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 #: HL203836304M
Compliance #: HL203839502C

Date Concluded: December 5, 2024

Name, Address, and County of Licensee Investigated:
St. Cloud Carefree Living
1225 E Division St
St Cloud, Mn 56304
Benton County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:
Katherine Barnhardt RN, Special Investigator

Finding: Substantiated, facility responsibility

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 facility neglected the resident when facility licensed staff gave Tegretol (analgesic and anti-seizure medication) to the resident who had a known severe allergy to the medication. The resident required hospitalization for an altered level of consciousness.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. Facility licensed staff processed and dispensed Tegretol to the resident who had a known history of a severe allergic reaction to the medication. The medication caused a severe adverse reaction that required the resident's hospitalization.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, unlicensed staff, a rounding provider, and pharmacy staff. The investigator contacted a medical rounding service and a pharmacy. The investigation included review of the resident record, hospital records, pharmacy records, facility internal investigation, facility

incident reports, personnel files, staff schedules, and related facility policy and procedures. The investigator observed unlicensed staff administer medications.

The resident resided in an assisted living facility. The resident's diagnoses included multiple sclerosis and dementia. The resident's service plan included assistance with medication management and administration. The resident communicated clearly with others, experienced anxiety, had impaired mobility function and cognitive changes due to dementia.

The residents record indicated the resident was allergic to Tegretol and had two severe allergic reactions to the medication while a resident at the facility. The resident's record included signed physician orders and a profile sheet indicating the resident was allergic to Tegretol. The resident's record indicated a rounding provider visited the resident the first week of October and ordered a new medication carbamazepine, a generic form of Tegretol. The resident's record indicated licensed staff entered the medication into the resident's electronic medication administration record (EMAR) and unlicensed staff administered four doses over three days. Mid- morning of the third day, unlicensed staff found the resident with severely altered communication and mobility capabilities and licensed staff arranged for the resident to be evaluated at a hospital.

Hospital records indicated the resident arrived at the emergency room with a deconjugate gaze (eyes do not move together in same direction), inability to move her lower legs, inability to follow commands, and was combative with increased confusion. Hospital records indicated physicians conducted numerous tests and reached out to the family of the resident for information. The physicians learned from family the resident's symptoms were similar to an adverse reaction the resident experienced when prescribed and administered Tegretol while hospitalized four years earlier. Hospital records indicated emergency room physicians confirmed with the facility the resident had received four doses of carbamazepine (generic form of Tegretol) during the days leading up to the recent hospitalization. The resident was hospitalized for twelve days and treated for a severe medication reaction. The resident did not return to baseline functioning during the twelve days hospitalized and discharged to a rehabilitation unit for therapy.

An after-visit note from a rounding provider listed the resident's allergy to the medication Tegretol. One month later, the rounding provider records indicated the resident was seen by the same rounding provider and given a prescription for carbamazepine 100 milligram (mg) twice daily by mouth, the generic form of Tegretol.

Pharmacy records indicated the pharmacy received the rounding provider prescription from licensed staff at the facility by fax. The pharmacy was not connected to the electronic medication system used by the rounding provider or the facility. Pharmacy records indicated the facility provided a resident profile to the pharmacy that listed allergies and the resident's medication history; however, the resident profile provided to the pharmacy did not include the resident's Tegretol allergy. The pharmacy delivered the medication to the facility. Pharmacy

records indicated the pharmacy was notified by facility licensed staff four days later the resident had a severe reaction to the Tegretol and was hospitalized. Pharmacy records indicated the pharmacy reached out to the rounding provider, updated the provider they were unaware of the allergy and requested order clarification.

The facility's internal investigation indicated the rounding provider ordered Tegretol for the resident and facility unlicensed staff administered it. A facility licensed staff approved the Tegretol order, and it was processed into the resident's electronic medication record through the rounding provider's medication portal. Facility licensed staff printed the order and faxed it to the resident's pharmacy. The pharmacy delivered the medication to the facility and the medication was placed into the medication cart by facility licensed staff to be administered by unlicensed staff. On the evening of delivery, the resident received the first dose, the next day the resident received two doses and on the third day the resident received a morning dose. The resident was found mid-morning on the third day by unlicensed staff with slurred speech and excessive incontinence. Staff arranged for the resident to be evaluated at a hospital.

During interview, unlicensed staff stated they would not know what medications the resident was allergic to unless they searched a separate tab in the resident's electronic medication record (EMAR). Unlicensed staff stated they would not know to look for the tab and were not trained to look for or review that tab in the EMAR. Unlicensed staff stated there was nothing that would alert them the resident was allergic to a medication they were assigned to administer.

During an interview, the rounding medical provider stated she had taken over for a previous provider mid-summer and rounded twice a month at the facility. The rounding provider stated she had spent two days with the previous rounding provider learning the residents. The rounding provider stated she did not have access to the facility's electronic medication record and the electronic record system used by the rounding provider did not update in real time. The rounding provider stated she did not directly review resident records and a rounding assistant that worked with the rounding provider reviewed medication records. The rounding provider stated she was unaware the resident had an adverse reaction to Tegretol and stated she had been told by facility licensed staff the resident had not received any doses of the Tegretol ordered. The rounding provider stated she received a note from the pharmacy questioning the Tegretol order six days after the order was written and the medication was discontinued.

During an interview, pharmacy staff stated facility licensed staff provided the resident medication profile sheets to the pharmacy which included allergies. Pharmacy staff stated they did not have access to the facility's electronic medication system and relied on facility licensed staff to provide critical resident information. Pharmacy staff stated the pharmacy had not been updated to the resident's allergy to Tegretol (name brand for carbamazepine). Pharmacy staff stated the resident's medication history on file with the pharmacy included a previous order for Tegretol four years earlier, but the history did not list Tegretol or carbamazepine as an allergy

for the resident. Pharmacy staff stated they received a new medication request for Tegretol for the resident from the facility by fax, the pharmacy filled the order, and they delivered the medication to the facility. Pharmacy staff stated four days after delivering the medication, facility licensed staff notified the pharmacy the resident required hospitalization for an allergic reaction to the Tegretol. Pharmacy staff stated they sent a note to the rounding provider notifying the rounding provider they were unaware of the resident's allergy to Tegretol.

During interview, facility licensed staff stated the resident was seen by a rounding provider for pain and prescribed carbamazepine (generic form of Tegretol). Facility licensed staff stated an order for the new medication was available through the rounding provider's electronic communication system after the provider's visit and facility licensed staff accepted the order so it could be printed off and faxed to pharmacy. Facility licensed staff stated there was a high turnover of licensed staff, and licensed staff that processed the order did not realize the medication's generic name as the same medication Tegretol that was listed on the resident's profile as an allergic medication. Facility licensed staff stated due to staff shortages and licensed staff turnover, details and daily tasks were difficult for one licensed staff to manage.

During interview, a family member stated the resident was hospitalized with a severe allergic reaction when a rounding provider ordered, facility licensed staff approved and unlicensed staff administered Tegretol to the resident. The family member stated Tegretol was listed on the facility's and rounding provider's medication list as an allergy for the resident. The family member stated the resident was hospitalized and sent to a rehabilitation unit after the hospital discharge due to significant changes in the resident.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

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.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility conducted an internal investigation.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

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
Benton County Attorney
St. Cloud City Attorney
St. Cloud Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20383	A. BUILDING: ______ B. WING ______	C 11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CLOUD CAREFREE LIVING LLC	**1225 DIVISION STREET EAST SAINT CLOUD, MN 56304**

(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 *****ATTENTION****** ASSISTED LIVING LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.01 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL203836304M/#HL203839502C On November 21, 2024, 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 49 residents receiving services under the assisted living license. The following correction orders are issued for #HL203836304M/#HL203839502C, tag identification 1850 and 2360.	0 000	Minnesota Department of Health is documenting the State 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. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
01850 SS=G	144G.71 Subd. 16 Written or electronic prescription	01850		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20383	A. BUILDING: ____ B. WING ____	C 11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CLOUD CAREFREE LIVING LLC	**1225 DIVISION STREET EAST SAINT CLOUD, MN 56304**

(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
01850	Continued From page 1	01850		

When a written or electronic prescription is received, it must be communicated to the registered nurse in charge and recorded or placed in the resident's record.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure the registered nurse (RN) over saw changes in medication orders for one of one resident (R1) receiving medication management services. The facility ordered and dispensed Tegretol (carbamazepine) to R1 who had a known allergy and previous negative reaction to the medication. R1 had a severe allergic reaction to the Tegretol and required hospitalization.

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:

Review of R1's medical record indicated R1 was admitted to the licensee for services on August 1, 2016. R1's diagnoses included multiple sclerosis and dementia.

R1's facesheet with a printed date of July 28, 2023, indicated R1's drug allergies included Tegretol that caused a severe allergic reaction of an altered mental state.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20383	A. BUILDING: ____ B. WING ____	C 11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CLOUD CAREFREE LIVING LLC	1225 DIVISION STREET EAST SAINT CLOUD, MN 56304

(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
01850	Continued From page 2 R1's Individualized Service Plan dated October 1, 2023, indicated R1 received the following services: medication management, appointment assistance, behavior management, dressing, grooming, monthly vitals, safety checks, laundry and housekeeping weekly. R1's Annual Physician Orders dated January 25, 2024, indicated R1 was allergic to Tegretol (carbamazepine.) R1's new prescriber orders dated October 4, 2024, included Tegretol 100 milligrams (mg) by mouth (PO) twice daily (BID). R1's record indicated the last RN assessment was completed and electronically signed on October 9, 2024, and indicated R1 was not experiencing allergic or adverse reactions to medications, however, R1 was hospitalized on October 6, 2024, for a severe allergic reaction to carbamazapine (generic form of Tegretol) started on October 4, 2024. R1 was hospitalized for twelve days then transferred to a rehabilitation unit for therapies related to the adverse medication reaction. R1's October 2024 Medication Administration Record (MAR) indicated R1 was allergic to Tegretol, however, unlicensed personnel (ULP's) administered Tegretol 100 mg to R1 on October 4, 2024, at 7:00 p.m., October 5, 2024, at 7:00 a.m. and 7:00 p.m., and October 6, 2024, at 7:00 a.m. R1's progress notes dated October 6, 2024, at 9:15 a.m. indicated staff found R1 with slurred speech and excessive incontinence. R1 was sent to the emergency room, hospitalized for twelve days then transferred to a rehabilitation unit to	01850		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20383	A. BUILDING: ______ B. WING ______	C 11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CLOUD CAREFREE LIVING LLC	**1225 DIVISION STREET EAST SAINT CLOUD, MN 56304**

(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
01850	Continued From page 3 recover with the assistance of therapies. R1 had not returned to baseline and had not returned to the facility. On November 21, 2024, at 1:00 p.m., licensed practical nurse (LPN)-C stated she reviewed and approved medications entered into R1's record through a provider portal approval button. LPN-C stated the pharmacy did not have the allergy listed in R1's pharmacy record and the pharmacy sent the medication to the licensee. LPN-C stated ULP's administered the medication under the generic name carbamazapine and would not have known carbamazapine was the generic form of Tegretol. LPN-C stated the allergy was listed as Tegretol (name brand) in R1's resident record. LPN-C stated she did not have RN support or oversight due to the facility's RN turnover. On November 25, 2024, unlicensed personnel (ULP)-G stated ULP's would not know about allergies related to medications unless they checked under a separate tab within the electronic system. ULP-G stated the ULP's would not know to look for that information and were not taught to look for medication allergies during medication administration training. The licensee's Implementation of Medication Prescriptions, and Treatments and Therapy Orders policy, dated August 3, 2022, indicated the RN and/or Licensed Health Professional is responsible for assuring that the prescriptions and orders have been implemented appropriately through resident monitoring, supervision of staff and review of resident records. Within 24 hours the RN or Licensed Health Professional must take action to implement the order and reconcile the contraindications or the order against the MAR and services and, if applicable, contact the	01850		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20383	A. BUILDING: ______ B. WING ______	C 11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CLOUD CAREFREE LIVING LLC	**1225 DIVISION STREET EAST SAINT CLOUD, MN 56304**

(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
01850	Continued From page 4 prescriber to clarify any uncertainties about the order. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01850		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: Based on observations, interviews, and document review, the facility failed to ensure one of two residents reviewed (R1) was free from maltreatment. Findings include: On November 21, 2024, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	02360		