Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL285132242M
Compliance #: HL285131208C

Date Concluded:

Name, Address, and County of Licensee Investigated:
Oak Terrace Senior Housing
622 Aberdeen Ave
Jordan, MN 55352
Scott County

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

Evaluator's Name: Lena Gangestad, 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 a staff member combined Metolazone and Mirtazapine in the same bottle. As a result, the resident was hospitalized due to fluid overload.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Due to the resident's complex health history, there was insufficient evidence to prove that the incident caused the resident's death. Although a staff member combined Metolazone and Mirtazapine in the same bottle, the error was an isolated incident. The resident's weight was elevated, and he was sent to the hospital due to fluid overload. He received treatment and returned to the facility two days later.

The investigator conducted interviews with administrative staff and a family member. The investigation included review of the resident's records, internal investigation documentation, incident reports, policies, and procedures.

The resident resided in an assisted living building. The resident's diagnoses include end stage renal disease and heart failure. The resident's service plan included assistance with all activities of daily living which included hygiene, dressing, toileting, medications, meals, and housekeeping.

According to the resident's medication administration record, the resident was prescribed Metolazone 5 milligrams (mg) by mouth daily for excess fluid, and Mirtazapine 7.5 mg at bedtime for sleep and mood.

According to the progress notes, the resident's health had been declining, and his weight had fluctuated between 166-175 lbs. over the past three months.

An incident report indicated that a staff member notified a nurse about Mirtazapine pills being mixed into the Metolazone bottle. The facility did not know when this happened or who mixed the medications together.

According to hospital records, the resident was admitted to the hospital due to fluid overload. His baseline weight was 167-168 pounds (lbs.), and his weight at admission was 180 lbs. The record also indicated that the resident elected to forgo dialysis.

The documentation of death indicated that the cause of death was end-stage kidney disease and type 2 diabetes.

During an interview, a nurse stated that a staff member told her there were two different pills, metolazone and mirtazapine, in a metolazone bottle. She started the investigation but could not determine when and who combined the medications. She immediately notified the kidney specialist and the family. The resident had an appointment with the kidney specialist the next day, and the specialist agreed that it was fine for him to wait until the appointment. He was sent to the hospital right after his appointment due to shortness of breath and was discharged back to the facility after two days. As soon as a nurse found out about the incident, a staff meeting was scheduled, and she said she provided re-education to all the staff about not combining medications.

During an interview, a family member stated that a nurse called her and informed her about the medication incident. She said he was sent to the hospital but did not remember how long his stay was.

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. The resident was deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
A Medication Pass meeting was held where it was discussed that medications should never be mixed, or pill bottles combined. In addition, all staff members who pass medications were given an acknowledgment form to sign and return, confirming that they understand they cannot combine pill bottles and must use each bottle until it is gone.

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
	28513	A. BUILDING: _____ B. WING _____	C 06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK TERRACE HOUSING OF JORDAN	622 ABERDEEN AVENUE JORDAN, MN 55352

(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 June 18, 2024, the Minnesota Department of Health initiated an investigation of complaints #HL285133365M/HL285133548C and #HL285132242M/HL285131208C. No correction orders are issued.	0 000		