Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL34184005M
Compliance #: HL34184006C

Date Concluded: January 30, 2020

Name, Address, and County of Licensee Investigated:
Polar Ridge Senior Living
2365 Helen Street
North Saint Paul, MN 55109
Ramsey County

Facility Type: Home Care Provider

Investigator's Name: Casey DeVries, RN
Special Investigator

Finding: Substantiated, individual 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: It was alleged that a client was neglected when the alleged perpetrator administered the client's morning medications twice, which resulted in the facility sending the client to the hospital for observation.

Investigative Findings and Conclusion:
Neglect was substantiated. The alleged perpetrator (AP) was responsible for the maltreatment. The AP failed to provide safe medication administration services, which resulted in the client receiving a double dose of her medications that included heart and blood pressure medications. The client was transported to the hospital for monitoring of low blood pressure due to medication overdose.

The investigation included interviews with facility staff, including administrative staff, nursing staff, and unlicensed staff. The investigator reviewed facility incident reports, client medical records, staffing records, facility policies and procedures, grievances and made observations of day-to-day operations including medication administration procedures.

The client received services from the comprehensive home care provider for diagnoses that included dementia, hypertension, bronchiectasis and congestive heart failure. The client's service plan indicated facility staff assisted the client with daily checks, bathing, dressing, grooming, toileting, escorts and medication administration in the assisted living unit of the facility.

The client's medication administration record (MAR) indicated the following physician orders: Levothyroxin (thyroid agent) 75 micrograms (mcg) at 6:30 a.m. daily one hour prior to food. At 8:00 a.m., the MAR indicated staff should administer acetaminophen 1000 milligrams (mg) for pain, albuterol inhaler, atenolol 50mg for blood pressure, diltiazem 240mg for blood pressure, duloxetine 30mg for depression, Advair inhaler, furosemide 20mg for congestive heart failure, gabapentin 400mg for nerve pain, irbesartan 300mg for blood pressure, Mucinex 1200mg for allergy, quetiapine 12.5mg for hallucinations, sodium chloride nebulizer inhalant and vitamin D 2000 unit for supplement.

Observation during the on-site investigation revealed that facility staff utilized tablet style electronic devices, which provided staff with information about their assigned group of clients for the shift, including medication administration records and plans of care. Staff were only able to view the information for the clients in their assigned service schedule for that particular shift. Viewing another group of clients required the staff to log out of their assignment and into another.

Facility internal investigation summary notes indicated the facility had scheduled the AP to work a double shift, which included an overnight shift the night before the medication error into the day shift. During the overnight shift, the AP was responsible for the client's care, which involved the administration of a 6:30 a.m. medication. In addition to the 6:30 a.m. medication, the summary notes indicated the AP decided to also administer the client's 8:00 a.m. medications earlier than scheduled to get a head start on the day. Because the client had previously been part of a group routinely assigned to the AP for the day shift, the AP made the assumption the client still was a part of her assigned group. The AP remained logged into the overnight shift assignment on her tablet, thus, the AP did not realize the client was no longer a part of her day shift assignment. She did not utilize the client's electronic medication administration record (EMAR) or document the administration of the 8:00 a.m. medications.

The summary notes indicated the assigned caregiver (unaware of the AP's actions) administered the client's morning medications a second time per instruction of the EMAR. After this occurrence, facility management interviewed the AP. The facility documented that the AP stated she was not aware that the client was not on her day shift service schedule, but since the client usually was, the AP went ahead and administered the 8:00 a.m. medications by memory without logging into the day shift EMAR. The summary notes indicated the AP stated after she administered the 8:00 medications to the client, the AP announced to other staff over the walkie-talkie that she gave the medications and then walked to the office and again stated she gave the medications.

During an interview, the staff member assigned to the client stated after she administered the client's 8:00 a.m. medications, she happened to notice a handwritten date on the medication blister cards. The staff member stated the date on the card was the current day so she immediately notified the nurse of her finding as she was uncertain if a previous staff member inadvertently wrote the wrong date during a prior medication pass or if the client had somehow already received her medications that morning. The staff member stated the AP did not alert anybody that she had already administered the client's medications until after the medication error occurred and the nurse asked the AP directly.

During an interview, the nurse stated the AP did not alert the other staff in person or via walkie-talkie that she had administered the client's medications until after the nurse questioned her. The nurse stated the AP indicated she had administered medications to the client from memory versus using the tablet, which contradicted how the facility trained staff. The nurse stated she immediately checked on the client and sent an urgent message to the client's primary care provider regarding the incident. The nurse stated when she spoke to the client's primary care provider, although the client's status had not yet changed, they decided to send the client to the hospital as a precaution.

During an interview, the client's family member stated the facility called her on the day of the incident to inform her that emergency medical services (EMS) was transporting the client to the hospital due to a medication error. The family member stated once at the hospital, the client's vital signs plummeted due to large amounts of blood pressure medication ingested and the client "was out of it." The family member stated the hospital flushed the client with fluids and monitored the client overnight. The family member stated the client returned to the facility at her normal baseline.

The client's hospital record indicated the hospital admitted the client for observation due to an accidental or unintentional calcium channel blocker (medications used to lower blood pressure) overdose. The hospital discharged the client the following day.

Review of the AP's personnel record indicated the facility had adequately trained the AP in medication administration, which include usage of health technology equipment, such as tablets and documentation of medication administration on the EMAR.

In conclusion, neglect was substantiated. The AP did not provide safe medication administration services to the client when she administered the client's medications from memory and failed to document the administration. The AP acted in a manner that was inconsistent with her training or the accepted standard of practice.

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.
(c) For purposes of this section, a vulnerable adult is not neglected for the sole reason that:
(1) the vulnerable adult or a person with authority to make health care decisions for the vulnerable adult under sections 144.651, 144A.44, chapter 145B, 145C, or 252A, or sections 253B.03 or 524.5-101 to 524.5-502, refuses consent or withdraws consent, consistent with that authority and within the boundary of reasonable medical practice, to any therapeutic conduct, including any care, service, or procedure to diagnose, maintain, or treat the physical or mental condition of the vulnerable adult, or, where permitted under law, to provide nutrition and hydration parenterally or through intubation; this paragraph does not enlarge or diminish rights otherwise held under law by:
(i) a vulnerable adult or a person acting on behalf of a vulnerable adult, including an involved family member, to consent to or refuse consent for therapeutic conduct; or
(ii) a caregiver to offer or provide or refuse to offer or provide therapeutic conduct; or
(2) the vulnerable adult, a person with authority to make health care decisions for the vulnerable adult, or a caregiver in good faith selects and depends upon spiritual means or prayer for treatment or care of disease or remedial care of the vulnerable adult in lieu of medical care, provided that this is consistent with the prior practice or belief of the vulnerable adult or with the expressed intentions of the vulnerable adult;
(3) the vulnerable adult, who is not impaired in judgment or capacity by mental or emotional dysfunction or undue influence, engages in consensual sexual contact with:
(i) a person including a facility staff person when a consensual sexual personal relationship existed prior to the caregiving relationship; or
(ii) a personal care attendant, regardless of whether the consensual sexual personal relationship existed prior to the caregiving relationship; or
(4) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult which does not result in injury or harm which reasonably requires medical or mental health care; or
(5) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult that results in injury or harm, which reasonably requires the care of a physician, and:
(i) the necessary care is provided in a timely fashion as dictated by the condition of the vulnerable adult;

(ii) if after receiving care, the health status of the vulnerable adult can be reasonably expected, as determined by the attending physician, to be restored to the vulnerable adult's preexisting condition;
(iii) the error is not part of a pattern of errors by the individual;
(iv) if in a facility, the error is immediately reported as required under section 626.557, and recorded internally in the facility;
(v) if in a facility, the facility identifies and takes corrective action and implements measures designed to reduce the risk of further occurrence of this error and similar errors; and
(vi) if in a facility, the actions required under items (iv) and (v) are sufficiently documented for review and evaluation by the facility and any applicable licensing, certification, and ombudsman agency.

Vulnerable Adult interviewed: The investigator met with the client; however, the investigator was not able to effectively interview the client about the incident due to the client's cognitive status.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: No, the AP did not respond to requests for an interview.

Action taken by facility:
The facility suspended the AP pending internal investigation. The facility disciplined the AP for failure to follow policy and procedure and/or standards of practice. The facility re-trained the AP in medication administration and tablet usage and counseled the AP on appropriate communication.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long-Term
Ramsey County Attorney
City of North Saint Paul Attorney
City of North Saint Paul Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H31484	A. BUILDING: _____ B. WING _____	C 01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POLAR RIDGE SENIOR LIVING	2365 HELEN ST NORTH SAINT PAUL, MN 55109

(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 January 16, 2020, the Minnesota Department of Health initiated an investigation of complaint #HL31484006C/#HL31484005M. At the time of the survey, there were #75 clients receiving services under the comprehensive license. The following correction orders are issued for #HL31484006C/#HL31484005M, tag identification 0325.	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 observations, 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 January 30, 2020, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that an individual staff person 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	No Plan of Correction (PoC) is required. Please refer to the maltreatment public report for details.	