Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL201877543M
Compliance #: HL201872930C

Date Concluded: February 10, 2025

Name, Address, and County of Licensee Investigated:
Brainerd Carefree Living
2723 Oak Street
Brainerd, MN 56401
Crow Wing County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:
Katherine Barnhardt 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 warfarin (blood thinner) medications were not administered as ordered.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The AP failed to remove a temporary hold order for the resident's warfarin (blood thinner) and the resident was not administered four days of warfarin as ordered. When the error was found the AP notified the warfarin clinic, the resident's provider, and a new lab draw was completed. The provider ordered the same dose to restart and no harm to the resident resulted from the missed doses.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a home care and hospice agency. The investigation included review of the resident record(s), death record, hospital records,

pharmacy records, facility internal investigation, facility incident reports, personnel files, staff schedules, related facility policy and procedures. Also, the investigator observed facility staff perform medication tasks.

The resident resided in an assisted living facility. The resident's diagnoses included late-stage congestive heart failure (CHF), dementia, and numerous diagnoses that complicated the resident's overall health. The resident's service plan included assistance with medication administration and activities of daily living. The resident had a complex medication regimen, required frequent checks that tested the blood's clotting factors, and utilized several specialty providers.

The resident's record indicated the resident had weekly and as needed international normalized ratio (INR) blood checks (blood check to determine the amount of time for the resident's blood to clot). Facility licensed staff, a home care agency, and a family member completed the resident's INR tests. The resident's record indicated when INR tests were completed, the results were reported to a warfarin clinic, the clinic faxed new orders to the facility, the facility faxed new orders to the pharmacy and entered the new orders into the resident's electronic administration record. In late November, the resident had an abnormal INR result, and the provider requested the resident be seen at an emergency room. The resident was seen and returned to the facility by family the same day after licensed staff left for the day. New orders from the emergency room were not left with unlicensed staff and unlicensed staff notified facility triage staff. Facility triage called a family member, and the family member stated the resident's warfarin was ordered held for three days and to restart on the fourth day. The resident's record indicated medications were put on hold when the resident was sent to the emergency room, however, warfarin had not been restarted on the fourth day as ordered. When the medication error was found, the provider and warfarin clinic were notified, a new INR was completed, and the resident restarted the same dose of warfarin. The resident's record indicated a medication error had occurred; however, the error did not cause harm.

During interview, several licensed staff stated the resident's warfarin management was complicated and medication orders sometimes changed daily. Licensed staff stated an outside agency was utilized due to medication changes. Several licensed staff stated the AP had gone to the facility late one night to meet the pharmacy delivery and reset the electronic medication record with the latest warfarin order. Licensed staff stated the orders were entered and the warfarin was setup, however, the AP had forgotten to remove the hold on the warfarin and the warfarin was not administered until four days later when unlicensed staff found the warfarin medication had not been administered. Licensed staff stated the AP notified the warfarin clinic, the provider, and restarted the same warfarin dose as ordered by the provider. Licensed staff stated the facility and family were seeking placement for the resident at a facility that provided a higher level of care due to the medication challenges, however the resident was on hospice and passed away before a transfer was completed.

Review of the resident’s death record indicated the resident’s primary cause of death was end stage congestive heart failure.

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.

Vulnerable Adult interviewed: Deceased
Family/Responsible Party interviewed: Attempted
Alleged Perpetrator interviewed: Yes

Action taken by facility:
As soon as the medication error was found the AP notified the resident’s care team and the resident was evaluated by a rounding provider.

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20187	A. BUILDING: _____ B. WING _____	C 01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRAINERD CAREFREE LIVING LLC	2723 OAK STREET BRAINERD, MN 56401

(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 On January 15, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL201877662M/#HL201873123C and #HL201877543M/#HL201872930C. No correction orders are issued.	0 000		