Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H56263704M
Compliance #: H56265490C

Date Concluded: May 26, 2023

Name, Address, and County of Licensee Investigated:
Rochester Rehab and Living Center
1900 Ballington Boulevard NW
Rochester MN 55901
Olmsted County

Facility Type: Nursing Home

Evaluator's Name: Christine Bluhm, RN
Special Investigator

Finding: Substantiated, individual 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:
The alleged perpetrator (AP) neglected a resident when the AP administered the incorrect medications.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The AP was responsible for the maltreatment. The AP failed to provide accurate medication services when she administered the incorrect medications to two residents. The AP gave the resident another resident's medications. The resident was hospitalized and passed away that same day.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. Nursing students and resident families were also interviewed. The investigation included review of resident medication administration records, progress notes, ambulance records, emergency room and hospital records.
The resident admitted to a skilled nursing facility rehabilitation unit. The resident's diagnoses included hypertensive heart disease with heart failure, aortic stenosis (narrowing of heart valve), diabetes, chronic kidney disease and history of stroke. The resident's assessment indicated the resident required assistance with medication administration, activities of daily living, had medically complex conditions with the expectation that he was to be discharged to the community.

Review of the facility investigation summary indicated that the AP did not follow the standard of practice to ensure identification of the residents prior to giving the medications. The AP gave the wrong medications to two residents. Each resident got the other resident's medication.

The summary indicated the resident incorrectly received the following medications. Amlodipine besylate (blood pressure medication), tamsulosin (prostate medication), aspirin, Carvedilol (blood pressure medication), finasteride (prostate medication), isosorbide mononitrate (blood pressure medication), losartan potassium (blood pressure medication), ocular vitamin, senna plus (for constipation), and MiraLAX (for constipation). The medications the resident should have received were a daily vitamin, glimepiride (treats diabetes), aceon (blood pressure medication) and senna plus. The summary indicated the root cause of the incident was that the AP was not familiar with the residents and when she said a name, the resident responded to that name.

During interviews, nursing students who were in clinical rotation the same day provided statements indicating the AP and the student together verified and discussed each medication, indications for use, the order for the medication, and any priority assessments such as blood pressure readings needed prior to administration. When it was time to give the resident his medication, both the student and the AP went to the dining room where the resident was seated. The resident responded 'yes' when the AP asked his name. The student, under the AP's instruction, gave the resident the incorrect medications. A short time after both residents had already received the wrong medications, the error was realized.

Review of a signed statement provided by the AP indicated she performed a medication error and switched two residents' morning medications. The AP's statement indicated she would from now on actually ask their name if they cannot answer or ask another staff member to ensure the resident's identity.

During an interview, the director of nursing said both from statements and information she received indicated the AP did not follow nursing protocol. The director of nursing stated that there were multiple facility staff nearby to confirm the resident's identification if the AP was not sure.

During interview, the resident's family member stated that her father was doing well with rehab when the incident occurred, and the plan was for him to return to the community with a little more assistance.

The resident's death certificate indicated the cause of death as hypertensive, atherosclerotic, valvular heart disease complicated by the ingestion of multiple unprescribed antihypertensive medications. The manner of death is listed as an accident.

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.

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

(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.

Vulnerable Adult interviewed: No, he was deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Declined an interview with the investigator.

Action taken by facility:
After recognizing the medication error, facility staff contacted the resident’s family and the resident’s provider for directions. The resident was monitored and subsequently sent the to the hospital. The facility investigated the incident, interviewed multiple staff, and reported the incident to the Minnesota Board of Nursing. Audits were completed to ensure all residents had photo identification in the electronic record.

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
Olmsted County Attorney
Rochester City Attorney
Rochester Police Department
MN Board of Nursing
Board of Pharmacy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29822	A. BUILDING: _____ B. WING _____	C 03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHESTER REHABILITATION AND LIVING CI	1900 BALLINGTON BOULEVARD NW 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 #H56263704M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. The following correction order is issued/orders	2 000		

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2 000	Continued From page 1 are issued for #H56263704M, 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		
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.	21850		

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21850	Continued From page 2 This MN Requirement is not met as evidenced by: Based on observations, interviews, and document review, the facility failed to ensure two of two residents reviewed (R1 and R2) was free from maltreatment. R1 and R2 were neglected. Findings include: On February 22, 2023 , the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that an individual staff person was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	21850	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	