Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL205491181M
Compliance #: HL205491481C

Date Concluded: May 27, 2025

Name, Address, and County of Licensee Investigated:
Callista Court
1455 W Broadway
Winona, MN 55987
Winona County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name: Julie Serbus, 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 facility neglected the resident when they failed to implement and administer a new medication prescribed by the medical provider.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was not substantiated. The resident received a new order for an inhaler, however facility made an error in transcribing the new order and it did not get added to the resident's medication administration record. The error was an isolated incident, did not result in harm and, later when it was identified, was corrected.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a family member. The investigation included review of the resident record(s), provider visit notes, pharmacy communication, internal investigation, staff schedules, and related facility policies and procedures. Also, the investigator observed how medications are stored at the facility.

The resident resided in an assisted living memory care unit. The resident's diagnoses included centrilobular emphysema (progressive lung disease) and Alzheimer's disease. The resident's service plan included assistance with medication management and administration.

The progress note by nurse #1 indicated the resident was seen by the medical provider at the facility. The provider wrote two new oral medication orders, an order for some lab work, resident received an injection, and provider had asked facility if they had noticed the resident having a frequent cough or any signs of shortness of breath. This same progress note indicated nurse #1 updated the medication administration record for the two new medications and faxed the pharmacy. Nurse #1 indicated she replied to the medical provider via fax staff had not reported or witnessed the resident show signs of shortness of breath.

Five days later, the progress notes by nurse #2 indicated a day after the provider visit a fax was received from the provider ordering an inhaler. The note the inhaler required a prior authorization from the insurance company or to consider a possible alternative prescription. Nurse #2 indicated she called the provider and left a message related to the order not having a diagnosis, which was required. The nurse #2 requested the provider return her phone call.

A day later progress notes by nurse #2 indicated the pharmacy had delivered the ordered inhaler [this was seven days from the initial visit by the provider]. Nurse #2 indicated she placed the information on the report sheet to update staff and instructed the unlicensed medication passer for that shift to start the prescription that evening.

The next day a progress note by nurse #2 a day after the inhaler arrived indicated nurse #2 completed an updated assessment, service plan, and individual assessment policy. Nurse #2 indicated she added the new diagnosis for the inhaler and the order for the inhaler.

The resident's assessment indicated facility staff were to manage and administer medications according to provider orders. This same assessment indicated the medical provider adding a new diagnosis of centrilobular emphysematous which was the reason the new inhaler with spacer was prescribed.

Two months later the progress notes indicated the facility nurses had been in contact with the primary provider related to resident recently not feeling well, experiencing congestion, and cough. At this time, the facility became aware the inhaler was not being administered because it was not in the electronic medication administration record (EMAR).

At that time order was placed onto the electronic medication administration record and administration of the inhaler was initiated. The resident was taken to urgent care for evaluation with orders to continue the previously ordered inhaler twice a day, given a nebulizer treatment, and returned to facility. While at the urgent care, the resident was diagnosed with a viral respiratory illness. Due to weakness from the viral infection, the resident spent a short time receiving therapy at a long-term care transition unit and returned to facility.

Documented communication between the medical provider, pharmacy, and facility indicated that there had been a new inhaler order although there were issues that required clarification. While it was not clear exactly how the error occurred as multiple nurses were involved the medication did not get listed in the EMAR and the original order was misplaced. The facility conducted an internal investigation and reviewed its policies.

During an interview, nurse #1 stated the provider was at the facility to see the resident for a follow up visit. Nurse #1 stated the provider writes up orders from the visit that go to the west nurse's office to be reviewed. Nurse #1 stated she could remember the order coming back with a specific inhaler which needed a prior authorization. Nurse #1 stated she put the order back in the hold box in the west nurse's office and was the last interaction she had with that order. The follow-up box in the nursing office was for orders which required action before it could be completed, and nursing was to check the follow-up box each shift.

During an interview, nurse #2 stated when a resident is seen by a provider at the assisted living facility, the provider leaves a visit note which is processed by a nurse. Nurse #2 stated the new order was not complete since a diagnosis was needed along with a prior authorization for insurance coverage. Nurse #2 stated she called the provider's nurse and left a message for a return call. Nurse #2 stated the person who received the order typically transcribes the order. Nurse #2 stated she did not know where the original came from and never saw the order to place onto the medication record. Nurse #2 stated the process had been adjusted so that all the orders went to the same office.

During an interview, nurse #3 stated she had not seen the order, nor can they locate the original order. The incident was brought to her attention later when the resident was experiencing some cold/respiratory symptoms, and the medication error was identified. Nurse #3 stated the facility streamlined the process as a result of this occurrence to reduce the risk of recurrence.

In conclusion, the 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.

(d) For purposes of this section, a vulnerable adult is not neglected for the sole reason that:
(4) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult which does not result in injury or harm which reasonably requires medical or mental health care; or

(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: No
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: NA

Action taken by facility: The facility conducted an internal investigation and changed its process for medication orders.

Action taken by the Minnesota Department of Health: No further actions taken at this time.

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
	20549	A. BUILDING: _____ B. WING _____	C 05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALLISTA COURT	1455 WEST BROADWAY STREET WINONA, MN 55987

(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 May 13, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL205491481C/#HL205491181M. No correction orders are issued.	0 000		