Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL304002767M
Compliance #: HL304004697C

Date Concluded: October 27, 2022

Name, Address, and County of Licensee Investigated:
Sugar Brook Villa
20868 Sugar Hills Road
Cohasset, MN 55721
Itasca County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Barbara Axness, RN
Special Investigator

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 resident was neglected when the unlicensed personnel (ULP)/alleged perpetrator (AP) failed to report a change in condition to the registered nurse (RN), resulting in the resident passing away.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. It is unable to be determined if the resident's condition would have improved had the AP reported the change in a timely manner. The AP failed to notify the nurse after the resident's oxygen levels dropped

below normal ranges. However, the AP applied supplemental oxygen as ordered to the resident. The resident was on hospice services. When the hospice nurse was made aware of the drop in oxygen, no changes were made to the resident's end of life care plan. The facility nurse and hospice nurse stated no additional treatment measures would have been taken had the AP notified the nurse at the time the change was observed.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted the hospice nurse. The investigation included review of medical records, hospice records, and the resident's death record. In addition, the investigator observed resident care at the facility.

The resident resided in an assisted living facility. The resident's diagnoses included hypertension (high blood pressure). The resident's service plan included assistance with dressing, grooming, bathing, and medication administration. The resident's assessment indicated the resident was alert, oriented and cognitively intact.

During an interview, a facility nurse confirmed she was not notified of the drop in the resident's oxygen level. The nurse stated the resident was receiving hospice services, but at that time he wasn't actively dying. The nurse stated the resident had not had any dips in his oxygen levels since he moved to the facility but did have an order for supplemental oxygen if his oxygen levels dropped below 90%. The nurse stated she found out about the change when she arrived at the facility later that afternoon, several hours after the low oxygen was first noted by the AP. The nurse stated she felt the AP was overwhelmed while trying to complete other duties that morning and forgot to notify her of the change.

During an interview, the AP stated she had checked the resident's oxygen in the morning and knew she should have called the nurse right away. The AP stated she told the assisted living director about the low oxygen level and she was directed to call the nurse. The AP stated she placed supplemental oxygen on the resident and then went back to finish the medication pass and serve breakfast to other residents. The AP stated she didn't remember to notify the nurse until she saw her walk in the building later that day.

During an interview, another unlicensed personnel (ULP) working with the AP that morning stated the resident had a "complete 180 change in condition from the day before and was unresponsive." The ULP stated she directed the AP to call the nurse and was unaware the AP did not complete this task. The ULP stated the AP seemed overwhelmed that morning because she didn't normally pass medications and with "everything going on and trying to take care of the resident, she forgot."

During an interview, the hospice nurse stated the resident had not needed supplemental oxygen since moving to the facility and his oxygen levels had remained stable. The hospice nurse stated they weren't surprised to see the resident had declined quickly as he had been eating less and had been expressing to staff that he was "ready to go". The hospice nurse stated

their focus was treating symptoms, not numbers. The hospice nurse went on to say that if the resident was comfortable with the supplemental oxygen, no changes would have been made to the resident's plan of care despite the delay in communication of the resident's condition.

The resident's death record listed his cause of death as a hemorrhagic stroke

In conclusion, it was inconclusive whether neglect exploitation occurred.

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, deceased.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
No actions were taken by the facility.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30400	A. BUILDING: _____ B. WING _____	C 09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUGAR BROOK VILLA	20868 SUGAR HILLS ROAD COHASSET, MN 55721

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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: #HL304002602M, HL304004366C, HL304002583M/ HL304004399C, HL304002767M/HL304004697C, and HL304003065M/ HL304004985C. On September 28, 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 ten (10) residents receiving services under the provider's Assisted Living license. The following correction order is issued for HL304002767M/HL304004697C and HL304002583M/ HL304004399C, tag identification 2310. The following correction orders are issued for HL304002602M/HL304004366C, tag identification 1760, 1840.	0 000	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 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.	

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01760	Continued From page 1	01760		
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 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 administered as prescribed for one of one resident (R3) with records reviewed. 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: R3's diagnoses included type two diabetes and adjustment disorder with depressed mood.	01760		

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01760	Continued From page 2 R3's service plan, dated July 21, 2022, indicated the resident received the following services: assistance with dressing, grooming, bathing, transfers, and medication administration. On August 20, 2022, R3's hospice medical records indicated facility staff called to report the patient was restless and anti-anxiety medications had not been effective. The hospice progress note indicated the staff were directed to give 2 milligrams (mg) hydromorphone (pain medication) with Haldol (an anti-anxiety medication). The hospice note indicated the hospice nurse "lives out in the country and has no high speed internet, resulting in the telephone and computer not syncing." The note indicated that during the call, the hospice nurse's computer said the hydromorphone dose was 2 mg and after it was synced, it displayed the order for 1 mg. Once the hospice nurse noticed the mistake, he called the facility but the 2 mg dose had already been given to R3. The resident's facility medication administration record (MAR) indicated the resident had an order for 1 mg of hydromorphone (pain medication) to be given every hour as needed for pain. The resident's narcotic log indicated the resident received 2 mg of hydromorphone on August 20, 2022, at 4:40 p.m. On August 21, 2022, the resident's hospice medical records indicated the facility nurse called hospice staff due to concerns the resident had been getting antianxiety and pain medications every two hours over the night shift and seemed to be lethargic. The hospice progress notes indicate the resident's oxygen was reported to be 85% (normal is 90%-100%). The nurse practitioner was contacted who gave an order to	01760		

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01760	Continued From page 3 check the resident's vital signs (blood pressure, respirations, pulse, oxygen saturation, temperature) every hour until the resident woke up. The resident was also started on supplemental oxygen at 2 liters per minute. On September 28, 2022, at 1:30 p.m., licensed practical nurse (LPN)-B stated she had not been notified the resident was restless and she was not updated by staff that hospice directed to give the PRN medications. LPN-B stated when she came in the next morning (August 21, 2022), the resident "was snowed, not waking up," which prompted her to update hospice and have the resident's vital signs checked. On September 30, 2022, at 12:30 p.m., licensed assisted living director (LALD)-E stated she worked the overnight shift of August 20, 2022. LALD-E stated the resident had been restless so hospice staff were notified and they were directed to give some as needed medications. LALD-E stated she felt the nurse overreacted and she didn't think the monitoring the next day was necessary because they had an order to give those medications and he wasn't restless anymore. On September 30, 2022, at 1:15 p.m., hospice nurse (HN)-F confirmed the hospice nurse working on August 20, 2022, told staff to give 2 mg of pain medication instead of his scheduled 1 mg. HN-F confirmed the nurse's computer did not sync so he was not aware the order had recently been decreased to 1 mg. On October 14, 2022, at 1:05 p.m., LALD-E stated she was not aware R3 had received 2 mg of hydromorphone instead of his ordered 1 mg of hydromorphone on August 20, 2022. LALD-E	01760		

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01760	Continued From page 4 stated hospice staff have the say on what's given and staff would follow what hospice staff directed to give. LALD-E stated the staff member who administered the 2 mg dose, ULP-D, was trusting the hospice nurse was giving her the right information when he said to give 2 mg of hydromorphone instead of the 1 mg indicated in the resident's current orders and MAR. LALD-E stated ULP-D likely didn't think it was an order change because the order did read "hydromorphone HCl Tablet 2 mg: Give 1 mg by mouth every 1 hour as needed for pain. 1 mg= half tab." LALD-E stated since the order said 2 mg in it, despite the order saying to give half a tab for 1 mg, it wasn't really a medication error. LALD-E stated there had been a lot of changes with R3's medications that week so she didn't think it was anything different when she gave the 2 mg instead of what was listed on the MAR. The licensee's Medication Error policy, dated July 13, 2022, indicated if a medication error occured, staff would document, track, and resolve medication errors for quality improvement. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01760		
01840 SS=D	144G.71 Subd. 15 Verbal prescription orders Verbal prescription orders from an authorized prescriber must be received by a nurse or pharmacist. The order must be handled according to Minnesota Rules, part 6800.6200. This MN Requirement is not met as evidenced by:	01840		

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01840	Continued From page 5 Based on interview and record review, the licensee failed to ensure verbal prescription orders from an authorized prescriber were received by a nurse or pharmacist for one of one resident (R3). 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, but was not likely to cause 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: R3's diagnoses included type two diabetes and adjustment disorder with depressed mood. R3's service plan, dated July 21, 2022, indicated the resident received the following services: assistance with dressing, grooming, bathing, transfers, and medication administration. R3's signed prescriber orders indicated the resident had an order for 1 milligram (mg) of hydromorphone to be given every hour as needed for pain. On August 20, 2022, hospice medical records indicated unlicensed personnel (ULP)-D called hospice to report the patient was restless and as needed (PRN) lorazepam (medication for anxiety) given two hours prior to the call, was not effective. The hospice progress note indicated ULP-D was directed to give 2 mg hydromorphone with haldol (a medication for anxiety) and if the resident was still restless in two hours, to give	01840		

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01840	Continued From page 6 hydromorphone (pain medication) with lorazepam and to call back if not successful. The hospice note indicates the hospice nurse "lives out in the country and has no high speed internet," resulting in the telephone and computer not syncing. The note indicated that during the call, the hospice nurse's computer said the hydromorphone dose was 2mg and after it was synced, it displayed as a 1 mg dose. Once the hospice nurse noticed the mistake in what he directed staff to do, he called the facility but the 2 mg dose had already been given according to the progress note. A nurse practitioner for hospice was contacted and informed of the med error by the hospice nurse and the progress note indicates the nurse practitioner was "thankful for the call and said it would be ok." The resident's facility medication administration record (MAR) indicated the resident received 1 mg of hydromorphone at 4:48 p.m. The resident's narcotic log indicated the resident received 2mg of hydromorphone at 4:40 p.m. On October 14, 2022, at 1:05 p.m., LALD-E stated she was not aware R3 had received 2 mg of hydromorphone instead of his ordered 1 mg of hydromorphone on August 20, 2022. LALD-E stated that hospice staff are able to give phone orders and the usual procedure would be for the ULP to contact the facility nurse with the order so they can put it in the computer. LALD-E confirmed "that wasn't the case this day." LALD-E stated hospice staff have the say on what's given and staff would follow what hospice staff directed to give. LALD-E stated ULP-D was trusting the hospice nurse was giving her the right information when he said to give 2 mg of hydromorphone instead of the 1 mg indicated in the resident's current orders and MAR. LALD-E stated ULP-D	01840		

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01840	Continued From page 7 likely didn't think it was an order change because the order did read "hydromorphone HCl Tablet 2 mg: Give 1 mg by mouth every 1 hour as needed for pain. 1 mg= half tab." LALD-E stated since the order said 2 mg in it, despite the order saying to give half a tab for 1 mg, it wasn't really a medication error. LALD-E stated there had been a lot of changes with R3's medications that week so she didn't think it was anything different when she gave the 2 mg instead of what was listed on the MAR. A policy on procesing orders was requested, but not provided. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	01840		
02310 SS=H	144G.91 Subd. 4 Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for two of three residents (R1, R2) when the nurse was not notified of changes in condition. This practice resulted in a level three violation (a violation that harmed a resident's health or safety,	02310		

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02310	Continued From page 8 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 a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1's diagnoses included type two diabetes and Alzheimer's disease. R1's service plan dated July 19, 2022 , indicated the resident received the following services: assistance of 1 to 2 with dressing, grooming, bathing, feeding, transfers with two people using a hoyer lift, daily medication administration, and weekly housekeeping and laundry. The resident's most recent assessment, dated September 8, 2022, indicated the resident was severely cognitively impaired and nonverbal. A progress note entered by unlicensed personnel (ULP)- C on August 26, 2022, indicated she noticed hard, compacted ear wax/debris in the resident's ear canal that was blocked with a dark brown mass that was very hard. ULP-C documented " ...I removed it [ear wax] by safely grasping the end with a tweezer and pulling it out. Once I removed the mass from the front ear, I noticed the end that was attached to the rest of the compaction had some semi-fresh blood. The dark brown compaction appeared to be dried blood that accumulated in the ear canal (not diagnosed by a medical physician) I found [the resident's] right ear had the same findings as the	02310		

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02310	Continued From page 9 left ....I did not proceed further due to prevent injury to the ear and wouldn't go past the ear canal. Follow up needed." ULP-C did not report her findings to the nurse. A progress note entered by registered nurse (RN)-G on August 26, 2022, indicated staff getting the resident ready for dinner noted blood in both of the resident's ears. RN-G assessed the resident's ears and due to the presence of blood in the ear canal with unknown cause, the resident was sent to the emergency room for further evaluation. The resident's emergency room records indicate a CT scan was completed. The emergency room records note the resident had dried blood to both ears, both ears right tympanic membrane appeared to be perforated, and pooling blood in both ears was noted. No external ear trauma was noted. The resident was diagnosed with bilateral acute otitis media (middle ear infection) and bilateral externa media (infection of the outer opening of the ear and ear canal). The resident was prescribed antibiotics and discharged back to the facility. On September 28, 2022, at 1:10 p.m., licensed practical nurse (LPN)-B stated ULP-C did not report the concerns with the resident's ears having built up wax to her. LPN-B stated she only found out afterwards when staff on the evening shift called to report blood coming from the resident's ears. LPN-B stated she later found bloody tweezers in the laundry room sink and discovered ULP-C had used the tweezers to clean out excess wax from the resident's ears. On September 29, 2022, at 11:20 a.m., ULP-C confirmed she had used tweezers to clean ear	02310		

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02310	Continued From page 10 wax from both of the resident's ears. ULP-C stated she knew she shouldn't have used the tweezers and had not been trained to remove ear wax that way. ULP-C stated she was in a hurry when she was leaving work and forgot to update the nurse about what she had done. On September 29, 2022, at 1:50 p.m., the physician's assistant (PA)-H who treated the resident in the emergency department stated he couldn't say what was the cause of the ruptured ear drums. PA-H stated an ear infection could cause the rupture, but the tweezers could have also led to the rupture. On October 17, 2022, at 12:35 p.m., primary care provider (PCP)-I stated she didn't believe an infection led to the ruptured ear drums. PCP-I stated she had been following the healing of the resident's ears since she returned from the ER and felt some of the abrasions in her ear had been caused by the tweezers. PCP-I stated one of the resident's ear drums had healed but she was still monitoring and treating the other. R2 R2's diagnoses included hypertension (high blood pressure). R2's service plan dated July 13, 2022, indicated the resident received the following services: assistance with dressing, grooming, bathing, daily medication administration, and weekly housekeeping and laundry. The resident's most recent assessment, dated August 26, 2022, indicated the resident was bed bound and receiving hospice services. A progress note entered by ULP-D on August 26,	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30400	A. BUILDING: _____ B. WING _____	C 09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02310	Continued From page 11 2022 at 11:37 a.m., indicated R2's oxygen was 76% (normal range is 90-100%). On September 28, 2022, at 1:25 p.m., LPN-B confirmed she was not notified the resident's oxygen level had dropped. LPN-B stated R2 was on hospice services but he wasn't actively dying. LPN-B stated the resident had not had any dips in his oxygen levels since he moved in to the facility but did have an order for supplemental oxygen if his oxygen went below 90%. LPN-B stated an internal investigation was not done as to why staff did not notify the nurse and felt the staff member got overwhelmed trying to complete other duties that morning. On September 28, 2022, at 2:15 p.m., ULP-D stated she had checked R2's oxygen the morning of August 26th and when she got the low reading, she went and told LALD-E. ULP-D stated she knew she should have called the nurse and stated LALD-E told her she should call the nurse. ULP-D stated she put some oxygen on the resident but since she was in the middle of serving breakfast to other residents and doing the medication pass that morning, she forgot to call the nurse. ULP-D stated she knew the oxygen was low and knew she should have called the nurse but just got busy and didn't remember to notify the nurse until she saw her walk in the building later that day. On September 29, 2022, at 11:20 a.m., ULP-C stated she was working the morning of August 26th with ULP-D. ULP-C stated she noticed the resident had a "complete 180 change in condition from the day before and was unresponsive...we were wondering what the heck was going on." ULP-C stated ULP-D doesn't "work on meds a lot because she gets overwhelmed and her brain	02310		

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02310	Continued From page 12 can't respond and act fast and I'm guessing everything going on and trying to take care of the resident, she forgot." ULP-C stated ULP-D had notified her of the resident's low oxygen and she had suggested to ULP-D that she call the nurse and let her know. On September 30, 2022, at 9:00 a.m., hospice nurse (HN)-F stated the resident had a need for supplemental oxygen before admitting to hospice but had not had any episodes of low oxygen recently. HN-F stated once they were notified of the episode of low oxygen, they assessed the resident and did not make any changes to his care plan. HN-F stated they were not surprised the resident had a rapid change in condition as he had started to decline and expressed that he was "ready to go." On September 30, 2022, at 12:00 p.m., LALD-E confirmed ULP-D reported R2's low oxygen to her the morning of August 26, 2022. LALD-E stated she showed ULP-D how to chart it and stated she told the ULP to report the change to the nurse. LALD-E stated she was busy that morning and did not check in to make sure the nurse was notified. LALD-E stated she didn't see the drop in oxygen as a change in condition, "it's the ups and downs of the dying process." LALD-E confirmed no investigation or formal education was completed with staff after these incidents occurred. LALD-E stated, "It's not that we don't have the system in place, it's on them, it's the individuals job to follow through and report things to the nurses. I tell my staff all the time you need to tell the nurse or make a progress note to cover your ass so if the nurse doesn't follow through it's not on you." On September 30, 2022, at 1:50 p.m., RN-G	02310		

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02310	Continued From page 13 stated she was on call but not onsite on August 26, 2022. RN-G stated LPN-B notified her after she went to the facility that afternoon and that it would have been her expectation staff called her or LPN-B as soon as they noticed the resident's oxygen levels dropped below a normal range. R2 died on August 28, 2022. The resident's death certificate indicated the cause of death was a hemorrhagic stroke. A policy on notification of the nurse for resident change in conditions was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		