MDH Minnesota Department of Health

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:
Lighthouse of Columbia Heights

Facility Address:
3801 Hart Boulevard Northeast

Facility City:
Columbia Heights

State:	ZIP:	County:
Minnesota	55421	Anoka

Report Number:
HL26853011

Time of Visit:
10:30 a.m. - 5:00 p.m.
9:00 a.m. - 12:30 p.m.

Date of Visit:
September 27 and 28, 2016

Date Concluded:
November 8, 2016

Investigator's Name and Title:
Rhylee Gilb, RN Special Investigator

☒ **Home Care Provider/Assisted Living**

Allegation(s):
It is alleged that a client was neglected when staff failed to administer prescribed medications for pneumonia. The client had a change in condition when s/he was assessed and found to be deteriorating. The client was later hospitalized and passed away.

☒ State Statutes for Home Care Providers (MN Statutes, section 144A.43 - 144A.483)

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

☒ State Statutes Chapters 144 and 144A

Conclusion:
Based on a preponderance of evidence, neglect is substantiated. The home care provider staff failed to administer a client an ordered antibiotic for pneumonia. The client developed pneumonia and spesis, was hospitalized, and died.

The client received services from the home care provider for diagnoses that included diabetes and failure to thrive. The client required assistance with medication administration. The provider order for life sustaining treatment (POLST) indicated the client choose not to be resuscitated, but marked "yes" to the use of antibiotics. The client experienced a slow decline in health status including decreased appetite with weight loss, increased incidence of falls, and not sleeping well. One Wednesday, the client was seen by the nurse practitioner to address insomnia and weight loss. The next day, the client experienced a cough, runny nose, and fatigue. That Friday, the staff updated the nurse practitioner, who ordered a chest x-ray which found mild pneumonia. On Saturday at 11:00 a.m., the physician assistant prescribed an antibiotic and sent the prescription to the pharmacy.

The pharmacy delivered the antibiotic on Saturday evening at 5:20 p.m. A staff member who was not assigned to the client received the pharmacy delivery and brought the antibiotic to the staff member who was assigned to administer the client his/her medications. The staff member stated he/she placed the medication in the bottom drawer of the medication cart and continued with passing medications to clients. The client's antibiotic was scheduled to be given at 8:00 p.m. Each medication had two different names, a

trade name and a generic name. Although both the trade name and generic name were listed on the electronic medical record (EMAR) and the antibiotic supply card, the staff member omitted the medication and commented on the EMAR that the antibiotic was not available. The next day, a different evening staff member also commented that the antibiotic was not available, and omitted the medication.

On Monday, the licensed practical nurse (LPN) went to check the client's status. At that time, the LPN found the client had not received any of the prescribed antibiotic (two doses) for pneumonia. The LPN changed the antibiotic administration time to 2:00 p.m., found the antibiotic supply card in the bottom drawer of the medication cart with no tabs used, administered the first dose, and updated the registered nurse (RN). The RN investigated which staff had omitted the antibiotic and educated those staff members. The LPN stated the client experienced increased weakness, coarse cough, elevated respiration rate of 28, and an elevated heart rate of 106. The home care staff updated the physician on the medication error and the client continued to decline in condition. Late that evening, the client was sent to the hospital for evaluation. The hospital attempted intravenous antibiotics, but the client passed away on Friday. The client's death record indicated the cause of death was pneumonia and sepsis.

An interview with the client's physician stated that although the client's x-ray showed mild pneumonia, the clinical presented clinically ill enough to require an antibiotic. The physician explained that because of the client's co-morbidities that included congestive heart failure, diabetes, and chronic anemia, the delay in starting an antibiotic could have led the client to progress into sepsis.

During interviews with staff, one staff member stated s/he did not realize the antibiotic on the EMAR was the same as the antibiotic delivered that day for the client by the pharmacy. Therefore, the staff member stated s/he thought it had not been delivered yet. The other staff member stated s/he could not find the antibiotic in the medication cart and because it was marked not available the day before, assumed it still had not been delivered. Both staff members stated they normally update the nurse when a medication is missing, however they did not report a missing medication to the nurse with this incident.

Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557)

Under the Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557):

☐ Abuse ☒ Neglect ☐ Financial Exploitation

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

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:

Staff are trained by the RN to pass medications, accept delivery of medications from the pharmacy, read the prescription label with the EMAR drug order and administer medications correctly. They are also trained if they have questions or cannot find a medication, they are to update the nurse.

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:

State Statutes for Maltreatment of Minors Act (MN Statutes, section 626.556) - Compliance Not Met
The requirements under the State Statutes for Maltreatment of Minors (MN Statutes, section 626.556) were not met.

State licensing orders were issued: ☒ Yes ☐ No

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

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) - Compliance Not Met
The requirements under State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) were not met.

State licensing orders were issued: ☐ Yes ☐ No

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

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:

Facility Corrective Action:

The facility took the following corrective action(s):

Definitions:

Minnesota Statutes, section 626.5572, subdivision 17 - Neglect

"Neglect" means:

(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:

- ☒ Medical Records
- ☒ Medication Administration Records
- ☒ Nurses Notes
- ☒ Assessments
- ☒ Physician Orders
- ☒ Physician Progress Notes
- ☒ Facility Incident Reports
- ☒ Service Plan

Other pertinent medical records:

☒ Hospital Records ☒ Death Certificate

Additional facility records:

- ☒ Staff Time Sheets, Schedules, etc.
- ☒ Facility Internal Investigation Reports
- ☒ Personnel Records/Background Check, etc.
- ☒ Facility Policies and Procedures

Number of additional resident(s) reviewed: na

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: client is deceased

Interviews: The following interviews were conducted during the investigation:

Interview with complainant(s) ○ Yes ○ No ◉ N/A

Specify: _____

If unable to contact complainant, attempts were made on:

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

Interview with family: ○ Yes ◉ No ○ N/A Specify: Attempts to contact on 10/3/16, 10/5/16, 10/

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

○ Yes ○ No ◉ N/A Specify: client is deceased

Did you interview additional residents? ○ Yes ◉ No

Total number of resident interviews: _____

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

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: six

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:

☒ Medication Pass

☒ Cleanliness

☒ 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 - Home Care & Assisted Living Program

The Office of Ombudsman for Long-Term Care

Anoka County Medical Examiners

Columbia Heights Police Department

Anoka County Attorney

Columbia Heights City Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H26853	A. BUILDING: _____ B. WING _____	C 10/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIGHTHOUSE OF COLUMBIA HEIGHTS	3801 HART BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

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0 000	Initial Comments *****ATTENTION****** HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: On 9/27/16 and 9/28/16, a complaint investigation was initiated to investigate complaint #HL26853011 . At the time of the survey, there were 76 clients that were receiving services under the comprehensive license. The following correction orders are issued.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors ' 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. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144A.474 SUBDIVISION 11 (b)(1)(2)	
0 325 SS=G	144A.44, Subd. 1(14) Free From Maltreatment Subdivision 1. Statement of rights. A person who receives home care services has these rights:	0 325		

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0 325	Continued From page 1 (14) the right to be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act; This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the licensee failed to ensure a client's right to be free from maltreatment when staff omitted an ordered antibiotic for one of one clients (C1) reviewed. This practice resulted in a level three violation (a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: C1's medical record was reviewed. C1 received services from the licensee for diagnoses that included diabetes and failure to thrive. C1's service plan dated 3/23/16 indicated C1 required assistance with medication administration. A physician note dated 8/17/16 indicated C1 had a history of decreased appetite and gradual weight loss over the past year from 175 pounds to 150 pounds. C1 was on a nutritional supplement and labs had been unremarkable. A physician note dated 8/17/16 indicated C1 was seen by the nurse practitioner for difficulty sleeping and concerns about weight loss. The nurse practioner discontinued the C1's	0 325		

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0 325	Continued From page 2 levothyroxine (thyroid medication) and metformin (anti-diabetic medication). A physician communication note dated 8/19/16, stated C1 began not feeling well on 8/18/16 and experienced a runny nose, cough, and fatigue. On 8/19/16 at 2:30 p.m., the nurse practioner ordered a chest X-ray of C1. X-ray results showed mild pneumonia and were sent to the physician for review. On 8/20/16 at 11:00 a.m., a physician assistant ordered Levaquin 500 milligrams, one tab daily for seven days. A pharmacy delivery record confirmed the Levaquin was delivered on 8/20/16 at 5:20 p.m. Unlicensed personnel (ULP)-E accepted the delivery. C1's electronic medical administration record (EMAR) dated August 2016, reflected C1 did not receive the first two doses of Levaquin, which were scheduled for 8/20/16 and 8/21/16. On 8/22/16, the first dose was administered to C1 at 2:00 p.m. by licensed practical nurse (LPN)-B. C1's nurse notes dated 8/22/16 at 3:44 p.m., indicated C1 was pale, weak, had a productive cough, and had wheezes in the right lower lung. C1's pulse was 106 beats per minute and respirations were elevated, at 28 breaths per minute. A nurses note dated 8/22/16 at 9:35 p.m., indictated C1 was transported to the emergency department per physician recommendations. C1's death record indicated C1 died on 8/26/16. The cause of death was listed as pneumonia and sepsis. During an on-site visit on 9/27/16, medication administration was observed. The home care provider's practice for storage of as-needed medications or short term medications (such as antibiotics) was to place the medications in the bottom drawer of the medication cart, organizaed	0 325		

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0 325	Continued From page 3 by client name. The EMAR system will alert staff to new medications by highlighting the order in yellow. During an interview on 9/27/16 at 1:48 p.m., ULP-C stated s/he recalled C1 had a new order for an antibiotic for pneumonia and it did highlight in yellow on the EMAR. ULP-C stated C1 had a cough and requested cough syrup on 8/20/16, which ULP-C provided. However, ULP-C stated she did not see the antibiotic in the medication cart and therefore did not administer the medication. ULP-C stated both LPN-B and RN-A notified her of the medication error.ULP-C stated that in the future, she would notify the nurse if a medication could not be found. On 9/27/16 at 4:30 p.m., ULP-D stated that on 8/21/16, she was aware of the new antibiotic C1 required as it showed up in yellow on the EMAR. ULP-D stated she looked everywhere in the cart for the bubble pack of the medication but could not find it. ULP-D stated she asked other medication passers if they knew about C1 starting a new antibiotic, however, they did not know. Therefore, ULP-D stated, she marked the antibiotic on the EMAR as not administered due to not being delivered by pharmacy. Also, ULP-D stated she was busy that night passing medication and assisted with cares due to working short staffed. ULP-D stated RN-A spoke to her about the medication error. ULP-D stated she normally will update the nurse if a medication is missing, but forgot that evening. During an interview with ULP-E on 9/28/16 at 11:00 a.m., ULP-E verified her signature on the pharmacy delivery slip that included C1's Levaquin. ULP-E stated the staff only have keys to open their own assigned medication cart and	0 325		

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0 325	Continued From page 4 therefore she gave the medication to ULP-C. During an interview with RN-A on 9/28/16 at 11:30 a.m., RN-A stated ULP-C and ULP-D both stated they did not realize Levofloaxcin was the same drug as Levaquin although both medication names were on the EMAR order. RN-A stated she counseled both ULP-C and ULP-D and watched them more carefully during medication administration. RN-A stated C1 had continued to decline Monday night after receiving the first dose of the Levaquin and the facility chose to send him to the hospital Tuesday morning. On 10/3/16 at 3:00 p.m., LPN-B stated on 8/22/16 she observed C1's status and found that C1 had not received any of the Levaquin. LPN-B stated she changed the antibiotic administration time to 2:00 p.m. so she could administer the first dose right away and found the antibiotic supply card in the bottom drawer of the medication cart. LPN-B stated she confirmed that no tabs had been used. LPN-B stated she updated the RN, the physician, and C1's family on the medication error. LPN-B stated C1 experienced increased weakness, coarse cough, and an elevated respiration rate of twenty-eight. During an interview with C1's physician on 10/3/16 at 3:35 p.m., the physician stated C1's X-ray showed mild pneumonia, however because of C1's clinical symptoms Levaquin was ordered. The physician explained C1 was frail with multiple co-morbidities including congestive heart failure, diabetes, and chronic anemia. The physician stated the delay in starting C1's antibiotic could have caused C1 to progress into a septic infection. The licensee policy titled "Requesting and	0 325		

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0 325	Continued From page 5 Receiving Medication Prescription and Refills" dated 9/14/14, indicated if the pharmacy delivers when a nurse is not on-site, the medication passers are to sign the pharmacy delivery slip after verifying medications that are received match. The licensee policy titled "Documentation of Medication Services on the MAR" dated 9/14/14, indicated the nurse is to be notified of medications that are not administered as ordered. TIME PERIOD FOR CORRECTION: Twenty One (21) days	0 325		
02015 SS=A	626.557, Subd. 3 Timing of Report Subd. 3. Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21,	02015		

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02015	Continued From page 6 clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to report maltreatment	02015		

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02015	Continued From page 7 immediately (no longer than twenty-four hours) for one of one clients (C1) reviewed, when the client did not receive an antibiotic for two days and the client was hospitalized . This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: A Vulnerable Adult Maltreatment report was received by the Office of Health Facility complaints from the licensee on 9/1/16. C1's medical record was reviewed. C1 admitted to the licensee with diagnoses that included diabetes and failure to thrive. C1's service plan dated 3/23/16 indicated C1 required assistance with medication administration. A physician communication note dated 8/19/16, indicated C1 began not feeling well on 8/18/16 and experienced a runny nose, cough, and fatigue. On 8/19/16 at 2:30 p.m., the nurse practioner ordered a chest X-ray of C1. X-ray results showed mild pneumonia and were sent to the physician for review. On 8/20/16 at 11:00 a.m., a physician assistant ordered Levaquin 500 milligrams, one tab daily for seven days. Pharmacy delivery record confirmed the Levaquin was delivered on 8/20/16 at 5:20 p.m. and unlicensed personnel (ULP)-E accepted the delivery.	02015		

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LIGHTHOUSE OF COLUMBIA HEIGHTS	3801 HART BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

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02015	Continued From page 8 C1's electronic medical administration record (EMAR) dated August 2016, reflected C1 did not receive the first two doses of Levaquin on 8/20/16 and 8/21/16. On 8/22/16, the first dose was administered to C1 at 2:00 p.m. by the licensed practical nurse (LPN)-B. C1's nurse notes dated 8/22/16 at at 3:44 p.m., indicated C1 was pale, weak, had a productive cough, and had wheezes in right lower lung. C1's pulse was elevated to 106 beats per minute and elevated respiration of 28 breaths per minute. A nurses note dated 8/22/16 at 9:35 p.m., indictated C1 was transported to the emergency department per physician recommendations. C1's death record indicated C1 died on 8/26/16 with the cause of death as pneumonia and sepsis. During an interview on 9/28/16 at 11:30 a.m., registered nurse (RN)-A stated she could not remember exactly when she submitted the vulnerable report for C1, but recalls it was after he passed way. The licensee policy titled "Vulnerable Adult Reporting and Investigation Policy" dated 11/12/15, indicated if it is unsure whether maltreatment had occurred, the RN will immediately begin investigating the incident. If within twenty-four hours following the initial report of the incident and the RN is still unsure whether the incident is reportable, the RN will make an oral report to Minnesota Adult Abuse Reporting Center. TIME PERIOD FOR CORRECTION: Twenty One (21) days	02015		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

August 15, 2017

Ms. Tammy Kucera, Administrator
New Perspective - Columbia Heights
3801 Hart Boulevard NE
Columbia Heights, MN 55421

RE: Complaint Number HL26853011

Dear Ms. Kucera :

On August 3, 2017 an investigator of the Minnesota Department of Health, Office of Health Facility Complaints completed a re-inspection of your facility, to determine correction of orders found on the complaint investigation completed on October 11, 2016 with orders received by you on November 19, 2016. At this time these correction orders were found corrected and are listed on the attached State Form.

You are encouraged to retain this document for your records. 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,

Matthew Heffron

Matthew Heffron, JD, NREMT
Health Regulations Division
Office of Health Facility Complaints
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone: (651) 201-4221 Fax: (651) 281-9796

MH/ja
Enclosure

cc: Home Health Care Assisted Living File
Anoka County Adult Protection
Office of Ombudsman
MN Department of Human Services