Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL307832321M
Compliance #: HL307833993C

Date Concluded: September 23, 2022

Name, Address, and County of Licensee Investigated:
Cottage Grove White Pine II
6950 East Point Douglas Road South
Cottage Grove, MN 55016
Washington County

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

Evaluator's Name:
Maerin Renee, 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.

Initial Investigation Allegation(s):
The facility neglected a resident when they failed to administer the residents blood thinning medication (warfarin) and the resident missed several doses. The resident suffered a stroke, and subsequently died.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility staff members were inconsistent in notifying the nursing staff that the resident had run out of warfarin. Upon receiving notification that the resident was out of warfarin, nursing staff failed to reorder the warfarin from the pharmacy. The resident missed her daily dose of warfarin for fourteen days.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the primary care physician. The

investigation included review of the resident's medical record, facility internal investigation, policies and procedures, and personnel files. In addition, the investigator toured the facility and observed staff administering medications and interacting with residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia, atrial fibrillation, antiphospholipid antibody syndrome, high blood pressure, high cholesterol embolus syndrome, and a history of cerebrovascular accident. The resident's service plan included assistance with medication management, meals, and activities of daily living. The resident's assessment indicated the resident required reality orientation at every contact.

Review of the resident's medication administration record (MAR) indicated the resident was prescribed one tablet of warfarin one (1) milligram (mg) daily for atrial fibrillation, antiphospholipid antibody syndrome, and history of cerebral vascular accident. The resident's MAR indicated staff did not administer warfarin as prescribed to the resident for fourteen days and documented the medication was not available. There was no further follow up documented by staff.

Review of the facility's internal investigation indicated the resident did not receive warfarin for fourteen days, related to missed lab work for warfarin dosing (the INR, which measures speed of blood clotting), and lack of communication to the physician and/or the pharmacy. The nurse eventually discovered the resident missed a lab draw and contacted the physician to send an order to the pharmacy for warfarin. The resident missed fourteen days of warfarin, was then administered one dose of warfarin, and was hospitalized the following day at which time the resident was diagnosed a stroke.

When interviewed, an unlicensed staff stated she had filled out missing medication forms on at least two shifts when the resident didn't have warfarin available to be administered. The unlicensed staff stated they put the missing medication forms on the nurse's desk.

During an interview, a management staff stated he passed medications one evening and documented in the resident's medication administration record (MAR) that warfarin was not available. He stated he did not notify nursing the resident had no warfarin to administer and did not follow up. Review of the management staff trainings records he had not been trained or competency-tested prior to passing medications.

During an interview, a nurse stated the resident had been sent to the hospital with symptoms of a possible stroke. The nurse stated the resident's family called from the hospital and informed her the resident was diagnosed with a stroke. The nurse stated that prompted her to review the residents MAR. At that time, the nurse discovered staff had not administered warfarin to the resident for fourteen days. The nurse stated staff neglected to send the most current lab requisition form to the lab for the resident's blood draw for warfarin dosing, and an updated warfarin order had not been sent to the pharmacy. The nurse stated she had not run reports for missing, late, or refused medications because that was the duty of another nurse

whom she supervised. The nurse stated the facility had protocols in place to ensure medications were administered according to physician orders, however, the protocols were not implemented. The nurse stated staff had not notified her the resident's warfarin was out of stock. However, later during the investigation the nurse discovered a note from staff in the shredder notifying her the resident's warfarin was out of stock.

When interviewed, the physician stated the resident missing fourteen doses of warfarin could have contributed to the development of the stroke for which she was hospitalized.

When interviewed, the resident's family member stated the family was not aware the resident missed any doses of warfarin until the resident was hospitalized with a stroke. The family member expressed they felt the resident missing fourteen doses of warfarin contributed to the resident suffering a stroke.

Review of emails between the nurse and the pharmacy indicated the nurse made the pharmacy aware the resident did not receive her warfarin for fourteen days. The nurse indicated the facility should have discovered sooner that the resident had no warfarin to be administered.

The resident died ten days after being hospitalized. The resident's death certificate indicated the resident's immediate cause of death was cerebrovascular accident, and atrial fibrillation with recent subtherapeutic INR level was listed as a contributing factor. The certificate indicated the manner of death was natural.

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.

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: Deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not applicable.

Action taken by facility:
The facility provided refresher medication training for staff trained to pass medications.

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30783	A. BUILDING: _____ B. WING _____	C 08/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTAGE GROVE WHITE PINE II	6950 EAST POINT DOUGLAS ROAD S COTTAGE GROVE, MN 55016

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0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING 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: #HL307833993C/#HL307832321M On August 23, 2022, 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 36 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL307833993C/#HL307832321M, tag identification 1740, 1760, and 2360.	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 Assisted Living Facilities. 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 evaluators ' 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 SUBDIVISION 1-3.	
01740 SS=F	144G.71 Subd. 6 Administration of medication	01740		

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01740	Continued From page 1 Medications may be administered by a nurse, physician, or other licensed health practitioner authorized to administer medications or by unlicensed personnel who have been delegated medication administration tasks by a registered nurse. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure one employee, licensed assisted living director (LALD)-A had been trained and competency-tested by a registered nurse prior to administering medications to one of one residents, R1, reviewed for medication errors. This had the potential to affect all residents receiving medication administration assistance. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 was admitted to the facility on November 26, 2021, with diagnosis including dementia, atrial fibrillation, antiphospholipid antibody syndrome, history of cerebral vascular accident, high blood pressure, and high cholesterol embolus syndrome. R1 medication administration record (MAR) indicated R1 was prescribed warfarin (blood thinner) for treatment of atrial fibrillation. R1's MAR indicated staff did not administer R1's	01740		

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01740	Continued From page 2 warfarin from July 7, 2022-July 21, 2022. Staff documented in the MAR the medication was not available. R1's medication administration record (MAR) indicated LALD-A administered the residents medications on the evening of July 18, 2022, and documented in R1's MAR that warfarin was not available. R1's progress notes indicated the resident developed symptoms of a stroke on July 22, 2022, and was transferred to the hospital. R1 was diagnosed with right internal carotid artery occlusion, and posterior cerebral artery occlusion, which resulted in right hemisphere ischemia (stroke). R1 passed away on August 2, 2022. LALD-A employee file indicated a hire date of November 29, 2021. LALD-A's employee file lacked documentation he had been trained and competency-tested by a registered nurse prior to administering medication. LALD-A's employee file indicated he did not receive medication administration training or competency evaluation until August 8, 2022. During an interview on August 23, 2022, at 1:40 p.m., LALD-A stated he received medication administration training prior to passing medications but could not remember who trained him. LALD-A stated he administered R1's medications on the evening shift of July 18, 2022. LALD-A stated R1 did not have warfarin available to administer so he documented the medication wasn't available in R1's MAR. However, LALD-A stated he did not directly report to a nurse R1 did not receive her warfarin according to physician orders. During an interview on August 23, 2022, at 1:50 p.m., assistant director of nursing (RN)-B	01740		

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01740	Continued From page 3 confirmed LALD-A administered medications to residents on July 18, 2022. RN-B stated she thought LALD-A had been trained to administer medications but could not say for sure. RN-B denied training LALD-A on medication administration and stated she did not provide staff training while she was employed at the facility. The facility's Competency Training Evaluations policy dated August 1, 2021, indicated a registered nurse or licensed health professional must ensure unlicensed personnel are trained and able to demonstrate competencies prior to performing delegated tasks. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	01740		
01760 SS=G	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted 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 interview and document review, facility	01760		

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01760	Continued From page 4 staff failed to administer warfarin (a blood thinner) as prescribed for one of one resident, R1, reviewed for medication errors. R1 missed 14 days of warfarin. This practice resulted in a level three violation (a violation that harmed a resident'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 residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1's medical record indicated the resident had diagnoses including dementia, atrial fibrillation, antiphospholipid antibody syndrome (blood clotting disorder), history of cerebral vascular accident (stroke), high blood pressure, and high cholesterol embolus syndrome. R1's service plan, signed April 9, 2022, indicated the resident received services for medication management, meals, safety checks, and assistance with activities of daily living. R1's Medication Administration Record (MAR), dated July 2022, indicated R1 was prescribed 1 tablet of warfarin 1 milligram (mg) daily for atrial fibrillation, antiphospholipid antibody syndrome, and history of cerebral vascular accident. R1's MAR indicated staff did not administer warfarin as prescribed to R1 from July 7, 2022-July 20, 2022, and documented the medication was not available. R1's progress notes dated July 22, 2022, staff	01760		

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01760	Continued From page 5 observed left-sided neglect in R1's appearance and R1 was transported to the hospital, where she was diagnosed with a right internal carotid artery occlusion and a right posterior cerebral artery occlusion, which caused right hemisphere ischemia. R1 died on August 2, 2022. During an interview on August 23, 2022, at 1:00 p.m., unlicensed personnel (ULP)-D stated she had filled out missing medication forms on at least two shifts and put them on RN-B's desk, per protocol, to inform RN-B R1 had no warfarin in stock. ULP-D passed medication on July 7, 2022, and July 21, 2022. During interview on August 23, 2022, at 1:40 p.m., the licensed assisted living director (LALD)-A stated he passed medications one evening and documented in the resident's MAR warfarin was not available. He stated he did not notify the nurse the medication was not available and did not follow up. During an interview on August 23, 2022, at 1:50 p.m., the assistant director of nursing (RN)-B, stated she discovered the medication error after R1 was hospitalized. RN-B stated R1's son informed her R1 had a stroke, which prompted RN-B to review R1's MAR. RN-B stated that is when she discovered R1 had not received warfarin from July 7, 2022, to July 21, 2022. RN-B stated protocols were in place to prevent missed medication but staff failed to implemented the protocols and staff did not notify her R1's warfarin was out of stock. However, RN-B said she did find a note from staff indicating the resident was out of warfarin in the facility's shredder. RN-B stated she assumed the licensed practical nurse (LPN) saw the note and shredded it without acting on it. RN-B stated she had not run reports for	01760		

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01760	Continued From page 6 missing, late, or refused medications because that was the LPN's duty. RN-B said she did not provide staff training during her employment at the facility. The facility undated internal investigation documents indicated the resident's international normalized ratio (INR) lab was drawn on June 20, 2022. The resident's primary care provider (PCP) ordered a recheck of the resident's INR on July 4, 2022. Due to the holiday, the next lab draw was scheduled for June 27, 2022, instead. The pharmacy sent fourteen (14) tablets of warfarin on June 20, 2022. The resident's lab was drawn on June 27, 2022, but at that time the pharmacy said it was too soon to refill the warfarin. The facility did not follow up with the pharmacy. The pharmacy had originally been scheduled to deliver more warfarin on July 4, 2022, but since the pharmacy did not receive a new order or follow-up from the facility, no warfarin was delivered for R1. The resident received her last dose of warfarin on July 6, 2022, after which staff marked warfarin as "not available" on the MAR through July 20, 2022. On July 11, 2022, the resident's INR was drawn again, and the resident's PCP ordered another lab draw for July 18, 2022, and to continue warfarin 1 mg daily. The facility did not send the warfarin order to the pharmacy, nor was the lab requisition sent to the lab, so the resident did not get her INR checked on July 18, 2022. On July 19, 2022, RN-B noticed the resident's INR draw was missed on July 18, 2022. She instructed the LPN to request new orders for warfarin from the resident's PCP. The physician order was then sent to the pharmacy, and	01760		

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01760	Continued From page 7 warfarin was sent to the facility on July 20, 2022. The resident was administered a dose of warfarin on July 21, 2022 and was then hospitalized on July 22, 2022, with a stroke. The facility's Medication & Supplies-Reordering policy dated August 1, 2021, indicated nursing staff will assist residents to make sure medications and supplies are ordered and available as needed. 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 covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: Based on observations, interviews, and document review, the facility failed to ensure one of one residents reviewed (R1) was free from maltreatment. R1 was neglected. Findings include: On August 23, 2022, 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.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	