DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL28513002M
Compliance #: HL28513003C

Date Concluded: October 10, 2022

Name, Address, and County of Licensee Investigated:
Oak Terrace Housing of Jordan
622 Aberdeen Avenue
Jordan, MN 55352
Scott County

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

Evaluator's Name: Laura duCharme, RN
Christine Bluhm, RN
Special Investigators

Finding: Inconclusive

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 facility neglected a resident when they did not administer the correct dose monoclonal antibodies (also called REGEN-COV, a medication to treat positive COVID patients) and not following the resident's care plan which contributed to the resident's death due to COVID-19.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was inconclusive. A facility nurse administered a partial dose of monoclonal antibodies without a physician's order to a resident that had COVID-19 infection. It is not known if administering the full dose of the medication to the resident would have resulted in a different outcome.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The resident's physician was interviewed. The investigation included review of facility incident reports, resident deaths, grievances, and multiple resident records. Also, the investigator observed general care facility staff provided to residents. COVID practices in the facility were observed.

The resident resided in an assisted living memory care unit. The resident's diagnoses included chronic obstructive pulmonary disease, dementia, and COVID- 19 infection. The resident's service plan included assistance with all activities of daily living such as dressing, bathing, toileting, two-person assistance with mobility, and medications. The resident's assessment indicated the resident had a history of dysphagia with a pureed diet and required assistance with meals.

A physician's clinical note indicated the resident had a history of unresponsive episodes. A palliative care approach was taken, and the resident was placed on hospice. Physician orders included oxygen saturation (oxygen blood levels) checks, oxygen to keep oxygen levels above 90% and nebulizers (medication to ease breathing) for shortness of breath.

The resident's nursing progress note indicated the resident had increased sleeping periods and her appetite declined, but the resident continued to be comfortable without complaints of pain. The notes indicated the facility routinely tested the resident for COVID and had negative results up until she tested positive and was quarantined to her room per facility COVID protocol. The note indicated the family wanted the resident to receive the monoclonal antibodies injection. The note indicated the resident had become less responsive, with increased wheezing and fever. Staff continued to provide comfort cares. Nebulizer treatments and Tylenol were given as needed.

Review of a facility incident investigation form indicated a nurse gave the monoclonal antibodies medication to the resident without a physician's order. The note indicated the resident only received half the full dose as did another resident who did have a physician's order for the medication. The nurse did not document that either medication was given.

During interview, the former director of nursing (DON) stated the nurse's action was a medication error. The DON stated the nurse gave the monoclonal antibodies injection to the first two residents who tested positive for COVID, but only one of them had a physician's order to do so and neither resident received the full dose that day.

During interview, the nurse stated the resident was the facility's first COVID patient. She stated she gave the resident less than the full dose in error and then did not properly document after she gave the medication. The nurse stated she thought verbal orders for the medication were in place for the resident as it was common for the day shift nurse to get the verbal order and not actually put the order in to the computer. The nurse stated she called the DON that night for direction and support, but the DON was not helpful.

During interview, a family member stated that they wanted the resident to receive the medication and did receive a text from the nurse after it was given. The family member learned of the medication error several days later when she went to the facility to visit the resident. During the visit, the family found the resident in her room, with her meal tray still in front of her and a nebulizer mask on that had dried vomitus in it. The family member stated it looked like staff had not been in the resident's room for some time.

During interview, an unlicensed staff person stated staff were repositioning and bathing the resident in bed as the resident was not able to do anything on her own. The unlicensed staff person stated the resident was not eating much but they still tried to feed her. The staff person did not know why the nebulizer mask was left on the resident or if anyone had tried to feed her that day.

During interview, the resident's primary physician reviewed the resident's clinical note and stated that several days prior to testing positive for COVID-19, the resident was more lethargic, had not been interested in eating for a while, and oxygen saturations were falling into the mid-80s. The physician stated the resident tested positive and died several days later, and from a physician's standpoint, it was a severe and fast COVID, and stated she was not sure any treatment would have stopped the progression. As for the nebulizer mask that was left on for unknown amount of time, the resident was still receiving oxygen through it and would not have caused additional harm.

Review of the REGEN-COV (casirivimab and imdevimab, co-formulated product) fact sheet, the product was approved for emergency use for adults with a positive SARS-CoV-2 viral testing, and who were at elevated risk for progression to severe COVID-19, including hospitalization or death.

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:
(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.

Vulnerable Adult interviewed: No, the resident was deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility conducted an internal investigation of the medication incident. The nurse was placed on suspension and a notification of the incident was forwarded to the MN Board of Nursing. Nurses were educated on proper administration and documentation of the Regen medication.

Action taken by the Minnesota Department of Health:

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.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28513	A. BUILDING: _____ B. WING _____	C 04/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK TERRACE HOUSING OF JORDAN	622 ABERDEEN AVENUE JORDAN, MN 55352

(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 Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING 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: #HL28513002M/#HL28513003C On April 5, 2022, 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 67 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL28513002M/#HL28513003C, tag identification 1760 and 1820.	0 000	Assisted Living Provider 144G. Minnesota Department of Health is documenting the State Licensing 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.	
01760 SS=D	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	01760		

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01760	Continued From page 1 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 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 medications were documented after administration for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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). Findings include: R1 had a history of dementia, chronic obstructive pulmonary disease (COPD), and COVID-19 infection. R1's service/care plan dated November 16, 2021, indicated R1 received services from the assisted living provider which included medication administration.	01760		

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01760	Continued From page 2 R2 had a history of cognitive impairment and COVID-19 infection. R2 ' s service/care plan dated October 29, 2020, indicated R2 received services from the assisted living provider which included medication administration. R2 ' s physician signed order dated November 11, 2021, indicated R2 could have a one-time only 10 milliliter (mL) subcutaneous injection of REGEN-COV for a positive COVID diagnosis. R2 ' s medication administration record (MAR) dated November 2021, indicated the 10 mL of REGEN COV one time only for one day entries were blank on days November 12 and November 13. Review of medication incident report form indicated R1 was administered medication, monoclonal antibodies without an order. Provider investigation form signed and dated November 15, 2021, indicated registered nurse (RN)-E gave another resident ' s (R2) medication intentionally to R1 without an order for R1 to receive the treatment. Administration of treatment was not documented on either resident. In addition, RN-E stated she incorrectly gave two injections to both residents not four. PCP for both residents updated. During interview, RN-E stated she did not document that the medication was given to either resident. RN-E stated she could not come up with a good rationale for not completing the documentation.	01760		

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01760	Continued From page 3 Policy titled 7.08 Medication Management - Administration and Setup, dated August 1, 2021, indicated the nursing staff and unlicensed personnel trained to provide medication administration at Oak Terrace will document any medication administration provided accurately in each resident record. TIME PERIOD FOR CORRECTION: Seven (7) Days.	01760		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure medications were administered as ordered for one of one resident (R2), and failed to ensure there was a doctor's order prior to medication administration for one of one residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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). Findings include:	01820		

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01820	Continued From page 4 R1 had a history of dementia, chronic obstructive pulmonary disease (COPD), and COVID-19 infection. R1's service/care plan dated November 16, 2021, indicated R1 received services from the assisted living provider which included medication administration. R2 had a history of cognitive impairment and COVID-19 infection. R2 ' s service/care plan dated October 29, 2020, indicated R2 received services from the assisted living provider which included medication administration. R2 ' s physician signed order dated November 11, 2021, indicated R2 could have a one-time only 10 milliliter (mL) subcutaneous injection of REGEN-COV for a positive COVID diagnosis. R2 ' s medication administration record (MAR) dated November 2021, indicated the 10 mL of REGEN COV one time only for one day entries were blank on days November 12 and November 13. Review of medication incident report form indicated R1 was administered medication, monoclonal antibodies without an order. Provider investigation form signed and dated November 15, 2021, indicated registered nurse (RN)-E gave another resident ' s (R2) medication intentionally to R1 without an order for R1 to receive the treatment. Administration of treatment was not documented on either resident. RN-E stated she incorrectly gave two injections to both residents not four. PCP for both residents	01820		

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01820	Continued From page 5 updated. During interview, RN-B stated she was instructed how to give the REGEN-COV injection by the physician ' s assistant and had received and entered the order for residents. RN-B confirmed that R1 did not have orders for the REGEN-COV. A Policy for medications with a physician ' s order was not provided. TIME PERIOD FOR CORRECTION: Seven (7) Days.	01820		