State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL339752887M
Compliance #: HL339754827C

Date Concluded: January 3, 2023

Name, Address, and County of Licensee Investigated:
Maple Woods Assisted Living
33310 State Highway 6
Deer River, MN 56636
Itasca County

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

Evaluator's Name: Jill Hagen, 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.

Initial Investigation Allegation(s):
The alleged perpetrator (AP) neglected a resident when they gave Resident #1 Clozapine (anti-psychotic medication) prescribed to Resident #2 resulting in Resident #1 requiring treatment at a hospital.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The AP was responsible for the maltreatment. The AP gave Resident #1 Clozapine (anti-psychotic medication) 400 milligrams (two tablets) prescribed to Resident #2 without ensuring the correct medication was given to the correct resident. As a result, Resident #1 required admission to a hospital for evaluation and treatment with a reduced level of consciousness.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident's medical

and hospital record, the facility's medication error reports, policies and procedures for medication administration, maltreatment reporting, and the AP's personnel file.

Resident #1 resided in an assisted living memory care unit with diagnoses including heart disease, chronic obstructive lung disease, anxiety, and depression. Resident #1's service plan included staff assistance with medication management including medication ordering, set-up, and administering Resident #1 medications. Resident #1 was able to make her needs known to others.

The facility incident report indicated late one evening a pharmacy delivered Resident #2's Clozapine to the facility and a licensed nurse directed the AP to administer the medication to Resident #2. Resident #1 and Resident #2 shared the same first name, however, Resident #1 lived on the assisted living portion of the facility and Resident #2 lived in the memory care unit. The licensed staff gave the medication and medication card to the AP who was working on the assisted living side of the facility. The AP thought the medication was for Resident #1 who lived on the assisted living side, not Resident #2. The AP checked Resident #1's medication administration record (MAR) and attempted to notify the licensed nurse that Resident #1's MAR did not list Clozapine as a medication Resident #1 was prescribed. The AP was unable to contact the licensed nurse, the AP sent a message to the on-call nurse indicating Clozapine needed to be added to Resident #1's MAR. The AP administered the Clozapine to Resident #1.

The next morning, a licensed staff saw the message from the AP to add Clozapine to Resident #1's medication record. The licensed nurse knew Resident #1 did not have Clozapine prescribed and directed facility staff to check on Resident #1. Facility staff found Resident #1 unresponsive and foaming at the mouth. Staff arranged for Resident #1 to be taken to an emergency room for an evaluation.

Review of Resident #1's hospital record indicated Resident #1's admission diagnoses included acute encephalopathy (functional alteration of mental state), excessive saliva flow, and accidental drug overdose. Resident #1 initially was difficult to arouse and required suctioning of secretions and had slurred and garbled speech. Resident #1's mental alertness gradually improved with continued therapy. Resident #1 was discharged from the hospital four days later to a different facility.

During an interview, the licensed nurse stated the pharmacy was late delivering Resident #2's doses of Clozapine. Usually, the evening staff administered Resident #2's Clozapine, however, that evening the licensed nurse delegated the administration to the AP on night shift. The licensed nurse provided the AP with instructions to give Resident #2 Clozapine and gave the AP the medication card containing Resident #2's name, medication name, and medication dose. The licensed nurse stated the AP made no contact with her that night with questions.

During an interview, the administrative nurse stated staff communicate to the nurse and each other through an electronic system called "snap" through Rtask, the facility's electronic medical

record. The facility used the system for updates about residents. When staff need to address an immediate resident concern, they call the nurse. The next morning, the administrative nurse opened the electronic record and reviewed a message delivered from the AP the previous night. The AP requested a nurse add the Clozapine to Resident #1's MAR. The administrative nurse stated Resident #1 did not take Clozapine and contacted facility staff to check on Resident #1. The administrative nurse stated facility staff found Resident #1 unresponsive and arranged for Resident #1 to be taken to a local hospital.

During an interview, the AP stated the evening of the incident the licensed nurse told her to give a resident Clozapine and handed the AP a full bubble pack (medication card containing the medications in punch out bubbles) of the medication. The AP stated two residents in the facility share the same first name, Resident #1 who resided in the assisted living, and Resident #2 who resided in the memory care. The AP stated when the licensed nurse said the first name of the resident, and the licensed nurse gave the AP the medication on the assisted living not memory care part of the facility, the AP thought the medication was for Resident #1, not Resident #2. The AP checked Resident #1's computerized chart for Clozapine but it was not in her medication record. The AP stated sometimes the nurses were late entering a medication on the electronic record, so the AP gave Resident #1 the medication without ensuring she was giving the correct medication to the correct resident. The AP had no response when asked whether the AP checked the bubble pack for the correct resident name, correct medication, dose, and time. The AP attempted to check with the licensed nurse, but the nurse had left for the evening. The AP stated she received medication management training from the facility.

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: No due to cognition.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
Management provided a review of the facility's medication administration policy and procedure and required medication administration training for the AP.

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.

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

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 Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Itasca County Attorney
Deer River City Attorney
Deer River Police Department