required extensive staff assistance with all activities of daily living. The resident's daily medication included Lasix (a diuretic medication), Prednisone (a corticosteroid medication) for acute heart failure, and Coumadin (an anticoagulant medication) for atrial fibrillation. The resident did not take any antihypertensive medications, and his/her baseline blood pressure was 112/60.

Two days after the resident was admitted to the facility, the AP administered all eight of another resident's morning medications to R1 during the 7:00 a.m. - 8:00 a.m. medication pass. The resident incorrectly received the following medications: Coreg 25 mg, Cardura 4 mg, Cozaar 150 mg, Digoxin 125 mcg, Lasix 40 mg, Folic acid 1 mg, Finasteride 1 mg, and Aspirin 81 mg. The AP recognized the error within three minutes

Conclusion:

of giving the wrong medications to the resident, when the AP returned to the medication cart to document the doses administered. The AP realized s/he had mis-identified the resident by not verifying the residents first and last name. The resident's room was two rooms away from the other resident who's medication they received, and both resident's had the same first name. The AP immediately assessed R1. R1 was alert and oriented with a blood pressure of 122/80. The medical provider was notified of the error and staff were instructed to monitor R1's blood pressure every 15 minutes, until normal. R1's blood pressure gradually declined over a 45-minute period. At 8:20 a.m., R1 was transferred to the hospital with a blood pressure of 70/50 and complaints of dizziness.

Hospital documentation indicated the resident was admitted to the Intensive Care Unit with bradycardia. R1 was placed on a dopamine drip to support his/her blood pressure. Reversible causes of R1's bradycardia were eliminated, but R1 remained bradycardic. Two days later, R1 was transferred to another hospital for PPM, to help control R1's heart rate and rhythm. The resident did not experience any post-procedural complications, and three days after PPM, the resident returned to baseline and returned to the facility. The resident's facility admission blood pressure was 112/74.

The resident was interviewed and stated s/he remembered the medication error and hospital stay related to complications. The resident stated s/he continues to feel weak and tired. The resident had no care or safety concerns at the facility.

The AP stated s/he was unfamiliar with the resident as s/he had not been assigned to the residents unit for a long time. On the morning of the medication error, the AP was standing at the medication cart and observed a nursing assistant weighing the resident. The AP asked the nursing assistant who s/he weighing and the nursing assistant responded with the resident's first name. The resident had the same name as the other resident, and the nurse prepared the other resident's medication and administered them to R1. After the resident took the medications, the AP caught the medication error within several minutes when the AP returned to the medication cart to document the doses administered. The medical provider was notified of the error. The AP monitored the resident's vital signs every ten minutes, but the resident's blood pressure continued to gradually drop. The resident was transferred to the hospital for further intervention. The AP acknowledged s/he failed to adhere to the medication administration procedure which directs staff to ensure accurate identification of a resident prior to medication administration, which includes verifying the first and last name of the resident and confirming identity with the resident's photo on the medication administration record.

The facility's corrective action plan for the AP included disciplinary action, re-education on standards of practice related to medication administration procedures, and competency evaluation through monitored medication pass surveys. At the time of the investigation, the AP had no further medication errors.

The facility's policy on medication administration indicated staff were to administer medications accurately and safely by ensuring the "8 Rights of medication administration: right resident, right drug, right dose, right dosage form, right route, right time, right reason, and right documentation."

☐ Abuse ☒ Neglect ☐ Financial Exploitation

☒ Substantiated ☐ Not Substantiated ☐ Inconclusive based on the following information:

Click Here and Type

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 provided the AP with orientation and training regarding the nurses' accountability to meet professional standards of practice and to follow the facility's policies and procedures, with a primary role to administer medications and treatments to residents according to physicians' orders. On the day of the medication error, the AP did not adhere to the facility's medication administration procedure; R1's unit was staffed with the normal staffing pattern and the AP was responsible for administering medications to ten residents.

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.

State Statutes Chapters 144 & 144A – Compliance Not Met - Compliance Not Met
The requirements under State Statues for Chapters 144 &144A were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

Compliance Notes:

Definitions:

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.

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.

The Investigation included the following:

Document Review: The following records were reviewed during the investigation:

- [x] Medical Records
- [x] Care Guide
- [x] Medication Administration Records
- [x] Nurses Notes
- [x] Assessments
- [x] Physician Orders
- [x] Care Plan Records
- [x] Other, specify:

Other pertinent medical records:

☒ Hospital Records

Additional facility records:

☒ Staff Time Sheets, Schedules, etc.

☒ Facility Internal Investigation Reports

☒ Personnel Records/Background Check, etc.

☒ Facility In-service Records

☒ Facility Policies and Procedures

Number of additional resident(s) reviewed: Six

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 reporter(s) ◉ Yes ○ No ○ N/A

Specify: _____

If unable to contact reporter, attempts were made on:

Date:	Time:	Date:	Time:	Date:	Time:

Interview with family: ○ Yes ◉ No ○ N/A Specify: Attempts to reach family were unsuccessful.

Did you interview the resident(s) identified in allegation:

◉ Yes ○ No ○ N/A Specify: _____

Did you interview additional residents? ◉ Yes ○ No

Total number of resident interviews: Three

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

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: Nine

Physician Interviewed: ○ Yes ◉ No

Nurse Practitioner Interviewed: ○ Yes ◉ No

Physician Assistant Interviewed: ◯ Yes ◉ No

Interview with Alleged Perpetrator(s): ◉ Yes ◯ No ◯ N/A Specify: _____

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:

☒ Personal Care
☒ Nursing Services
☒ Use of Equipment
☒ Medication Pass
☒ Dignity/Privacy Issues
☒ Safety Issues
☒ Facility Tour

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: _____

cc:

Health Regulation Division - Licensing & Certification

Minnesota Board of Nursing

The Office of Ombudsman for Long-Term Care

Rice County Attorney

Northfield Police Department
Northfield City Attorney

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245450	A. BUILDING _____ B. WING _____	C 07/31/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE LINKS CARE CENTER	815 FOREST AVENUE NORTHFIELD, MN 55057

(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 complaint #H5450032. Three Links Care Center is in compliance with 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	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

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	00564	A. BUILDING: _____ B. WING _____	C 07/31/2018

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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: A complaint investigation was conducted to investigate complaint #H5450032. The following correction order is issued:	2 000	The facility's policy on medication administration indicated staff were to administer medications accurately and safely by ensuring the "8 Rights of medication administration: right resident, right drug, right dose, right dosage form, right route, right time, right reason, and	

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2 000	Continued From page 1	2 000	right documentation."	
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 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: Based on observation, interview, and document review, neglect did occur when a nurse incorrectly administered all eight of R2's morning medications to R1, which included three cardiac medications. Within 45 minutes of receiving the wrong medications, R1's blood pressure dropped dangerously low, necessitating R1's emergent transfer to the hospital. R1 was admitted to the Intensive Care Unit (ICU) with bradycardia and then transferred to another hospital for permanent pacemaker implantation (PPM). Observations of three morning medication passes on 03/02/18 by three different nursing personnel established that the facility's medication	21850		

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21850	Continued From page 2 administration procedure required staff to accurately identify a resident prior to medication administration, by verifying the resident's first and last name and confirming identity with the photo on the medication administration record. R1's room was located two rooms away from R2's room. R1 and R2 had the same first name. R2's medical record indicated R2 was admitted to the facility in late January 2018 on palliative care. R2 required extensive staff assistance with all activities of daily living. R2 had multiple co-morbidities, including significant cardiac disease, heart failure, and atrial fibrillation. On a daily basis, R2 received three antihypertensive medications in the morning, including Coreg, Cardura, and Cozaar. R2 also received daily Lasix (a diuretic medication) for heart failure and daily Digoxin for atrial fibrillation that staff administered in the morning. R1's medical record indicated R1 was admitted to the facility in early February 2018, after being hospitalized for pneumonia and acute heart failure. R1 was weak and needed therapies for rehabilitation before R1 could return to his/her prior residence. R1 required extensive staff assistance with all activities of daily living. R1 was oxygen-dependent due to chronic heart failure. On a daily basis, R1 received Lasix (a diuretic medication) and Prednisone (a corticosteroid medication) for acute heart failure and Coumadin (an anticoagulant medication) for atrial fibrillation. R1 did not take any antihypertensive medications. R1's baseline blood pressure was 112/60. R1 was alert, oriented, and able to express his/her preferences. A medication error report, dated 02/04/18, indicated that a nurse administered all of R2's	21850		

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21850	Continued From page 3 morning medications to R1, during the 7:00 a.m. - 8:00 a.m. medication pass. R1 incorrectly received the following medications: Coreg 25 mg, Cardura 4 mg, Cozaar 150 mg, Digoxin 125 mcg, Lasix 40 mg, Folic acid 1 mg, Finasteride 1 mg, and Aspirin 81 mg. The nurse mis-identified R1 by not verifying R1's first and last name. After R1 took the medications, R1's blood pressure gradually declined over a 45-minute period. At 8:20 a.m., R1 was transferred to the hospital with a blood pressure of 70/50 and complaints of dizziness. R1's hospital record indicated R1 was admitted to the Intensive Care Unit with bradycardia. R1 was placed on a dopamine drip to support his/her blood pressure. Reversible causes of R1's bradycardia were eliminated, but R1 remained bradycardic. Two days later, R1 was transferred to another hospital for PPM, to help control R1's heart rate and rhythm. PMM was successful. R1 did not experience any post-procedural complications. Three days after PMM, R1 returned to the facility at baseline. R1's admission blood pressure was 112/74. The facility's policy on medication administration indicated staff were to administer medications accurately and safely by ensuring the "8 Rights of medication administration: right resident, right drug, right dose, right dosage form, right route, right time, right reason, and right documentation." A Suggested Method of Correction: 1) Ensure all staff who administer medications to residents receive ongoing competency training regarding medication safety. 2) Conduct routine audits of medication passess to ensure nursing personnel are conforming to the facility's medication administration procedure.	21850		

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21850	Continued From page 4 3) Document all training and oversight of nursing staff who make medication errors. Time Period for Correction: Twenty-one (21) days.	21850		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 31, 2018

Administrator
Three Links Care Center
815 Forest Avenue
Northfield, MN 55057

Re: Reinspection Results - Complaint Number H5450032

Dear Administrator:

On August 28, 2018 an investigator from the Minnesota Department of Health, Office of Health Facility Complaints, completed a reinspection of your facility, to determine correction of licensing orders found during the investigation completed on July 31, 2018. At this time these correction orders were found corrected.

You may request a hearing on any assessments that result from non-compliance with these licensing orders by providing a written request to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the president of your facility's governing body.

Please feel free to call me with any questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File