Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306839845M
Compliance #: HL306837927C

Date Concluded: April 3, 2024

Name, Address, and County of Licensee Investigated:
Brookdale Eagan
1365 Crestridge Lane
Eagan, MN 55123
Dakota County

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

Evaluator's Name: Deb Schillinger RN
Special Investigator

Finding: Substantiated, facility responsibility

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 the facility failed to administer blood thinners as ordered.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The resident admitted to the facility with orders for warfarin (an anticoagulant to prevent blood clots) but the facility did not administer warfarin for six days. The resident fell, exhibited new left-sided paralysis, and was diagnosed with an acute stroke.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family members. The investigation included review of the resident record, hospital records, facility internal investigation, facility incident reports, personnel files, staff schedules, related facility policy and

procedures. Also, the investigator toured the facility and observed interactions between the residents and facility staff.

The resident resided in an assisted living facility. The resident's diagnoses included atrial fibrillation (an abnormal heartbeat that can lead to blood clots), history of a stroke (a loss of blood flow to an area of the brain causing damage), and Alzheimer's dementia. The resident's service plan included assistance with medication management. The resident's assessment indicated the resident walked with a walker and required fall prevention interventions.

The resident's admission orders indicated an order for warfarin (also known as Coumadin or Jantoven) to be given every evening for five days, then to have the resident's blood drawn after the fifth dose to monitor if the resident's blood levels were at a therapeutic level to prevent blood clots as intended.

The electronic medication administration record (EMAR) indicated the facility administered warfarin on the first day the resident admitted. However, the same document indicated the facility did not administer warfarin on the second through the fourth day after the resident admitted.

The progress notes indicated there was an entry time-stamped for each day from the second through the fifth day reporting that the resident did not receive warfarin because it was not available.

On the sixth day, the EMAR did not show an order was in place for warfarin.

Also, on the sixth day the medical records indicated the resident had a blood draw to check if the warfarin was at therapeutic levels. The facility notified the medical provider regarding of the blood draw on the seventh day.

On the morning of the seventh day an incident report indicated the resident was transferred to the hospital for evaluation after presenting with left-sided weakness.

The hospital records indicated the resident had an acute stroke and had a subtherapeutic blood level for warfarin.

During an interview, nurse #2 stated a medication error occurred regarding the resident's warfarin. Nurse #2 stated the EMAR listed "warfarin" but in the medication cart it was packaged as "Jantoven" [Coumadin and Jantoven are trade names for the generic medication warfarin] and the unlicensed caregiver(s) who were responsible for medication passes were not familiar with that term. Nurse #2 stated she verbally instructed the unlicensed caregiver regarding the different names in EMAR and on the medication packaging, however she did not place additional instructions in the EMAR or the medication packaging. Nurse #2 stated there were

progress notes in the resident's medical record by the unlicensed caregiver indicating the medication was not given, but the progress notes were not individually reviewed.

During an interview, an unlicensed caregiver stated she was assigned to the resident's medication pass during her time at the facility. The unlicensed caregiver stated she did not initially receive training regarding the medication package showing a different drug name in the EMAR and on the medication packaging. The unlicensed caregiver stated she left notes for 2-3 days on the nurses' desk and reported to oncoming unlicensed caregivers the warfarin was not available. She was off work for two days and then came back as scheduled when nurse #2 showed her the medication was present.

During an interview, nurse #1 stated if a medication was not available the unlicensed caregivers knew they were to notify a nurse. Nurse #1 stated neither she nor nurse #2 were notified the medication was not available by the unlicensed caregiver. Nurse #1 stated she nor nurse #2 viewed the progress notes made by the unlicensed caregiver(s) which indicated the warfarin was not available to administer because there would no reason to check the resident's progress notes unless an unlicensed caregiver had notified them the warfarin had not been given.

During an interview, the medical provider stated the facility sent a message over the portal (electronic communication) that the resident had a subtherapeutic warfarin blood value and that the resident had not received warfarin as ordered upon admission. When the provider requested information as to why resident was not given medication, the provider was informed the resident was sent to hospital earlier that day. The provider stated the resident was taking warfarin for atrial fibrillation, with the goal of the warfarin to thin the resident's blood to prevent a stroke. The provider stated the risk to the resident if not receiving warfarin as ordered was for clot formation causing a stroke.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred. Insert maltreatment definition here.

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. Not able to interview due to cognitive loss.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
Resident sent to hospital for treatment. The facility provided training to other caregivers regarding critical medications and communication.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

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

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Dakota County Attorney
Eagan City Attorney
Eagan Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30683	A. BUILDING: _____ B. WING _____	C 02/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAGAN	1365 CRESTRIDGE LANE EAGAN, MN 55123

(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****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. 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: #HL306837927C/#HL306839845M On February 21, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 39 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for #HL306837927C/#HL306839845M, tag identification 1760 and 2360.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License 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 144G.31 subd. 1, 2, and 3.	
01760 SS=J	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted	01760		

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01760	Continued From page 1 living facility staff must be documented in the resident's record. The documentation 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 resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on document review and interviews, the licensee failed to ensure medication was administered as prescribed for one of one resident (R1) resulting in the hospitalization of R1 with an acute cardiovascular accident (CVA) 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 residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). R1's diagnoses listed in admission orders dated November 28, 2023, included atrial fibrillation (A-fib), atrial flutter, history of a stroke, chronic anticoagulation therapy and Alzheimer's dementia. R1's service plan dated November 30, 2023, indicated the resident received assistance with medication administration and needed cueing due to cognitive impairment.	01760		

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01760	Continued From page 2 R1's assessment dated November 30, 2023, indicated the resident ambulated using a walker, and needed assistance of one caregiver to provide cueing to complete most tasks. R1's admission orders indicated the facility was to recheck an INR level on December 5, 2023. R1's December 2023, medication administration record (MAR) indicated R1's provider order included warfarin (blood thinner) 2.5 milligrams (mg) medication every evening with the order discontinuing on December 4, 2023. A review of the December 2023 MAR indicated there was not an order for warfarin on December 5, 2023, or December 6, 2023. R1's hospital records dated December 6, 2023, indicated R1 arrived at the emergency room with left sided deficits and speech changes after a fall. The same records indicated the hospital found the resident had subtherapeutic International Normalized Ratio (INR) and the resident had an acute CVA (stroke). During an interview on February 21, 2024, at 1:46 p.m., LPN-A stated a medication error occurred regarding the resident's warfarin. LPN-A stated the MAR listed "warfarin" but in the medication cart it was packaged as "Jantoven" [a trade name for warfarin] and the ULP(s) who were responsible for medication passes were not familiar with that term. LPN-A stated she instructed the ULP(s) regarding the different names. LPN-A she did not add additional instructions in the MAR or on the medication packaging to include the generic medication name. LPN-A stated there were progress notes in R1 medical record indicating the medication	01760		

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01760	Continued From page 3 was not given, but the progress notes were not individually reviewed. During an interview on March 11, 2024 at 1:10 p.m., unlicensed personnel (ULP)-D stated she was assigned to R1's medication pass during her time at the facility. ULP-D stated she did not initially receive training regarding the medication packaging showing a different drug name than what was listed in the MAR. ULP-D denied training was provided regarding the medication package showing a different drug name. ULP-D stated she left notes for 2-3 days at the nurse's desk and relayed reporting to the oncoming staff regarding the medication not being available. ULP-D stated she was off for 2 days then when reporting back on scheduled workday, she was shown showed the medication was present. ULP-D stated the packaging remained with a different name than was listed in the MAR. ULP-D stated she did not know the medication with a different name that was in the medication cart was the same medication listed on the MAR. During an interview, the registered nurse (RN)-E stated if a medication was not available the ULP's were trained to notify a nurse. RN-E stated neither she nor the LP-D were notified. During that same interview, the RN-E stated no alert is sent to the nurse if a medication is missed by the electronic medical record system. When asked if a progress note is made automatically by system when a medication is missed, the RN-E confirmed it does but stated the progress note would not relay why the medication was not given. The RN-E stated she nor LPN-D would "have no reason to" look at R1 progress notes as the ULP(s) were trained to report when medications were not given and had also been trained to know where the medication was in the	01760		

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01760	Continued From page 4 cart. A progress note dated December 1, 2023, at 8:07 p.m. indicated the R1 did not receive the medication as the medication was not available. A progress note dated December 2, 2023, at 8:35 p.m. indicated R1 did not receive the medication as the medication was not available. A progress note dated December 3, 2023, at 7:41 p.m. indicated R1 did not receive the medication as the medication was not available. A progress note dated December 4, 2023, at 7:17 p.m. indicated R1 did not receive the medication as the medication was not available. During an interview, the physician's assistant (PA) stated she had not yet established care with this resident. The provider stated a message was received on the provider's portal regarding a subtherapeutic INR and that R1 had not received medication since admission on November 30, 2023. The provider requested information as to why resident was not given medication, the provider was informed R1 was sent to hospital as unable to move left arm and leg after a fall earlier that morning. In that same interview, the PA stated the resident was receiving warfarin for atrial fibrillation, with the goal of the warfarin to thin the resident's blood to prevent a stroke. The PA stated the risk of not receiving warfarin would be the formation of a blood clot causing a stroke. The hospital discharge summary indicated R1 had missed 5 doses of warfarin as the medication had not been given since admission to the facility.	01760		

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01760	Continued From page 5 A magnetic resonance imaging (MRI) was completed on December 6, 2023, indicated R1 sustained an acute right anterior cerebral artery infarction (stroke). R1 required hospitalization for 7 days before transferring to a rehabilitation facility with ongoing left sided weakness after an acute stroke. During an interview, a family member (FM)-H stated R1's current level of functioning has decreased and has been admitted to hospice. FM-H stated R1 is completely dependent on current facility staff for care, must be transferred from her bed to wheelchair with a Hoyer lift, is incontinent, and speaks very little. The licensee provided policy titled "Medication & Treatment - Medication Packaging Policy CS-40-12" dated August 2022 indicated medications provided from any source should be checked by the nurse to verify the medication provided matches the current resident order, and that the packaging is intact. If the medication is not a match or appears to have been tampered with, the medication may not be accepted by the community. The community may then order the appropriate dose and packaging from the preferred provider to ensure medication availability. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment	02360		

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02360	Continued From page 6 covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No plan of correction is required for this tag.	