Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL203164841M
Compliance #: HL203166340C

Date Concluded: October 31, 2024

Name, Address, and County of Licensee Investigated:
Ecumen Centennial House of Apple Valley
14625 Pennock Ave
Apple Valley, MN 55124
Dakota County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name: Deb Schillinger 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 the resident when the resident did not receive prescribed medications as ordered.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Upon review of the resident record, transcription errors were present, and medications were not given to the resident as prescribed, however, the alleged perpetrator was unaware of errors in the order transcription process.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member. The investigation included review of the resident record, hospital records, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy

and procedures. Also, the investigator made an onsite visit observed staff interactions with residents.

The resident resided in an assisted living facility. The resident's diagnoses included congestive heart failure (inability of the heart to pump enough blood to meet the body's needs), chronic obstructive pulmonary disease (a lung disease that restricts breathing) and atrial fibrillation (an abnormal heart rhythm) and a pacemaker. The resident's service plan included assistance with medication management. The resident's assessment indicated the resident was able to walk independently using a cane and was alert to person, place, time, and situation.

One month a concern arose that the resident was not receiving her medications as ordered. During the previous several weeks, the resident had been out of the facility, then re-admitted twice with new medication orders. However, the new orders were missed, and the medication changes did not take place.

Initial Hospitalization

The resident's medical record indicated the resident was sent to the hospital from the facility and remained there for nine days. The resident's progress notes indicated the resident's heart rate was 141 beats per minute when he was sent to the hospital.

From the hospital the resident transferred to a nursing home for transitional care. The resident was at the nursing home for about two weeks before readmission back to the facility.

Prior to this hospitalization, the resident's electronic medication administration record (eMAR) indicated the following:

1. The resident's prescribed medications included carvedilol
2. The resident's prescribed medications did not include metoprolol

As the end of the month approached, the nursing home prepared to discharge the resident back to the facility.

Return from the Nursing Home

On the 1st day of the month, the progress notes indicated the resident's discharge orders from the nursing home would be faxed by the end of that day. The same note indicated the resident would return to the facility the following day (the 2nd day of the month).

A fax dated the 1st day of the month from the nursing home indicated the resident had been hospitalized for more than a week and then went the nursing home for recovery. The fax indicated it included the orders from the nursing home for discharge back to the facility. The same document indicated the reason for the hospitalization was for CHF exacerbation and atrial fibrillation with "RVR" [rapid ventricular response]. The same document indicated the resident had been with a high heart rate which was attributed to a possible pacemaker malfunction and metoprolol was increased for the ongoing high heart rate.

A review of the medications listed in the fax indicated the resident should receive metoprolol. The same review found no mention of carvedilol regarding continuing or discontinuing.

A progress note dated the 2nd day of the month indicated the resident returned to the facility that day and that his “discharge paperwork” was in the resident’s chart.

A review of the copy of the fax provided by the facility for the investigation indicated the fax had been sent to the attention of a nurse other than the alleged perpetrator. The copy of the fax included no indication any facility staff member from the facility reviewed it.

A review of the resident’s eMAR indicated the following:

1. The facility continued to administer carvedilol
2. The facility began administering metoprolol upon readmission

However, a comparison of the dose described in the fax did not match the dose that displayed on the eMAR.

The resident’s eMAR indicated the facility did not perform medication reconciliation of the resident’s medication upon readmission, nor did the facility clarify the status of the carvedilol with the resident’s prescriber.

Second Hospitalization

On the 9th day of the month the progress notes indicated the resident had “flu-like” symptoms. The same document indicated the resident said he had caught a cold at the nursing home. The facility tested the resident for COVID but that was negative. The resident’s heart rate was 70 beats per minute. The same document indicated the resident’s medical provider was updated and he was encouraged to increase his fluid intake. The resident was encouraged to consider hospitalization, but he declined.

A late entry progress note for the same day, entered on the 11th day of the month, indicated the facility sent the resident to the hospital for concerns regarding the resident’s breathing.

Return from the Hospital

On the 15th day of the month the resident readmitted to the facility. The medication orders indicated to discontinue carvedilol. The same orders included the same metoprolol dose as the fax dated the 1st day of the month.

A progress note indicated the resident returned to the facility on the 15th of the month. The same note indicated there were new medication orders which included to discontinue carvedilol and to begin metoprolol. The same document indicated the resident’s medical provider would see the resident in two days.

A review of the resident's eMAR indicated the following:

1. The facility continued to administer carvedilol for two days and then it was discontinued
2. The facility continued administering the incorrect dose of metoprolol for two days, then began administering the medication dosage as indicated in the readmission orders.

A progress note dated the 18th day of the month indicated the resident's medical provider saw the resident the day prior and gave new orders which included discontinuing carvedilol.

Facility Investigation

The facility internal investigation summary indicated the resident's medical provider informed the facility of possible medication errors on or about the 17th of the month. The same documents indicated on the 2nd and the 15th day of the month when the resident returned to the facility. The same documents indicated the alleged perpetrator was the nurse who readmitted the resident on both occasions.

The facility investigation included notes taken during an interview with the alleged perpetrator. The notes indicated she had been unaware of the medication errors until the internal investigation was conducted. When asked if she understood the readmission process, the notes indicated she stated she felt like she understood the process.

The notes indicated the alleged perpetrator described the following steps when a resident returns to the facility from another setting:

- Take the resident off LOA (leave of absence) in "service minder" [a reference to the software used for the electronic medical record (EMR)
- Notify the medical provider of the return
- Then enter details and review new orders

The same document indicated she described the medication reconciliation process, which included these points:

- Ask the social worker or nurse [from the discharging facility] if the prescriptions were sent directly to the pharmacy or if the orders were sent with the resident.
- If there are new orders on the discharge paperwork, make sure the social worker or nurse sent the prescriptions to the pharmacy
- If not, then fax them to the pharmacy
- Then review the medications in the "Pending Review" in the "service minder" [a reference to the functions of the electronic medical record software]

Regarding the readmission on the 2nd day of the month, when asked if she had done the medication reconciliation upon return from the hospital the notes indicated the alleged perpetrator said yes.

Regarding the readmission on the 15th day of the month the notes indicated the alleged perpetrator said when she learned the resident was returning to the facility, the resident was

already being transported back. The same document indicated she said she found discharge paperwork in the fax inbox and observed metoprolol had been increased and that the hospital had faxed the orders to the pharmacy. The alleged perpetrator said she did not ensure medications were updated nor confirm them in the “pending review” in “service minder”. She said she if the hospital sends the prescriptions to the pharmacy, she does not send the discharge paperwork.

The facility investigation summary indicated an audit was completed for the previous two months and discovered a pattern of incomplete medication reconciliations for readmissions completed by the alleged perpetrator. The same report indicated an audit of standard order changes completed by the alleged perpetrator were without errors.

Interviews

During an interview, the alleged perpetrator indicated she obtained her nursing license and then had her orientation as a facility nurse the following month. This orientation included completing online learning and following a nurse at a different facility for about ten days. The alleged perpetrator stated she was not aware of competency skills being evaluated during her orientation process. The alleged perpetrator stated she had been made aware of a transcription error one time the month prior to the incident.

During the same interview, the alleged perpetrator stated that during the first readmission, she was the only nurse working and had three readmissions and one admission on that day. Regarding the second readmission [on the 15th day of the month] she stated she spoke with the hospital discharge planner and was told the orders were faxed to the pharmacy.

A review of the resident’s discharge orders for the 15th day of the month indicated the medications ordered upon discharge were sent to the hospital pharmacy, not the pharmacy contracted with the assisted living facility.

During an interview, a nurse manager stated she was unaware of a specific process for a resident readmission, however, on the job training was provided to all newly hired nurses by another nurse. The nurse manager stated the facility implemented a new temporary process when the concern arose on readmissions.

After the interview, the nurse manager provided a document that indicated a “double check” in place on a temporary basis.

Employee Record

A review of the alleged perpetrator’s employee file included a review of her training records. The records included notes indicating training provided in the previous year regarding the EMR. Those same documents did not indicate if the training included “pending review” or the process of medication reconciliation in the EMR.

The employee file did include a coaching on a medication error identified in the month prior to the errors associated with the resident's readmission; no other corrective actions were identified regarding medication errors in the alleged perpetrator's employee file.

Action taken by facility
Two weeks after the initiation of the investigation, the facility conducted education for the nurses. The document used for education included the following steps for the readmission process:

- Remove resident from LOA
- Fax DC [discharge] paperwork to pharmacy and request the pharmacy profile all new/changed medications and send ASAP [as soon as possible]
- Any orders that were "DC'd" [discontinued] need to be stopped in the eMAR by site nurse

The same document included the following expectations:

- The medication list from the hospital or nursing home should be compared "line by line" to the current medications
- Any change should be reflected in the eMAR
- Any discrepancies should be clarified with the medical provider

A review of the alleged perpetrator's employee file which predated this training did not identify documents which provided this level of specificity or detail regarding readmission orders.

During an interview, the family member stated he was not notified of the medication errors at the time of the incident. The family member stated when the resident did return to the facility, the resident did return to his baseline health condition.

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.

(d) 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.

Therapeutic conduct: Minnesota Statutes, section 626.5572, subdivision 20
"Therapeutic conduct" means the provision of program services, health care, or other personal care services done in good faith in the interests of the vulnerable adult by:
(1) an individual, facility, or employee or person providing services in a facility under the rights, privileges and responsibilities conferred by state license, certification, or registration; or
(2) a caregiver.

Vulnerable Adult interviewed: Attempts to interview the resident were unsuccessful
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by the Minnesota Department of Health:
No further action taken at this time.

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
	20316	A. BUILDING: _____ B. WING _____	C 10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CENTENNIAL HOUSE APPLE VALLEY	14625 PENNOCK AVENUE APPLE VALLEY, MN 55124

(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
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL203166340C/#HL203164841M On October 1, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 68 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for #HL203166340C/#HL203164841M, tag identification 0650.	0 000	The Minnesota Department of Health documents the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes. The assigned tag number appears in the 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." Following the evaluators' findings is the Time Period for Correction. 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.	
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must	0 650		

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0 650	Continued From page 1 include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure the employee record contained the required content for one of one employee records (RN-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	0 650		

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0 650	Continued From page 2 RN-D was transitioned to an RN role in March 2023. RN-D's record lacked evidence the licensee provided competency evaluation training to RN-D. The findings include: On October 01, 2024, at 4:00 p.m., the licensed assisted living director (LALD)-C stated she could not find any competencies signed off by an RN for RN-D. The licensee's Training Documentation Policy dated August 1, 2021, indicated a record of staff training and competency would be maintained. Each competency evaluation, training, retraining and orientation topic will contain the following: Facility name and location Facility license number Training topic or training program Training methodology Date of the training and/or competency evaluation Total amount of time for the training and competency evaluation Name and title of instructor Instructor's signature Name and title of the competency evaluator, if different from the instructor Competency evaluator's electronic signature, if different from the instructor Evaluator statement attesting the employee successfully completed the training and competency evaluation Name and title of the staff person completing the training Staff person's signature Staff person statement attesting the staff	0 650		

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0 650	Continued From page 3 person successfully completed the training as described No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		