Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL308152200M
Compliance #: HL308151162C

Date Concluded: June 20, 2024

Name, Address, and County of Licensee Investigated:

West View Assisted Living
240 6th Ave North 23
Osakis, MN 56360
Douglas County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:
Jana Wegener, RN, Special Investigator

Finding: Inconclusive

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 resident was neglected when the alleged perpetrator (AP), facility staff, failed to provide medication reminders. The resident did not take anticoagulant medications as prescribed. When the resident did not attend breakfast, staff neglected to check on her. Three hours later the resident was transferred to the emergency department (ED) with stroke symptoms.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. The resident received meal services but did not require meal reminders or morning safety checks at the time the incident occurred. Although the AP failed to provide medication reminders at 8:00 a.m. the day of the incident and 2 days prior, the resident's hospital record indicated the resident's anticoagulation status was adequate at the time the incident occurred. As a result, it could not be determined if the AP's medication reminder omissions contributed to the resident having a stroke.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member. The investigation included review of the resident record(s), death record, hospital records, facility internal investigation, facility incident reports, personnel files, staff schedules, related facility policy and procedures. Also, the investigator observed residents receiving medication reminders, and meal services at the facility.

The resident resided in an assisted living facility with diagnoses including aphasia (difficulty communicating), and dementia.

The resident's service plan indicated the resident was independent with cares and received medication reminders and meals at the facility.

The resident's assessment indicated she had mild cognitive impairment and was forgetful at times. The assessment indicated the resident had recurring transient ischemic attacks (TIA) (mini strokes) causing two falls in the past year.

The resident's Kardex, service agreement, and service delivery of care record at the time the incident occurred indicated the resident required supervision and reminders with self-medication administration. The resident had one safety check scheduled at 10:00 p.m. which was completed with no concerns noted. The residents service agreement did not include meal reminders or any other safety checks.

The resident's medication administration record (MAR) indicated staff provided medication reminders at 8:00 a.m. and 8:00 p.m. The MAR indicated the resident's 8:00 a.m. medications included Aspirin, Zoloft, Eliquis (an anticoagulant/blood thinner), and Keppra (antiseizure medication). The MAR indicated the resident's 8:00 a.m. medication reminder was not provided the day the incident occurred.

The resident's progress notes indicated the resident had recurring episodes of possible TIA's prior to the incident. On the day the incident occurred a progress note indicated at 11:20 a.m. family arrived and found the resident still in bed, clammy, diaphoretic, with right sided weakness, and unable to communicate. 911 was called and the resident was transferred to the emergency department for evaluation and treatment.

A facility incident report indicated the AP failed to provide the resident's medication reminder at 8:00 a.m. the day the incident occurred, and two days prior.

The residents outside medical record indicated the resident had a history of TIA and atrial fibrillation (a condition causing irregular, often rapid heart rate causing poor blood flow). The resident was diagnosed with an acute ischemic stroke, and right mid lobe aspiration pneumonia. The resident's head CT identified chronic ischemic disease, with no acute bleed or

clot noted. The resident's labs indicated her anticoagulation status was adequate at the time the incident occurred despite the 2 missed doses of anticoagulant/blood thinning medication.

The resident's record of death indicated the resident died of natural causes related to presumed fatal cardiac arrythmia 8 days after the incident occurred.

When interviewed the AP stated the day the incident occurred, she was working on the medication cart and was running behind on passing medications to resident's while 2 other staff served breakfast in the dining room. The AP stated the resident did not have meal reminders at the time the incident occurred and was independent with dressing and bringing herself to the dining room for meals. The AP indicated she thought staff would have checked on the resident if she did not come out for breakfast, but they had not.

When interviewed staff working after the first medication reminder omission occurred indicated they had not observed or reported any concern with the resident not taking her morning medications. The staff indicated they had no concerns with the AP's conduct or completing assigned tasks timely prior to the incident.

When interviewed leadership staff stated after the incident occurred the AP stated she was busy the morning of the incident and had not provided the residents medication reminder prior to being found with stroke symptoms. Leadership staff stated at the time the incident occurred the resident did not have meal reminders or morning safety checks, and there was no formal process in place for staff to check on resident's if a resident did not come out for meals.

When interviewed the resident's family member stated she had not noticed any issued with the resident not receiving her medication or medication reminders prior to the incident. The family member stated the resident had a history of TIA's and the resident's provider told them she was at a risk for having a bigger stroke.

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

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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, deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
After the incident occurred, the facility reported the incident to the Minnesota Adult Abuse Reporting Center (MAARC), investigated the incident, provided additional training to staff involved, implemented 6:00 a.m. safety checks on all residents, and implemented a formal process for meal attendance and resident checks if they did not attend.

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
	30815	A. BUILDING: _____ B. WING _____	C 05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST VIEW ASSISTED LIVING APT	240 6TH AVENUE NORTH OSAKIS, MN 56360

(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 May 16, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL308152200M/#HL308151162C. No correction orders are issued.	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 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.	