MDH Minnesota Department of Health

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:
Vision Quest Property Management

Facility Address:
5771 Meadowview Drive

Facility City:
White Bear Lake

State: Minnesota | **ZIP:** 55110 | **County:** Ramsey

Report Number:
HL28288004 and HL28288005

Date of Visit:
April 4, 2016

Time of Visit:
11:00 a.m. - 6:00 p.m.

Date Concluded:
December 29, 2016

Investigator's Name and Title:
Karen Johnson, RN

☒ **Home Care Provider/Assisted Living**

Allegation(s):
It is alleged that a client was neglected when staff failed to follow the physician's medication orders. The client did not receive prescribed medication for 11 days, suffered a stroke, and was hospitalized.

☒ 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 the evidence, neglect occurred. The client did not receive a prescribed anticoagulant medication for 14 days because the medication was not reordered by the licensed nursing staff, alleged perpetrator (AP), and staff members failed to report that it had not been administered. Within a week after the issue was discovered, the client had a stroke requiring hospitalization. The client died as a result of this stroke.

The client received services from the home care provider, including medication management. The client was on long term oral anticoagulant therapy due to a higher risk of stroke, secondary to atrial fibrillation and a history of prior stroke.

Ten days prior to the client's death, routine testing was conducted of the client's blood clotting rate to ensure the client's medication was at a safe and effective dose. Upon review of the clotting time results, AP noted it was abnormally low. The AP reviewed the medication administration record that indicated one milligram (mg) of warfarin was to be given daily on Tuesday, Thursday, Saturday, and Sunday, and 0.5 mg on Monday, Wednesday, and Friday. The AP discovered the client had not received any anticoagulation medication for the preceding 14 days. Pharmacy documentation confirmed the client's medications were not on a scheduled delivery, and needed to be reordered every 14 days. The medication had not been reordered by the AP during the time period prior to the 14 days of missed doses. The AP notified the client's physician and was directed to restart the medication at the previous dose and to redraw the blood work in one week. Due to the client's fragile condition, the physician did not order any additional interventions.

Four days later, the client had symptoms of stroke, emergency medical services were called, and the client was admitted to the hospital. The client was diagnosed with a stroke and treated with intravenous blood thinners. The client subsequently passed away, and the death certificate indicated the immediate cause of death was an embolic vascular accident.

The family was interviewed and stated they had not been informed of the missed anticoagulation medication, until hospital staff notified them.

The primary care physician was interviewed and indicated in his/her medical opinion, the client missing 14 days of oral anticoagulant therapy was a direct cause of the client's death.

The AP stated during an interview that the nurse who usually reordered the medications was off duty for an extended period of time. The AP was refilling the client's medications, and missed reordering the anticoagulation medication. The AP indicated that if the medication was listed on the client's medication administration record but was not in supply, the personnel who were assigned to administer medications should have reported the medication was not administered as prescribed. Several staff members had assisted the client with medications, but none had reported the medication being unavailable.

Minnesota Vulnerable Adults Act (MN 626.557)

Under the Minnesota Vulnerable Adults Act (MN. 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:

A system was in place to ensure accurate medication administration to clients; yet, the facility failed to ensure multiple personnel followed the policy and procedure for medication administration. The AP knew the facility's policy and procedures for medication management, but failed to follow the policy and reorder medications for the client. The AP had written warnings for medication concerns in 2009, 2010, and an additional 2016 medication incident for three missed anticoagulation doses.

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 Home Care Providers (MN Statutes section 144A.43 - 144A.483) - Compliance Not Met

The requirements under State Statutes for Home Care Providers (MN Statutes, section 144A.43 - 144A.483) 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:

(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] Treatment Sheets
- [x] Physician Progress Notes
- [x] Care Plan Records
- [x] Skin Assessments
- [x] Facility Incident Reports
- [x] ADL (Activities of Daily Living) Flow Sheets
- [x] Service Plan

Other pertinent medical records:

- [x] Hospital Records
- [x] Death Certificate

Additional facility records:

- [x] Staff Time Sheets, Schedules, etc.
- [x] Personnel Records/Background Check, etc.
- [x] Facility In-service Records
- [x] Facility Policies and Procedures

Number of additional resident(s) reviewed: 3

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: 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: _____

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

○ Yes ◉ No ○ N/A Specify: Deceased

Did you interview additional residents? ◉ Yes ○ No

Total number of resident interviews: 5

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

Tennessen Warnings

Tennessen Warning given as required: ○ Yes ○ No

Total number of staff interviews: 5

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:

- [x] Personal Care
- [x] Nursing Services
- [x] Infection Control
- [x] Medication Pass
- [x] Cleanliness
- [x] Dignity/Privacy Issues
- [x] Safety Issues
- [x] Transfers
- [x] Meals
- [x] Facility Tour
- [x] Incontinence

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

Minnesota Board of Nursing

The Office of Ombudsman for Long-Term Care

Osseo Police Department

Osseo City Attorney

Hennepin County Attorney

Hennepin County Medical Examiner

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H28288	A. BUILDING: _____ B. WING _____	C 08/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISION QUEST PROPERTY MANAGEMENT	5771 MEADOWVIEW DRIVE WHITE BEAR LAKE, MN 55110

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0 000	Initial Comments On April 4, 2016, a complaint investigation was initiated to investigate complaint # HL28288004. At the time of the survey, there were 32 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 that 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 subd. 11 (b) (1) (2)	
0 325 SS=J	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 interview and document review, the licensee failed to ensure a client was free from maltreatment (neglect) when a prescribed medication was not administered as ordered for 1 of 3 clients (C1) reviewed, when C1 did not receive 14 doses of an anticoagulation medication (warfarin), suffered a stroke, and died. This resulted in a level 4 violation (a violation that results in serious injury, impairment, or death) and is 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 had occurred only occasionally or in a limited number of locations). Findings include: C1's medical record was reviewed. C1's care plan dated July 7, 2015, was completed by registered nurse (RN)-H and indicated the client had diagnoses including lung nodules, hypertension, atrial fibrillation, and malignant neoplasm/breast. C1's service plan written on July 7, 2015, indicated C1 required assistance of one staff for medication management, safety checks three times a day, bathing, and ambulation assistance when using a walker. C1 was independent for toileting, dressing, personal grooming, oral care, eating, transferring, and bed mobility. C1 used a power chair for mobility and wore a safety	0 325		

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0 325	Continued From page 2 pendant. C1's lab results indicated that on February 23, 2016, C1's international normalized ratio (INR) was 2.6 (acceptable level is 2.0-3.0). On that same day, RN-B received orders from C1's primary care physician (PCP)-G to continue warfarin one milligram (mg) tablets, with directions to administer half a tablet on Monday, Wednesday, and Friday, and full one mg tablet on Tuesday, Thursday, Saturday, and Sunday. C1's medication administration record (MAR) for March 2016 was reviewed. From March 8 through March 22, 2016, four doses were signed as given, three doses were signed and circled as not given with no further explanation, and the rest of the doses were not addressed. C1's lab results indicated on March 22, 2016, C1's INR results were 1.1 (critically low). RN-B notified primary care physician (PCP)-G and new orders were received to continue the warfarin with no changes in the dosing order and to redraw the INR blood test on March 30, 2016. Nursing progress note dated March 28, 2016 (listed as a late entry for March 26, 2016) indicated the nurse received a call from staff that C1 was not herself and staff thought C1 was having a stroke. The nurse instructed staff to call emergency services and C1 was taken to the hospital. C1's hospital discharge record dated March 30, 2016, indicated C1 was admitted for a large embolic right middle cerebral artery cerebral vascular accident (stroke) and that C1 had a history of chronic arterial fibrillation on anticoagulation therapy. C1's prognosis for	0 325		

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0 325	Continued From page 3 recovery was poor. An interview with RN-B was conducted on April 4, 2016 at 12:15 p.m. RN-B indicated that on every Monday the licensed practical nurse (LPN) checked that all client medications cards are correct and are compared to the client's MAR. The LPN then reordered any medications that are not on an automatic refill system. C1's warfarin was not on an automatic refill system. Due to an unplanned staffing issue, the LPN was off duty for six weeks, and RN-B then assumed responsibility for the weekly check of the medication cards, including comparing them to the MARs and ordering refills. RN-B acknowledged that when C1's medication locked box was checked, there was no warfarin. RN-B acknowledged she was responsible for refilling the warfarin, but had not reordered it from the pharmacy. On March 22, 2016 PCP-G was notified of the INR 1.1 results and of the missed administration of the medication Warfarin. Orders were received to resume the Warfarin at the current dosing order and to redraw the INR on March 26, 2016. RN-B stated she did not notify the family or the client of the missed administration of the Warfarin medication because she did not want them to get upset. Review of the facility Policy and procedure titled "3.07 Supervision of ULP," dated May 30, 2014, indicated staff providing delegated nursing or therapy home care tasks will be supervised by a RN. Supervision will include observation of the staff administering the medication or treatment and the interaction with clients. Review of the facility Policy and procedure titled "5.11 Medication Administration - weekly dosage box set up," dated May 30, 2014, indicated the	0 325		

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0 325	Continued From page 4 licensed nurse is to set up the client weekly dosages timely and accurately and the licensed nurse will review the dosage boxes on a weekly basis to assure that all the previous weeks medications were administered and documentation is then made on the MAR. Review of the facility position description for Registered Nurse, not dated, indicated the registered nurse completes medication set ups as needed to assist LPN, completes professional nursing tasks such as order transcription, charting, foot care, treatments and injections, MD calls, family calls and conferences. Review of the facility position description for Resident Assistant (RA), not dated, indicated under General Position Statement; Under the general direction of the RN, Resident Services Director, the Resident Assistant position provides and documents personal care and supervision in a manner conductive to the resident's safety, comfort, security and greatest degree of independence as possible. Operates within the parameters of each resident's service plan, care plan, and schedule as directed and assigned by the Registered Nurse. TIME PERIOD FOR CORRECTION: Seven (7) days	0 325		
0 935 SS=J	144A.4792, Subd. 8 Documentation of Administration of Medication Subd. 8. Documentation of administration of medications. Each medication administered by comprehensive home care provider staff must be documented in the client's record. The documentation	0 935		

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0 935	Continued From page 5 must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the client's needs when medication was not administered as prescribed and in compliance with the client's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure a prescribed medication was administered as ordered by a physician for 1 of 3 clients (C1) reviewed, when C1 did not receive 14 doses of an anticoagulation medication (warfarin), suffered a stroke, and died. This resulted in a level 4 violation (a violation that results in serious injury, impairment, or death) and is 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 had occurred only occasionally or in a limited number of locations). Findings include: C1's medical record was reviewed. C1's care plan dated July 7, 2015, was completed by registered nurse (RN)-H and indicated the client had diagnoses including lung nodules,	0 935		

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0 935	Continued From page 6 hypertension, atrial fibrillation, and malignant neoplasm/breast. C1's service plan written on July 7, 2015, indicated C1 required assistance of one staff for medication management, safety checks three times a day, bathing, and ambulation assistance when using a walker. C1 was independent for toileting, dressing, personal grooming, oral care, eating, transferring, and bed mobility. C1 used a power chair for mobility and wore a safety pendant. C1's lab results indicated that on February 23, 2016, C1's international normalized ratio (INR) was 2.6 (acceptable level is 2.0-3.0). On that same day, RN-B received orders from C1's primary care physician (PCP)-G to continue warfarin one milligram (mg) tablets, with directions to administer half a tablet on Monday, Wednesday, and Friday, and full one mg tablet on Tuesday, Thursday, Saturday, and Sunday. C1's medication administration record (MAR) for March 2016 was reviewed. From March 8 through March 22, 2016, four doses were signed as given, three doses were signed and circled as not given with no further explanation, and the rest of the doses were not addressed. C1's lab results indicated on March 22, 2016, C1's INR results were 1.1 (critically low). RN-B notified primary care physician (PCP)-G and new orders were received to continue the warfarin with no changes in the dosing order and to redraw the INR blood test on March 30, 2016. Nursing progress note dated March 28, 2016 (listed as a late entry for March 26, 2016) indicated the nurse received a call from staff that	0 935		

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0 935	Continued From page 7 C1 was not herself and staff thought C1 was having a stroke. The nurse instructed staff to call emergency services and C1 was taken to the hospital. C1's hospital discharge record dated March 30, 2016, indicated C1 was admitted for a large embolic right middle cerebral artery cerebral vascular accident (stroke) and that C1 had a history of chronic arterial fibrillation on anticoagulation therapy. C1's prognosis for recovery was poor. An interview with RN-B was conducted on April 4, 2016 at 12:15 p.m. RN-B indicated that on every Monday the licensed practical nurse (LPN) checked that all client medications cards are correct and are compared to the client's MAR. The LPN then reordered any medications that are not on an automatic refill system. C1's warfarin was not on an automatic refill system. Due to an unplanned staffing issue, the LPN was off duty for six weeks, and RN-B then assumed responsibility for the weekly check of the medication cards, including comparing them to the MARs and ordering refills. RN-B acknowledged that when C1's medication locked box was checked, there was no warfarin. RN-B acknowledged she was responsible for refilling the warfarin, but had not reordered it from the pharmacy. On March 22, 2016 PCP-G was notified of the INR 1.1 results and of the missed administration of the medication Warfarin. Orders were received to resume the Warfarin at the current dosing order and to redraw the INR on March 26, 2016. RN-B stated she did not notify the family or the client of the missed administration of the Warfarin medication because she did not want them to get upset.	0 935		

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0 935	Continued From page 8 Review of the facility Policy and procedure titled "3.07 Supervision of ULP," dated May 30, 2014, indicated staff providing delegated nursing or therapy home care tasks will be supervised by a RN. Supervision will include observation of the staff administering the medication or treatment and the interaction with clients. Review of the facility Policy and procedure titled "5.11 Medication Administration - weekly dosage box set up," dated May 30, 2014, indicated the licensed nurse is to set up the client weekly dosages timely and accurately and the licensed nurse will review the dosage boxes on a weekly basis to assure that all the previous weeks medications were administered and documentation is then made on the MAR. Review of the facility position description for Registered Nurse, not dated, indicated the registered nurse completes medication set ups as needed to assist LPN, completes professional nursing tasks such as order transcription, charting, foot care, treatments and injections, MD calls, family calls and conferences. Review of the facility position description for Resident Assistant (RA), not dated, indicated under General Position Statement; Under the general direction of the RN, Resident Services Director, the Resident Assistant position provides and documents personal care and supervision in a manner conductive to the resident's safety, comfort, security and greatest degree of independence as possible. Operates within the parameters of each resident's service plan, care plan, and schedule as directed and assigned by the Registered Nurse. TIME PERIOD FOR CORRECTION: Seven (7)	0 935		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISION QUEST PROPERTY MANAGEMENT	5771 MEADOWVIEW DRIVE WHITE BEAR LAKE, MN 55110

(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
0 935	Continued From page 9 days	0 935		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

August 15, 2017

Mr. Charles Petrich, Administrator
Vision Quest Property Management
5771 Meadowview Drive
White Bear Lake, MN 55110

RE: Complaint Number HL28288004

Dear Mr. Petrich :

On July 26, 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 August 15, 2016 with orders received by you on December 30, 2017. 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
Ramsey County Adult Protection
Office of Ombudsman
MN Department of Human Services