Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL302461800M
Compliance #: HL302466860C

Date Concluded: May 5, 2026

Name, Address, and County of Licensee Investigated:
Regina Assisted Living
1008 1st Avenue
Hastings, MN 55033
Dakota County

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

Evaluator's Name: Willette Shafer, 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 the facility failed to administer the resident's blood pressure and anxiety medications for several days causing the resident increased anxiety and high blood pressure.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility recognized the medications were not delivered by pharmacy and made numerous attempts to obtain the medications. The facility worked with the pharmacy and contacted the resident's primary care provider for medication renewals. The pharmacy also contacted the resident's primary care provider and requested prescription renewals as four medications, including medications for depression, anxiety and blood pressure, as the expiration date approached. The primary care provider denied the renewal requests indicating "change not appropriate" although the medications requested were the same as previously ordered. Also, at the time of the incident the resident had Covid-19 which may have caused the resident's increased blood

pressure and anxiety. After a week, and multiple renewal request from pharmacy and the facility, the PCP renewed the resident's medications. The resident recovered from Covid-19 and her mental and physical health returned to normal.

The investigator conducted interviews with facility staff members, including administrative staff and nursing staff. The investigator interviewed pharmacy staff, the resident's primary care provider who practiced at an independent clinic, and the resident's family member. The investigation included review of the resident's medical records, hospital records, pharmacy records, email records, staff schedules, and related facility policy and procedures Also, the investigator toured the facility and observed staff administer medications.

The resident resided in an assisted living memory care unit. The resident's diagnoses included cognitive impairment, major depressive disorder, anxiety, high blood pressure, Covid-19, and nausea with vomiting. The resident's service plan included assistance with medication administration, bathing, grooming, and housekeeping.

The resident's progress notes indicated the resident was coughing and not feeling well. She tested positive for Covid-19 and the family requested Paxlovid (medication used to treat Covid-19) from the resident's primary care provider. The primary care provider denied the family's request for Paxlovid pending a kidney function test. The family and facility requested Paxlovid without a kidney function test as waiting for the test would delay treatment. The primary care provider agreed to order the medication three days after the family's initial request.

A progress note written a few days later indicated the resident vomited and her blood pressure was elevated with a reading of 148/79. Her legs felt weak, and she continued to have a dry cough. Nurse-1 attempted to update the primary care provider via phone, but the wait time was over 45 minutes. Nurse-1 faxed the primary care provider an update on the resident's condition. The primary care provider responded the resident's change in condition was due to Covid-19 and they could bring the resident to the clinic for an evaluation if needed. A family member brought the resident to the hospital for an evaluation. The hospital ordered an anti-nausea medication. Nurse-1 updated the primary care provider and pharmacy and requested the primary care provider sign orders for medications.

The resident's medication orders signed by her primary care provider indicated her prescriptions would expire in the middle of the month. Pharmacy delivered cycle fill medications (medications for the month) approximately two weeks before the medications expiration date.

The resident's medication administration record (MAR) indicated four medications, Protonix (for acid reflux), Celexa (antidepressant and antianxiety), Vistaril (antianxiety), and metoprolol (blood pressure), were marked "unavailable" for multiple days. The first day the resident's

medications were not administered was the day after the pharmacy cycle fill delivery (because they were not included due to expiration mid-month).

An email written by nurse-1 and sent to pharmacy on same day as the pharmacy delivery, indicated four of the resident's medications, Protonix, Celexa, Vistaril, and metoprolol were not received during the pharmacy's cycle fill delivery. The pharmacy indicated they would get the medications reordered and delivered on the evening delivery or the following day. A couple days later, nurse-1 sent a second email to the pharmacy indicating the resident was still missing her four medications. The pharmacy responded the resident's primary care provider denied the prescription renewal requests twice. Nurse-1 requested pharmacy to send a third renewal request explaining the resident was out of medications and requested the primary care provider send new prescriptions or discontinue the medications if desired. The pharmacy's email indicated they resent the request a third time.

A progress noted written by nurse-1 indicated she faxed the primary care provider explaining the resident was out of medications and needed prescriptions renewed. Nurse-1 updated the pharmacy and requested they reach out to the primary care provider again. A couple days later nurse-1 spoke to primary care provider-2 who worked with the resident's primary care provider. Nurse-1 told primary care provider-2 the pharmacy never filled the resident's medications because the prescriptions expired, and the primary care provider denied the refill requests. Primary care provider-2's nurse reported the prescriptions were denied because there was an active order at a different pharmacy. Primary care provider-2 reported he would call-in a short-term supply for Protonix, Celexa, Vistaril, and metoprolol. During the time the resident's scheduled antianxiety medication was unavailable, the facility administered her antianxiety PRN (medication given as needed).

A pharmacy renewal request faxed to the primary care provider the second day being without supply, indicated the resident's Protonix, Celexa, Vistaril, and metoprolol needed renewal.

A pharmacy renewal request response from the primary care provider two days later, indicated the medication renewal requests were denied due to "change not appropriate."

A fax sent by nurse-1 to the primary care provider the next day, indicated the resident needed Protonix, Celexa, Vistaril, and metoprolol prescriptions renewed. The fax indicated the resident was without these medications for several days already and pharmacy had requested refills twice and they were denied both times by the primary care provider.

The resident's MAR indicated the resident went nine days with Celexa and Vistaril. She went with out Protonix and metoprolol for eight days before supply was received.

The resident's vital record and progress notes indicated the facility monitored the resident's vital signs during the time she was without medication. A few days the resident's blood pressure and pulse were elevated, but not critical.

During an interview, nurse-1 said pharmacy did not deliver four of the resident's medications; Protonix, Celexa, Vistaril, and metoprolol for the month. She emailed the pharmacy and reported the missing medications. Pharmacy responded saying they would deliver the missing medications on the evening delivery or the following day. The medication passers and nurses check the medication carts. When medications were missing, the nurses contacted pharmacy. Pharmacy left a "cycle fill" report with each cycle fill (months' worth of medication) delivery. The report identified medications not filled by pharmacy and the reason. Pharmacy requested the primary care provider renew the resident's prescriptions because they were expiring. Pharmacy requested prescription renewals from the primary care provider several times, but the primary care provider denied the refill requests. Nurse-1 also reached out to the primary care provider requesting new prescriptions and explained the resident was out of her medications. She said in the past, the primary care provider denied ordering certain medications requested by the family and took excessive time ordering other medications. The resident was also diagnosed with Covid-19 which could have caused the resident's blood pressure changes and increased anxiety. The facility administered anti-anxiety medications as needed during the time her scheduled medications were unavailable. Those medications were documented as effective. The primary care provider reordered the residents Protonix, Celexa, Vistaril, and metoprolol and the resident recovered from Covid-19. The resident's health returned to baseline.

During an interview, pharmacy said they monitored prescription expiration dates and ensured the providers were notified when a prescription needed renewal. She said several messages were sent to the primary care provider. The primary care provider denied three separate renewal requests. The denial request indicated "change not appropriate" although the prescription requests were for the same medications previously ordered. Pharmacy and nurse-1 worked together to get the provider to renew the orders. Pharmacy said she was unsure why the provider continued to deny the request. The pharmacy's medication renewal history indicated the primary care provider had failed to renew prescriptions timely in the past. She followed the pharmacy's standard process for renewing prescriptions.

During an interview, the primary care provider said a team of nurses at the clinic received all medication renewal requests. The clinic nurses denied the medication renewals because the resident had active prescriptions at different pharmacy. She said the resident recently had hospice discontinued because the resident's health improved and the medications were ordered at the pharmacy hospice used. She acknowledged the facility updated the clinic when hospice was discontinued and there was documented information the resident was no longer on hospice services. The primary care provider said the pharmacy sent multiple prescription renewal requests. She said requests sent by pharmacy and the facility's nurse were documented. She said the resident was also due for a visit and needed to be seen in the clinic for prescription renewals.

During an interview, nurse-1 said she contacted the different pharmacy where the primary care provider's nurse said the medications were at. That pharmacy said no medications were ordered for the resident.

During an interview, a family member said the resident was recently diagnosed with Covid-19 and on comfort care. A nurse called and reported the resident vomited and her blood pressure and pulse were elevated. The family member took the resident to the hospital for evaluation. The hospital ordered a medication for nausea and sent her back to the facility. The vomiting may have been due to a medication recently ordered for Covid-19. She learned the resident was out of several medications after she expressed concern about the resident's increased anxiety. The family member said she was not notified about the missing medications until several days after the resident ran out.

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: No, due to cognitive deficit.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility reviewed the incident and adjusted their medication renewal process. The facility attempted to obtain the medications.

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

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

Minnesota Board of Medical Practice

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30246	A. BUILDING: _____ B. WING _____	C 04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA ASSISTED LIVING	1008 1ST STREET WEST HASTINGS, MN 55033

(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 April 10, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL302461080C/#HL302468422M and #HL302466860C/#HL302461800M. No correction orders are issued.	0 000		