Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL259042102M
Compliance #: HL259049948C

Date Concluded: June 28, 2024

Name, Address, and County of Licensee Investigated:
Bridgewell Memory Care Assisted Living
410 West Main Street
Osakis, MN 56360
Douglas County

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

Evaluator's Name: Barbara Axness, RN
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 facility neglected the resident when staff failed to administer the resident's medications according to physician orders and in accordance with the resident's service agreement. The resident was given his roommate's medications, which included a medication to treat high blood pressure. The resident was found unresponsive a few hours later and was taken to the emergency room where he was treated for shock and low blood pressure.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the resident was given the wrong medications, the error was an isolated incident. The resident was hospitalized and later discharged to a long-term care facility. The resident returned to his baseline health condition.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident records,

hospital records, facility internal investigation documentation, facility incident reports, personnel files, staff schedules, and related facility policies and procedures. Also, the investigator observed care and services provided in the facility.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia. The resident's service plan included assistance with dressing, grooming, bathing, and medication administration. The resident's assessment indicated the resident had impaired cognition and required assistance with medication administration.

The resident's medication administration record (MAR) indicated the resident's morning medications included vitamin D (supplement), an allergy medication, an antibiotic, and Tylenol.

A medication error report indicated the resident was given another resident's medications which included two medications for high blood pressure, a medication to treat high blood sugar for people with diabetes, two diuretics to reduce extra fluid in the body, and two medications to prevent blood clots.

The resident's medical record indicated staff notified the nurse around 10:30 a.m. that the resident wasn't feeling well, and he had thrown up. The resident was noted to be "cold, clammy, and diaphoretic (sweating)." The resident's family was notified. About half an hour later, a nurse went to the resident's room and observed the resident had poor color, was drooling, and unable to take a sip of water. The resident was not responsive to verbal stimuli but moaned with sternal rub. The resident's blood pressure was 56/48 (normal blood pressure is 120-80). Emergency medical services (EMS) was called at 11:10 a.m. and the resident was taken to the emergency room. At 12:05 p.m., the nurse was notified the resident may have been given the wrong medications and updated the hospital and the resident's family.

Hospital records indicated the resident arrived at the emergency room with low blood pressure and required the use of supplemental oxygen. The resident was given intravenous (IV) fluids, a blood transfusion, and admitted to the hospital for further monitoring. The resident later discharged to a long-term care facility.

Employee records indicated the unlicensed personnel (ULP) who made the medication error had received appropriate training and supervision related to administering medications.

The facility's internal investigation indicated ULP did not follow facility procedure when she dished up two resident medications at the same time and administered them to the wrong residents. The ULP completed additional education including re-education with the RN on medication administration and re-training with other ULP for two shifts. The ULP was placed on an improvement plan for six months to monitor and mitigate any additional medication errors or safety issues.

During an interview, the facility nurse stated she had checked on the resident after staff reported he wasn't feeling well. When the resident had a change in condition, she had called 911 and when she went back in the resident's room, the ULP was crying and said she thought this was her fault. She asked the ULP to clarify why she thought it was her fault and the ULP admitted to having dished up medications for two residents at the same time, which was not the facility's process. The nurse stated they identified what medications may have been given to the resident and updated the hospital so he could be treated appropriately. The nurse stated after the incident, they worked with the ULP to provide additional training and supervision and changed several of their internal processes to reduce the risk of a similar occurrence.

During an interview, the ULP stated she was running late that morning and felt behind and knew she shouldn't have administered medications that way. The ULP stated it was not her intention to hurt someone and when she figured out she gave the wrong medications, she was terrified and notified the nurse right away.

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, due to cognitive impairment
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility reported and investigated the incident. Additional training was provided to the ULP and the facility reviewed their medication administration process.

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
	25904	A. BUILDING: _____ B. WING _____	C 05/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEWELL ASSISTED LIVING	410 WEST MAIN STREET OSAKIS, MN 56360

(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 On May 10, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL259042102M/#HL259049948C. No correction orders are issued.	0 000		