Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL350516023M
Compliance #: HL350511300C

Date Concluded: August 16, 2023

Name, Address, and County of Licensee Investigated:
The Lodge
107 Bridgewater Way
Stillwater, MN 55082
Washington County

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

Evaluator's Name: Barbara Axness, RN
Special Investigator

Finding: Substantiated, facility responsibility

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 facility neglected the resident when they failed to administer medications as ordered, resulting in the resident getting incorrect doses of Bumex (a medication to reduce extra fluid/edema in the body) over the course of several weeks. The resident had a seizure and received treatment at the hospital.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to ensure the resident received his scheduled Bumex (a medication to reduce extra fluid/edema in the body) and missed approximately 56 doses of the medication. The resident suffered an episode of seizure-like activity and was treated in the emergency room for fluid overload. Facility nursing staff failed to notice the medication was documented as "not given" on the medication record and staff failed to notify the nurse the medication was not available and not administered.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted the primary care provider. The investigation included review of the resident's records including progress notes, medication administration records (MAR), assessments, the service plan, and hospital emergency room records. At the time of the onsite visit, the investigator observed cares and medication administration provided by facility staff.

The resident resided in an assisted living with dementia care facility. The resident's diagnoses included congestive heart failure, Parkinson's Disease, and Lewy Body Dementia. The resident's service plan included assistance with medication administration, morning and evening cares, and wrapping/unwrapping a dressing to his legs to reduce swelling. The resident's assessment indicated the resident had impaired decision making and relied on facility staff to monitor his medications.

Facility documentation indicated the resident's "eyes rolled back and he started to shake. 911 was called and the resident was taken to the emergency room and returned the same day." A progress note entered a few days later indicated, "it was discovered that resident was not getting his bumetadine [Bumex] since [date]." It was determined the pharmacy had the medication entered wrong in the system and it was not sent with the cycle medication refills."

The resident had a physician's orders for 4 milligrams (mg) of Bumex twice per day to reduce edema (swelling). The resident's MAR indicated approximately 56 doses of Bumex were not administered. During the time the medication was unavailable, the resident's MAR included documentation of the medication administered on several dates.

Hospital records indicated a chest x-ray was completed after wheezing was noted in the resident's lungs. The x-ray showed evidence of pulmonary edema/pulmonary vascular congestion (fluid buildup in the lungs). The resident was given intravenous (IV) Lasix (a diuretic) for fluid volume overload. Hospital notes indicated the resident's lungs were clear after administration of the IV Lasix and documentation included "given his chest x-ray findings and edema (swelling), suspect slight volume overload/CHF [congestive heart failure]."

During an interview, a facility registered nurse (RN) stated they didn't know staff documented the resident's Bumex as "not available" and was unaware of a medication dashboard within the facility's clinical software utilized to alert on what medications were withheld and the reason for not administering the medication. The RN did not think staff reported the Bumex being out of stock to the former Director of Nursing. The RN stated after they [RN] received training on the facility's clinical software, several missed doses were identified. The RN indicated medication error reports were not completed on the doses marked as administered, but should have been, as they were considered medication errors.

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 cognitive impairment
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility identified the medication error after conducting an audit. The facility immediately reported the incident to MAARC and completed a medication error report.

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.

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

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Washington County Attorney
Stillwater City Attorney
Stillwater Police Department
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35051	A. BUILDING: _____ B. WING _____	C 07/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LODGE	107 BRIDGEWATER WAY STILLWATER, MN 55082

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER 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: #HL350516023M/#HL350511300C #HL350513563M/#HL350515879C On July 17, 2023, 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 140 residents, with 78 receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL350516023M/#HL350511300C, tag identification 1760 and 2360. The following correction orders are issued for #HL350513563M/#HL350515879C, tag identification 1300 and 2360.	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 License 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 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 surveyors' 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 subd. 1, 2, and 3.	
01300 SS=F	144G.60 Subd. 2 Qualifications, training, and competency	01300		

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01300	Continued From page 1 All staff persons providing assisted living services must be trained and competent in the provision of services consistent with current practice standards appropriate to the resident's needs; and promote and be trained to support the assisted living bill of rights. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of one unlicensed personnel (ULP-A) was trained and competent in the provision of services with current practice standards appropriate to the residents' needs. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients). Findings include: ULP-A was hired August 29, 2022, to provide direct care and services to the licensee's residents. ULP-A's employee record contained a payroll action notice form with an effective date of September 26, 2022, indicating ULP-A resigned and was terminated after she left the locked memory care unit unattended on September 24, 2022, and had ongoing issues with attendance and being tardy over the last seven days. On September 25, 2022, ULP-A was not answering resident pendant calls and was found watching	01300		

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01300	Continued From page 2 football in a community room. On that same day, ULP-A took a one hour lunch break that wasn't approved and that ULP-A didn't punch out for. ULP-A was rehired on September 27, 2022. ULP-A's employee record lacked evidence a background study clearance letter was obtained after she was hired on August 29, 2022. NETStudy indicated ULP-A was affiliated to the licensee's roster on August 24, 2022, and supervision was required for the employee. ULP-A's employee record contained a background study clearance letter dated October 13, 2022. ULP-A's online education transcript indicated required dementia training was not completed until October 31, 2022. ULP-A's time card indicated the employee had worked 80 hours by October 3, 2022. ULP-A's employee record contained a payroll action notice with an effective date of November 9, 2022, indicating the employee was terminated for a policy violation. ULP-A's employee record lacked evidence of competency training, 30-day supervision from the registered nurse (RN), and record of orientation. Facility records indicated on November 7, 2022, around 9:00 p.m., several staff members contacted the clinical nurse supervisor after seeing a video posted by ULP-A to her Snapchat stories. The video showed R1 sitting in her wheelchair, pulling her pajama dress up. ULP-A could be heard saying, "This lady can't walk and she keeps trying to get up, she still wears a diaper." ULP-A could be heard laughing at the	01300		

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01300	Continued From page 3 resident and the video ended with ULP-A laughing. ULP-A was brought to the business office on November 9, 2022, where she admitted to taking and posting the video to her Snapchat stories. On July 18, 2023, at 1:03 p.m., licensed assisted living director (LALD)-B confirmed a background clearance letter from August 2022, had not been obtained. LALD-B confirmed ULP-A attended general orientation on August 29, 2022, but since the employee did not sign the attendance sheet, they had no documentation to show she was there. On July 18, 2023, at 1:31 p.m., LALD-B confirmed ULP-A did not have a 30 day supervision or nurse trained competencies in her employee record. No further information was provided. TIME PERIOD TO CORRECTION: Twenty-one (21) days	01300		
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	01760		

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01760	Continued From page 4 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 record review, the licensee failed to ensure medication was administered as prescribed for one of one residents (R2). 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: The licensee failed to ensure R2 received his scheduled Bumex (a medication to reduce extra fluid/edema in the body) and missed approximately 56 doses of the medication. The resident suffered an episode of seizure like activity and was treated in the emergency room for fluid overload. R2's diagnoses included Parkinson's Disease, confusion, type two diabetes, and lymphedema. R2's service plan, dated September 22, 2022, indicated the resident received assistance with morning and evening cares, medication management, and wrapping and unwrapping dressings to his legs.	01760		

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01760	Continued From page 5 R2's progress notes indicated the resident had seizure like activity on March 26, 2023. Documentation indicated "the resident's eyes rolled back and he started to shake. 911 was called and the resident was taken to the emergency room and returned to the facility the same day." A progress note from March 29, 2023, indicated "it was discovered that resident was not getting his bumetadine since 3/3/2023." It was determined the pharmacy had the medication entered wrong in the system and it was not sent with the cycle medication refills. A progress note from April 10, 2023, documented a communication sent to R2's provider to update her on his weight. The note included, "I just wanted to update you on [R2's] weight. Before the medication error with his Bumex, his weight was 251.8 lbs. [pounds] The following is his weight improvement once the PM dose was given again: 3/30/23: 259 lbs, 4/3/23 253.2 lbs, 4/10/23 (today): 251.6 lbs. He his back at baseline in regards to weight!..." R2's hospital records indicated he arrived in the emergency room on March 26, 2023, around 10:00 p.m. after a syncopal event at the facility. A chest x-ray was completed after wheezing was noted in the resident's lungs. The x-ray showed evidence of pulmonary edema/pulmonary vascular congestion (fluid buildup in the lungs). R2 was given intravenous lasix (a diuretic) for volume overload. Hospital notes indicated the resident's lungs sounded clear after the lasix was administered and "given his chest x-ray findings and edema (swelling), suspect slight volume overload/CHF."	01760		

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01760	Continued From page 6 R2's record contained an order dated January 30, 2023, to increase Bumex to 4 milligrams (mg) by mouth twice daily. R2's March 2023 Medication Administration Record (MAR) included the following: -Bumetanide (Bumex) 2 milligram tab, take two tablets by mouth two times a day at 8:00 a.m. and 8:00 p.m. The March 2023 MAR identified the 8:00 a.m. Bumex dose was given on March 1 and March 2. A note on March 3 indicated from March 4 through March 31, 2023, was marked with an X, indicating the medication was discontinued. The 8:00 p.m. dose was given March 1 and 2 and from March 3 through March 31, 2023, were also marked with an X, indicating the medication was discontinued. Another entry on the March 2023 MAR for the Bumex was for 2 mg tablet, take two tablets by mouth two times a day between 7:00 a.m. and 10:00 a.m. and between 7:00 p.m. and 10:00 p.m. The morning dose was documented as effective in the MAR on March 4, 2023. The March 2023 MAR identified the following morning doses were marked as not given: March 4 March 8 March 11 March 14 March 15 March 16 March 17 March 18 March 20 March 22	01760		

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01760	Continued From page 7 March 24 March 25 March 26 March 27 March 28 The MAR further identified the following morning doses were marked as administered, despite the medication not being available: March 5 March 6 March 7 March 9 March 10 March 12 March 13 March 19 March 21 March 23 March 29 March 30 March 31 The evening dose was documented as effective in the MAR on March 3, 2023. The March 2023 MAR identified the following evening doses were marked as not given: March 4 March 6 March 9 March 10 March 13 March 15 March 18 March 20 March 21 March 23 March 24 The March 2023 MAR also identified the following	01760		

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01760	Continued From page 8 evening doses were marked as administered, despite the medication not being available: March 3 March 5 March 7 March 8 March 11 March 12 March 14 March 16 March 17 March 22 March 25 March 26 March 27 March 28 March 29 March 30 March 31 In total, R2 missed 56 doses of Bumex from March 3rd through March 31st. R2's record contained a medication incident report dated March 27, 2023. The incident report indicated the resident didn't receive his Bumex for this cycle. Therefore, he was not given per MD order since March 3, 2023. The pharmacy was contacted and it was determined he did not get his Bumex due to an error in the system that did not have the medication on reorder every month. Contributing factors were noted to be "failure to follow policy and procedure, frequent distractions, pharmacy dispensing error, training required." The incident report did not identify any other factors to the error or identify a more definitive root cause. On July 20, 2023, at 2:10 p.m., registered nurse (RN)-B stated they didn't know staff were	01760		

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01760	Continued From page 9 documenting the medication as "not available" as they didn't know there was a medication dashboard within their clinical software that would show what medications were held and why. RN-B stated she didn't think staff had reported the medication being out to the former director of nursing. RN-B stated they had received training on their clinical software and after that, it was identified there were several missed doses. RN-B confirmed medication error reports were not completed on the doses that were marked as given while the medication was out, but there should have been, as that would also be a medication error. The licensee's Medication Error policy, dated August 1, 2021, indicated in the event an error occurs, staff would document, track, and resolve medication administration errors for quality improvement. Staff would be retrained if necessary. No further information was provided. 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: The facility failed to ensure 2 of 2 residents reviewed (R1, R2) were free from maltreatment. R1 was abused. R2 was neglected.	02360	No plan of correction is required for this tag.	

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02360	Continued From page 10 Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment of R2, in connection with incidents which occurred at the facility. The facility and alleged perpetrator (AP) were responsible for the maltreatment of R1, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		