Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL29079013M, HL29079015M
Compliance #: HL29079014C, HL29079016C

Date Concluded: February 5, 2020

Name, Address, and County of Licensee Investigated:
Transforming Age, DBA Minnesota Senior Living LLC
1980 112th Ave NE
Bellvue, WA 98004
King County

Name, Address, and County of Housing with Services location:
The Rivers
11111 River Hills Drive
Burnsville, MN 55337
Dakota County

Facility Type: Home Care Provider

Investigator's Name:
Amy Hyers, RN, Special Investigator

Finding: Substantiated, facility responsibility

Nature of Visit:
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.

Allegation(s):
It is alleged: The facility failed to ensure the client was free from neglect when medication transcription errors were made. The client's condition deteriorated, and she was hospitalized.

Investigative Findings and Conclusion:
Neglect was substantiated. The facility was responsible for the maltreatment. The AP (a licensed practical nurse) inadvertently failed to transcribe the entire order received by the provider. A second nurse failed to provide a second check to ensure transcription accuracy. As a result, the client did not receive several doses of a scheduled diuretic (removes excess fluid from the body); she was hospitalized and died five days later. Furthermore, there is no evidence staff notified a nurse of a significant weight change in the client; earlier intervention may have prevented the client's condition from resulting in death.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator conducted observations of the facility. The investigation involved review of records to include the client's record, facility incident reports, medication error reports, physician records, the facility's internal investigation report, employee files, the death certificate, and facility policies and procedures.

The client received comprehensive home care services for diagnoses that included congestive heart failure, lymphedema, and dementia. According to a service plan, the client received assistance with bathing, donning and doffing compression stockings, and medication management. Occasionally, she required some minor assistance with dressing and incontinence cares. She was independent with her mobility, had mild memory loss, and minor hearing impairment.

One day, the client's primary care provider faxed new medication orders to the facility. The medication orders indicated the client's diuretic medication (torsemide) would increase by 10 milligrams (mg) daily for five days, then return to the original order. Concurrently, the client's potassium medication dose increased to three times daily for five days from twice daily. The potassium medication order also indicated the dose should revert back to original (twice daily) dosing. The medication orders also included some lab tests to be completed and daily weights of the client for seven days. The potassium dose increase was necessary due to a side effect of the diuretic medication which is potassium level depletion.

The client's electronic medical record indicated the AP entered the medication order at 7:47 a.m. to increase the diuretic. The start date entered was the next day with an end date of five days later. Although the AP wrote a progress note in the electronic medical record to include all aspects of the order, she did not transcribe it properly into the electronic medication administration record (eMAR) segment of the client's record.

Review of the eMAR indicated that because of the timing for medication administration, the client did not receive any diuretic on the day of the order transcription. The current diuretic dose was discontinued prior to the scheduled medication administration time, and the new dose started the next day. Further review indicated that after the five day increase, the eMAR did not contain any diuretic orders. In addition, the eMAR indicated the client continued to receive the increased dose of potassium.

The faxed orders from the provider contained the initials of the AP at the end of the first of six listed orders. The order also contained a red ink hand stamped image of "FAXED" with an outlined box beneath the word. The same AP's initials were in the box indicating she faxed the orders to the pharmacy. Next to the box, the word "noted" was written in what appeared to be a different pen than the AP's initials were written in. It is unknown who wrote the word noted.

Review of the facility's internal investigation notes indicated facility management interviewed the LPN who worked the evening shift on the day of the client's medication order changes. She

stated although she would typically finish the medication order process, she instead passed medications during her shift. She stated three times that she never saw the medication order and left it for the night shift nurse to process.

The LPN declined an interview during this investigation.

During the course of the increased diuretic medication, the client's weight ranged between 170 to 171 pounds. Two days after the diuretic ceased, staff documented the client's weight as 166 pounds. The next day, the client's record indicated she weighed 173 pounds. There was no documentation to indicate any of the weight readings were further evaluated or re-checked. The unlicensed personnel wrote notes in the client's record to indicate other staff obtained the client's weight before the client ate breakfast; however, there was nothing in the client's record to indicate staff notified the nurse about the result.

On the seventh day of no diuretic, the client was confused, delusional, coughing, short of breath, and weak. She had an acute exacerbation of congestive heart failure due to the lack of diuretics for one week. The client's primary care provider observed the client, discovered the medication error, and in addition to the congestive heart failure believed the client was also hyperkalemic (too much potassium in blood system); she sent the client to the hospital. The client died five days later while in the hospital. The death certificate indicated the cause of death was hypercapnic respiratory failure (elevated blood and tissue levels of carbon dioxide; due to the decreased function of her lungs) and metabolic encephalopathy (abnormalities of the water, electrolytes, and other chemicals that adversely affect brain function).

Facility policies indicated the registered nurse (RN) is responsible for assuring that current medication orders are accurately added to the eMAR. There was no evidence to indicate an RN had any oversight of the medication transcription process.

During an interview, an RN said she was unable to determine if anything had been done in response to the weight changes. She looked in the electronic record and searched for anything handwritten. She said unlicensed personnel should notify a nurse of changes like that and a nurse should notify the provider even with no specific order to do so. She further stated she was unsure if there was an actual process in place at the time for medication order transcription.

During an interview, another RN said the process at the time was one nurse would take the order and transcribe it. She said, "The second nurse should double check and sign off the order". She also stated staff should notify a nurse with any five pound weight change noted in a client. She said the staff should have notified a nurse and the nurse should then notify the provider. She said she would expect them to call the provider immediately, especially because the client had congestive heart failure; a nurse should report any change in condition to the provider. The RN said if notification of the weight change was made, the client would likely have been sent in for evaluation. She said the "ball was dropped".

During an interview, an LPN stated two nurses were responsible for medication order transcription. The first nurse should have transcribed the order into the computer, faxed it to the pharmacy, and then placed it in a designated space. A second nurse was responsible to check for accuracy and file it in the client's chart. She stated the first nurse followed proper procedure. The LPN was uncertain if the second check by another nurse was in place at the time, but ultimately felt like it was. She said the night shift nurses were largely responsible for filing orders into charts, but the orders should contain that nurses initials as well. She further stated her expectation would be staff report and respond to a weight change of 3 pounds in a client. She said this may happen verbally or in documentation, but "something should have been done".

During an interview, the AP who transcribed the orders stated she responded to a client fall in the middle of processing the orders. She returned to finish the orders and inadvertently did not complete the process in its entirety. She said she placed the order on the shelf, as was proper protocol. She said when an order comes in the first nurse "does the order". She said the night nurse then "goes over" the order, signs it, and places it in the chart. She said the second nurse is supposed to write the word "noted" and sign (their name or initials). She stated she did not recollect staff ever notified her of the client's weight changes. She said if she was notified of a weight change like that, she would go re-weigh the client herself. If there was an obvious problem, she would report to the nurse manager and/or the provider.

During an interview, the primary care provider stated she increased the client's diuretic due to a gradual weight (fluid) increase over approximately six weeks. The expected outcome was the client would be able to breathe easier, have a decrease of leg edema (fluid build-up), and therefor would have a decrease in weight. The provider perused the client record for both phone and fax notification of any weight changes during the indicated timeframe, and stated there was none. She said staff should have called her with a change like that. The provider said the factors contributing to the client's condition decline were going from 50 mg of the diuretic to zero, and the increased dose of potassium that continued. The provider said, "She was having trouble with heart failure. She would have likely died from heart failure; however, it (the error) absolutely exacerbated her death."

In conclusion, neglect was substantiated. Earlier intervention and assessment by a nurse at the time of the weight discrepancy may have prevented the acute exacerbation of the client's disease process. Furthermore, if facility staff had followed the proper process of medication order transcription, the forcing functions built into the process would have prevented the error from occurring.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"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.

Vulnerable Adult interviewed: No; she was deceased at the time of the investigation.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The nurse who made the transcription error is no longer employed by the facility. Policies and procedures were improved. Re-education to all nursing staff was completed.

Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit: https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html, or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

The responsible party will be notified of their right to appeal the maltreatment finding.

cc:
The Office of Ombudsman for Long-Term Care
Dakota County Attorney
Burnsville City Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H29079	A. BUILDING: _____ B. WING _____	C 12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RIVERS	11111 RIVER HILLS DRIVE BURNSVILLE, MN 55337

(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****** HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, the Minnesota Department of Health issued a correction order(s) pursuant to a survey. 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: On December 12, 2019, the Minnesota Department of Health initiated an investigation of complaint #HL29079013M/HL29079014C, HL29079015M/HL29079016C, and HL29079017M/HL29079018C. At the time of the survey, there were 46 clients receiving services under the comprehensive license. The following correction orders are issued for HL29079013M/HL29079014C and HL29079015M/HL29079016C, tag identifications 0325 and 0980.	0 000	The Minnesota Department of Health documents 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 are 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. Per Minnesota Statute § 144A.474, Subd. 8(c), the home care provider must document any action taken to comply with the correction order. A copy of the provider's records documenting those actions may be requested for follow-up surveys. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider's Plan of Correction." The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144A.474, Subd. 11 (b).	
0 325	144A.44, Subd. 1(14) Free From Maltreatment Subdivision 1. Statement of rights. A person who receives home care services has these rights: (14) the right to be free from physical and verbal abuse, neglect, financial exploitation, and all	0 325		

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0 325	Continued From page 1 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 interviews and document review, the facility failed to ensure one of one client reviewed (C1) was free from maltreatment. C1 was neglected. Findings include: On December 12, 2019, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	0 325		
0 980 SS=J	144A.4792, Subd. 16 Written or Electronic Prescription Subd. 16. Written or electronic prescription. When a written or electronic prescription is received, it must be communicated to the registered nurse in charge and recorded or placed in the client's record. This MN Requirement is not met as evidenced by: Based on interviews and document review, the licensee failed to properly transcribe and implement physician orders for one of one client (C1) reviewed when the electronic medication	0 980		

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0 980	Continued From page 2 administration record (eMAR) did not reflect C1's current prescription. This practice resulted in a level four violation (a violation that results in 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 received comprehensive home care services for diagnoses that included congestive heart failure, lymphedema, and dementia. C1 received assistance with bathing; donning and doffing compression stockings; medication management; and occasional minor assistance with dressing and incontinence cares according to a service plan last revised on August 15, 2018. Document review of C1's record indicated her physician assistant (PA)-B faxed medication orders to the facility on July 25, 2019 at 7:26 a.m. The medication orders contained the following: 1) Discontinue torsemide 20 milligrams (mg) 2 tablets by mouth every day. 2) Torsemide 20 mg 2.5 tablets by mouth daily x 5 days. (Increase morning dose by 0.5 tablets x 5 days.) After 5 days, return to torsemide 20 mg 2 tablets by mouth daily indefinitely. 3) Discontinue potassium ER 10 mEq 1 tab by mouth twice daily. 4) Potassium ER 10 mEq 1 tab by mouth three times per day x 5 days, after 5 days return to potassium 10 mEq 1 tablet twice daily indefinitely. 5) BMP [basic metabolic panel], BNP [brain Natriuretic peptide]. 6) Daily weights x 7 days.	0 980		

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0 980	Continued From page 3 The faxed medication orders contained the initials of licensed practical nurse (LPN)-H at the end of the first of six listed orders. The medication order also contained a red ink hand stamped image of "FAXED" with an outlined box beneath the word. LPN-H's initials were located in the box indicating she faxed the medication orders to the pharmacy. Next to the box, the word "noted" was written in what appeared to be a different pen ink than LPN-H's initials were written in. Document review of C1's progress notes indicated LPN-H began transcribing the new orders on July 25, 2019 at 7:47 a.m. The start date entered for the increase of torsemide (a diuretic) was July 26, 2019; the end date entered was July 30, 2019. Document review of C1's July eMAR indicated C1 did not receive any torsemide on July 25, 2019, due to the order change placed prior to C1's medication administration time. The July eMAR further indicated the torsemide did not revert back to the original two tablets as ordered; therefore, no torsemide was given on July 31, 2019. Likewise, the potassium ER medication order did not revert back to the original order. C1 received 10 mEq three times daily on July 31, 2019. Document review of C1's August eMAR did not contain any medications orders for torsemide; consequently, C1 did not receive the prescribed medication. The potassium ER order remained at the increased dose of 10 mEq three times daily. Document review of the facility internal investigation indicated on August 6, 2019, LPN-J stated although she would typically finish the medication order process, she instead passed	0 980		

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0 980	Continued From page 4 medications during her shift (on July 25, 2019). She stated three times that she never saw the medication order for torsemide and left it for the night shift nurse to process. Document review of C1's progress note dated August 6, 2019 at 3:02 p.m., indicated C1 confused with an oxygen saturation level of 79% on room air. C1 was sent to the hospital for evaluation. Document review of an undated form titled, Incident Report, indicated a medication was not transcribed correctly and not administered for the previous seven days which contributed to C1's fluid retention. Document review of PA-B's follow-up visit notes with C1 on August 6, 2019, indicated C1 had an acute change in condition. C1 had increased confusion, delusions, a cough, and weakness. PA-B's investigation yielded the discovery of C1 missed administration of the diuretic (torsemide) doses, but continued receipt of the potassium ER doses. PA-B directed staff to send C1 to the hospital. Document review of C1's death certificate indicated C1 passed away in the hospital on August 11, 2019 at 12:20 a.m. The death certificate indicated the cause of death was hypercapnic respiratory failure (elevated blood and tissue levels of carbon dioxide due to the decreased function of her lungs) and metabolic encephalopathy (abnormalities of the water, electrolytes, and other chemicals that adversely affect brain function). Document review of facility in-service material for nursing staff dated August 9 to August 16, 2019,	0 980		

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0 980	Continued From page 5 indicated all nurses were re-trained on physician order processing, which included the topics titled, Entering Orders into PCC (Point Click Care) and Second Step -Verifying Order Entered Correctly. A new stamp was ordered for nurses to utilize for prompts to complete the transcription process thoroughly. Despite the re-education, transcription medication errors continued to occur. Document review of physician orders for C2 dated October 2, 2019, indicated the orders were filed into the client's chart without a second nurse's initials or date on the order. Document review of a form titled, Medication Error Report Form, dated November 23, 2019 at 9:00 a.m. indicated the following medication error: "Medication order expired and did not show up for CNA to give med. Order updated in system with end date: Indefinite, but start date entered for next day...so med not showing to be given..." Review of another Medication Error Report Form dated December 18, 2019 at 8:00 a.m. indicated the following medication error: "The order was not processed correctly -the warfarin 3.5 milligram (mg) dose was omitted in MAR leading to a missed dose. The nurse that verified the order missed the mistake too." During an interview on January 17, 2010 at 11:28 a.m., registered nurse (RN)-G said the process at the time (of the diuretic medication error) was one nurse would take the order and transcribe it. She said, "The second nurse should double check and sign off the order." During an interview on January 15, 2020 at 11:26 a.m., LPN-D stated two nurses were responsible	0 980		

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0 980	Continued From page 6 for medication order transcription. The first nurse should have transcribed the order into the computer, faxed it to the pharmacy, and then placed it in a designated space. A second nurse was responsible to check for accuracy and file it in the client's chart. She stated the first nurse followed proper procedure. LPN-D was later uncertain if the second check by another nurse was in place at the time, but ultimately felt like it was. She said the night shift nurses were largely responsible for filing orders into charts, but the orders should contain that nurse's initials as well. During an interview on January 21, 2010 at 9:26 a.m., LPN-H said she was in the midst of transcribing C1's orders when she responded to a client who fell. She returned to finish the orders and inadvertently did not complete the process in its entirety. She said she placed the order on the shelf, as was proper protocol. She said when an order comes in, the first nurse "does the order." She said the night nurse then "goes over" the order, signs it, and places it in the client's chart. LPN-H said the second nurse is supposed to write the word "noted" and sign (their name or initials). During an interview on January 15, 2020 at 10:23 p.m., PA-B said she increased C1's diuretic due to a gradual weight (fluid) increase over approximately six weeks. The expected outcome was C1 would be able to breathe easier, decrease his leg edema, and decrease his weight. PA-B said C1's decline in condition was going from 50 mg of the diuretic to zero with the increased dose of potassium that continued. PA-B said, "She was having trouble with heart failure. She would have likely died from heart failure; however, it (the error) absolutely exacerbated her death."	0 980		

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0 980	Continued From page 7 Document review of a policy titled, Medication and Treatment Orders, dated April 8, 2019 indicated the registered nurse is responsible for assuring that current, authorized prescriber orders for medications...are accurately add to the eMAR...". TIME PERIOD FOR CORRECTION: Seven (7) days	0 980		