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 #: H53692501M
Compliance #: H53696441C

Date Concluded: July 27, 2026

Name, Address, and County of Licensee Investigated:
St. Mark's Living
400 15th Avenue Southwest
Austin, Minnesota 55912
Mower County

Facility Type: Nursing Home

Evaluator's Name: Nicole Myslicki, RN
Special Investigator

Finding: Not Substantiated

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 alleged perpetrator (AP) neglected the resident when the AP administered another resident's medications to her.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the AP administered the wrong medication to the resident, the error was an isolated incident. The AP notified a nurse after the medication error. The nurse assessed the resident and monitored her. When the resident became unresponsive, the facility staff sent the resident to the hospital. At the hospital, the resident medication and therapy. The resident returned to their baseline health condition.

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

record, hospital records, facility internal investigation, facility medication error report, personnel file, staff schedule, and related facility policies and procedures.

The resident transitioned from the hospital into a short-term rehabilitation unit within a skilled nursing facility. The resident's diagnoses included dementia, chronic kidney disease, heart failure, and low blood pressure upon standing. The resident's care plan included assistance with medication administration. The resident's assessment indicated she needed partial assistance with transferring and walking.

A medication error report indicated the AP gave the resident medication that belonged to another resident. The nurse took the resident's vitals and notified the director of nursing, the provider, and family. The resident had initially been stable following the medication error and put her call light on to use the bathroom. Then, the resident became unresponsive. The director of nursing went to the resident's room and assessed her. The family had been in the room and agreed to send the resident to the hospital.

The facility's internal investigation indicated the AP informed the nurse of the medication error. The nurse then notified the provider, family, and director of nursing. Staff obtained vital signs which were in the normal range. When the resident became unresponsive, the facility sent the resident to the hospital. The facility relieved the AP from her position and interviewed her before sending her home. During the interview, the AP stated she did not ask for the resident's name or date of birth nor check the room number when she brought the medications to the wrong room. The AP discovered the medications were not for the resident after she administered them to her. The AP then tried to give an inhaler to the resident, but the resident told the AP she did not have one. The AP realized she may have made a mistake and went to double check the computer.

The ambulance run report indicated emergency medical services (EMS) arrived on scene to find the resident lying in bed, unresponsive. Her vitals were within normal limits, and she responded minimally to painful stimuli. Family present reported they arrived about an hour and a half after the medication administration. The resident had complained of some dizziness and nausea, then became unresponsive shortly after. EMS transported the resident to the hospital.

The resident's hospital record indicated the resident presented to the emergency department (ED) after being given another resident's medication. The resident received ten (10) medications including three that lower blood pressure, one to prevent seizures, one to help with depression, one that helps prevent blood clots, one for diabetes, one to help lower cholesterol, one to decrease stomach acid, and one for low potassium. The resident's hospital diagnoses included acute kidney failure, low blood pressure due to drugs, and unintentional underdosing of medication. The record indicated prior to hospitalization, the resident completed daily activities with assistance. But during the hospitalization, the resident had a decreased activity tolerance and strength, as well as impaired balance resulting in decreased safety and independence with moving. In the hospital, the resident experienced one episode of

low blood pressure which improved with intravenous (IV) fluids. Imaging showed no acute concerns with the brain and heart. The resident experienced dizziness and blurry vision upon standing, requiring medication management, compression wraps, hydration, and the use of an abdominal binder. The resident's acute kidney injury resolved with IV fluids. After four days in the hospital, the resident had been medically stable and discharged to a different skilled nursing facility's rehabilitation unit.

After the resident's stay in a rehabilitation unit at a skilled nursing facility, the resident admitted to an assisted living facility (ALF). The ALF's admission assessment indicated the resident required escorts to meals and activities, limited help from staff with some activities of daily living and help with walking and transferring as needed. The assessment indicated the resident used a walker or wheelchair.

During an interview, the nurse stated she received a call from the AP asking her to come to the unit. The nurse went to the unit, and the AP informed her she accidentally gave the resident another resident's medication. The nurse told the AP to write everything down, and she called the director of nursing to report the error. The nurse checked on the resident to see how she had been feeling. The nurse explained what happened to the resident and notified the family and provider. At that time, the resident had not been showing any signs of side effects from the medications, and her vitals signs were taken. The nurse went back to the other unit and told the AP she would be back. Shortly after getting to the unit, the AP called her to report the resident became unresponsive. The nurse went to the resident's room and checked her vitals. Although the resident had not been responsive, her blood pressure and oxygen levels were okay, and she did not feel clammy. The nurse called the director of nursing again, who instructed her to call 911.

During an interview, the director of nursing stated she received a call from the nurse reporting the AP gave the resident the wrong medicine. As soon as she got to the facility, she began walking to the resident's room. Before she got to the room, she received another call the resident became unresponsive. When the director of nursing got to the room, she observed the resident lying on the bed, and family had already arrived. She instructed the nurse to check the resident's vital signs again and talked to family who reported the resident just got back from using the bathroom. She laid down, said she did not feel well, and became unresponsive. The director of nursing conducted an assessment, performed a sternal rub to which the resident responded, and determined she needed to go to the hospital. After the resident left for the hospital via ambulance, they completed an investigation by talking with the AP, other staff on the floor, and other residents. During their interview with the AP, they discussed the rights of medication administration and what happened. The AP verified she knew the rights of medication administration. She looked at the picture of the resident and the room number on the computer, but she walked into the wrong room. The AP failed to verify the resident before giving the medication. The AP went back into the room to give a breathing treatment, and the resident said she did not use that. At that point, the AP knew she did not have the right resident. The AP did not do any of the verification of the rights and did not bring the computer

in to make sure the information on the computer matched the resident. After the investigation, they completed competencies with all staff who had the opportunity to use the medication cart, including agency staff. They ultimately decided not to have the AP return to the facility.

Although the AP declined to conduct an interview, she stated the medication error had been a mistake.

During an interview, the resident stated she admitted to the facility due to falling and hurting her back. The resident stated the AP came in with a container of pills and told her to take them. The resident stated she told the AP she did not take that many pills because there were 10 in the container, but the AP said she had to take them. Then, the AP gave the resident a "breathing thing" and told her to take it. The resident told the AP she had never used it before. The AP left the room crying and told the resident she gave her the wrong medication. The resident did not remember becoming unresponsive or much after. She thought she spent about an hour and a half in the hospital.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

"Not Substantiated" means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment 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.
(5) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult that results in injury or harm, which reasonably requires the care of a physician, and:
(i) the necessary care is provided in a timely fashion as dictated by the condition of the vulnerable adult;
(ii) if after receiving care, the health status of the vulnerable adult can be reasonably expected, as determined by the attending physician, to be restored to the vulnerable adult's preexisting condition;
(iii) the error is not part of a pattern of errors by the individual;
(iv) if in a facility, the error is immediately reported as required under section 626.557, and recorded internally in the facility;
(v) if in a facility, the facility identifies and takes corrective action and implements measures designed to reduce the risk of further occurrence of this error and similar errors; and

(vi) if in a facility, the actions required under items (iv) and (v) are sufficiently documented for review and evaluation by the facility and any applicable licensing, certification, and ombudsman agency.

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: No. The family member did not complete the scheduled interview.
Alleged Perpetrator interviewed: No. The AP declined to conduct an interview

Action taken by facility:
The facility assessed the resident and sent her to the ED. The facility also removed the AP from the floor and reported the incident to the staffing agency. The facility conducted an internal investigation and re-educated staff who pass medication.

Action taken by the Minnesota Department of Health:
MDH previously investigated the issue during a complaint survey under federal regulations, and substantiated facility 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.

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

The purpose of this investigation was to determine any individual responsibility for alleged maltreatment under Minn. Stat. 626.557, the Maltreatment of Vulnerable Adults Act.

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **07/09/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARKS LIVING	**400 15TH AVENUE SOUTHWEST , AUSTIN, Minnesota, 55912**

(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) COMPLETION DATE
20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: The Minnesota Department of Health investigated an allegation of maltreatment, complaint #H53692501M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. No correction orders are issued. The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the	20000		

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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20000	Continued from page 1 electronic documents.	20000		