Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL33743943M
Compliance #: HL333746564C

Date Concluded: August 9, 2023

Name, Address, and County of Licensee Investigated:
Birchwood Cottages
1845 Austin Rd.
Owatonna, MN 55060
Steele County

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

Evaluator's Name: Lena Gangestad, RN
Special Investigator

Finding: **Not Substantiated**

Nature of the 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 a resident when the facility failed to hold Coumadin, an anticoagulant medication, per the medical provider's order.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although Coumadin was not placed on hold as directed by the physician's order, the facility identified the error two days later, the Coumadin was placed on hold at that time, and the resident was not injured.

The investigator conducted interviews with facility staff members, including administrative staff and nursing staff. The investigator attempted to contact the resident's family member, but they were unable to reach. The investigation included review of resident's records, facility's policies

and procedures, and incident reports. The investigation included an onsite visit, observations, and interactions between residents and facility staff.

The resident resided in an assisted living facility. The resident's diagnoses included defective coagulation. The resident's service plan included medication services, which included Coumadin for anticoagulation. The resident's assessment indicated caregivers directed to monitor for indications or signs of bleeding, such as including bloody gums or excessive bruising and to contact the nurse if these were observed.

The progress notes indicated the resident had an international normalized ratio (INR) blood test, which measures the time it takes for blood to clot done used to monitor the effectiveness of Coumadin which showed the resident blood was too anticoagulated. The medical provider ordered the resident's Coumadin be held for two doses, however, an error occurred, and the resident received those two doses. The facility discovered the errored, contacted the medical provider, and the Coumadin was placed on hold correctly. The resident's assessment indicated a bruise was identified behind her right knee but no active bleeding.

During an interview, the nurse stated the medical provider checked the resident's INR and sent the information to the pharmacy. The nurse stated the initial order was not processed correctly and the Coumadin was not placed on hold. The nurse stated when the mistake was identified she informed the medical provider, the family, and the resident herself. The nurse stated she was the one who processed the original order and received a coaching and training session to prevent recurrence.

During an interview, a member of the administration confirmed the nurse received coaching and retraining to prevent recurrence of the medication error.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

"Not Substantiated" means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment 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: Yes, she does not remember the incident.
Family/Responsible Party interviewed: No, unable to reach.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The family, resident and NP were promptly informed about the incident. A comprehensive assessment of the resident's condition was conducted to ensure their well-being and safety. The administrator took proactive steps by providing coaching and guidance to the nurse involved, emphasizing the importance of adherence to proper protocols and procedures to prevent such occurrences in the future.

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
	33374	A. BUILDING: _____ B. WING _____	C 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD COTTAGES	1845 AUSTIN ROAD OWATONNA, MN 55060

(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 July 26, 2023, the Minnesota Department of Health initiated an investigation of complaints #HL333743183M/HL333745164C and HL333743943M/HL333746564C. No correction orders are issued.	0 000		