Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL30723001M
Compliance #: HL30723002C

Date Concluded: August 9, 2022

Name, Address, and County of Licensee Investigated:
Mankato Lodge Senior Living
1360 Adams Street
Mankato, Minnesota, 56001
Blue Earth County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Danyell Eccleston, 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 facility neglected the resident when the facility failed to ensure the resident had supply of prescribed blood thinner medication, Xarelto. The resident was not given Xarelto for four consecutive days and the resident experienced a stroke.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. The facility failed to ensure the resident had supply of the blood thinner, Xarelto, and the resident did not receive

the medication for four days. However, it could not be determined that the missed medication caused the resident to have a stroke.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the medical provider and resident family members. The investigation included review of the resident's medical record, facility policies and procedures, and the facility medication administration system. Observations were completed of resident cares and the facility medication system.

The resident resided in an assisted living facility. The resident's diagnoses included irregular heartbeat, loss of proper vein function of the legs, and blood pooling of the veins. The resident's service plan indicated the resident received assistance with medication management.

The resident's medical record indicated the resident was not given Xarelto for four consecutive days and on the fifth day experienced a stroke.

The resident's hospital record indicated the resident's stroke was due to a blocked artery or hardening of an artery in the brain. The stroke caused the resident to experience paralysis to her left side, speech issues, and swallowing difficulty. The hospital record indicated the resident reported not taking Xarelto for multiple days due to not having a supply of the medication. A provider note stated if the resident had not taken Xarelto for a few days she would have been at high risk for a stroke.

During interview, an unlicensed staff member stated the resident ran out of Xarelto and the supply was not sent from the pharmacy due to a high copay needing approval. The unlicensed staff member stated she tried to order the medication twice and could not obtain the medication due to the high copay. The unlicensed staff member stated at the time of the incident she did not know that Xarelto was a blood thinner.

During an interview, a nurse stated Xarelto is a high-risk medication and multiple efforts, including obtaining an emergency supply, should be made to ensure that residents do not go without high-risk medications. The nurse stated she recollected being contacted after the resident went to the hospital but did not recall being contacted about the resident not having a Xarelto supply.

During an interview, a provider stated the resident took Xarelto because she had an irregular heartbeat that made her prone to producing clots. The provider stated Xarelto was a blood thinner that decreased the chances of a stroke. The provider stated if the resident was not taking Xarelto her chances of having a stroke could possibly increase.

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 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, resident no longer at facility
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility: The facility conducted an internal investigation of the incident.

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
	30723	A. BUILDING: _____ B. WING _____	C 04/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANKATO LODGE SENIOR LIVING	1360 ADAMS STREET MANKATO, MN 56001

(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: #HL30723002C/#HL30723001M On April 20, 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 23 residents receiving services under the provider's Assisted Living License. The following correction order is issued for #HL30723002C/#HL30723001M , tag identification 1760.	0 000	The Minnesota Department of Health documents 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that 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. Per Minnesota Statute §144G.30, Subd. 5 (c), the assisted living facilities must document any action taken to comply with the correction order. A copy of the provider ' s records documenting those actions may be requested for follow-up surveys. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider ' s Plan of Correction." The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144G.31, Subd. 2 and 3.	
01760 SS=G	144G.71 Subd. 8 Documentation of administration of medication	01760		

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01760	Continued From page 1 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 residents, (R1), reviewed for missed medication. This had the potential for harm when R1 was not administered Xarleto (blood thinner) for four days after the medication supply ran out. The licensee failed to identify and document follow-up procedures that were provided to meet the R1's needs when medication was not administered as prescribed and in accordance with R1's medication management plan. 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).	01760		

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01760	Continued From page 2 Findings include: R1's Initial Information Sheet indicated R1 was admitted to the facility on February 14, 2018. R1's service plan, dated February 18, 2022, indicated the resident received assistance with oral care reminders, redirection, lifestyle activities, escorts, incontinence care, toileting assistance, and medications. R1's provider encounter note dated February 3, 2022, indicated R1's active medical problems included anticoagulation management, atrial fibrillation, benign hypertensive heard and kidney disease with chronic kidney disease with heart failure, venous statis dermatitis of both lower extremities, and irregular heartbeat. The note indicated R1 had atrial fibrillation and continued to take Xarelto for the condition. The note also indicated the resident was to take 15 mg of Xarelto daily. R1's medication administration record dated February 2022, indicated R1 was scheduled to take Xarelto 15 mg tablet daily at 5:00 p.m. R1 did not receive Xarelto on February 7-11, 2022. Medication note documentation from February 8, 9, 10, 2022 indicated R1 did not receive Xarelto due to the facility being out of the medication. An electronic message to R1's provider sent by registered nurse (RN)-A dated February 9, 2022, at 2:47 P.M. indicated the Xarelto refill request to the pharmacy for R1 was rejected due to a high copay and the medication was not sent. The note did not include information that R1 had not received Xarelto since February 7, 2022. An electronic message reply from the Certified Nurse Practitioner (CNP)-B on February 9, 2022, at 4:32	01760		

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01760	Continued From page 3 P.M. indicated she sent an authorization request to the clinic medication refill team regarding R1's Xarelto prescription. Review of R1's medical record from February 2022, contained no documentation of R1's emergency contacts being contacted regarding R1's Xarelto supply running out and not being administered. The facility policy titled Documentation of Medication, Treatment, and Therapies dated August 24, 2021, indicated the nurse will document actions to request and obtain needed refills for clients, including communications with the prescriber, pharmacy, client and/or the client's representative or family. A document titled Highlights of Prescribing Information for Xarelto (rivaroxaban) issued by the Food and Drug Administration, revised October 2017 (https://www.accessdata.fda.gov/drugsatfda_docs/label/2017/022406s024lbl.pdf) stated "Xarelto is a factor Xa inhibitor indicated to reduce the risk of stroke and systemic embolism in patients with nonvalvular atrial fibrillation". The document included a warning stating "premature discontinuation of any oral anticoagulant, including Xarelto, increased the risk of thrombotic events. To reduce this risk, consider coverage with another anticoagulant if Xarelto is discontinued for a reason other than pathological bleeding or completion of a course of therapy." The document stated, "If a dose of Xarelto is not taken at the scheduled time, administer the dose as soon as possible on the same day as follows... for patients receiving 20 mg, 15 mg or 10 mg once daily: The patient should take the missed Xarelto dose immediately".	01760		

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01760	Continued From page 4 During interview on April 20, 2022, at 3:08 p.m., unlicensed personnel (ULP)-C stated during the time in question a staff member informed her R1 had a few doses left of Xarelto. ULP-C stated she attempted to reorder the medication on two separate dates and due to a high copay, the Xarelto was not refilled. ULP-C stated at the time she did not know that Xarelto was an anti-coagulant and thought it would be okay for R1 to not have the medication for a few days. ULP-C stated she handed off the refill request to RN-A before leaving for vacation. During interview on July 8, 2022, at 10:02 a.m. R1's family member (FM)-D stated he and two other family members were listed as emergency contacts for R1 and none of the emergency contacts received messages from the facility, pharmacy, or R1's provider that R1 did not have a supply of Xarelto or that R1's Xarelto refill needed a copay approval. FM-D stated R1's phone did not have any messages left regarding issues with refilling her Xarelto supply. During interview on July 12, 2022, at 2:24 p.m. CNP-B stated R1 took Xarelto because she had a history of atrial fibrillation, and that atrial fibrillation can cause blood clots. CNP-B stated not taking Xarelto could possibly increase risks of having a stroke. During a follow-up interview on July 27, 2022, at 2:45 p.m. CNP-B stated she was informed on February 9, 2022, that R1's Xarelto had not been refilled due to a high copay, however, CNP-B was not informed that R1 was out of Xarelto and had not received a dose since February 6, 2022. CNP-B stated facilities are to refill medications before the medications run out. CNP-B stated if she was made aware that R1 was out of Xarelto, she would have contacted the	01760		

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01760	Continued From page 5 pharmacy directly and requested that the facility contact R1's family. CNP-B stated if the facility made her aware R1 missed doses of Xarelto, she would have reviewed protocols to see if there were other medical actions that needed to be taken as a result. CNP-B stated clinic nursing was coordinating R1's medication refills and the clinic nurses were not informed of R1's need for Xarelto refill or that R1 had not received Xarelto as prescribed. During interview on July 22, 2022, at 2:48 p.m. RN-A stated Xarelto is a high-risk medication and multiple efforts need to be taken to ensure residents receive high risk medication as indicated. RN-A stated she did not recall being informed R1 did not have a Xarelto supply. RN-A stated if she would have know she would have worked to receive emergency doses of Xarelto to ensure R1 was receiving the medication as prescribed. Time period for correction: Seven (7) days.	01760		