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 #: HL304615924M
Compliance #: HL304618585C

Date Concluded: November 7, 2024

Name, Address, and County of Licensee Investigated:
Mother of Mercy Assisted Living
230 Church Ave.
Albany, MN 56307
Stearns County

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

Evaluator's Name:
Jana Wegener, 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 they failed to ensure Tramadol (a controlled drug pain medication) was available to administer as ordered. The resident was brought to the emergency department (ED) with increased pain after several doses of Tramadol were missed.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to ensure the resident's scheduled Tramadol was available. After the resident did not receive approximately four doses of Tramadol, the resident experienced severe pain and withdrawal symptoms and was transported to the hospital for pain control.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member and case manager. The investigation included review of the resident record(s), hospital records,

pharmacy records, clinic records, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed resident's and staff at the facility.

The resident resided in an assisted living facility with diagnoses including anxiety, chronic back pain, fibromyalgia, and back pain.

The resident's assessment and plan of care indicated the resident utilized Tramadol along with Tylenol for chronic pain in her back and hips. The assessment and plan of care indicated the resident received medication management and administration services at the facility and indicated medications would be given according to the providers orders. The assessment and plan of care indicated the licensed nurse was responsible for monitoring medication supplies and reordering as needed.

The resident record indicated the facility utilized the electronic medical record system to reorder medications and fax refill requests to the pharmacy. The record indicated the facility faxed a request to refill the resident's Tramadol to the pharmacy on September 6, (5 days prior to the resident running out of the medication). Another request was sent on September 9, (3 days later), and again (2 days later, the day the resident ran out of Tramadol) that fax included a note to the pharmacy notifying them the resident would completely run out of all Tramadol at 5:00 p.m. that day. The record indicated the request was forwarded to the provider from the pharmacy at 11:22 a.m. The record indicated the resident's Tramadol refill was not authorized by the provider for a refill the following day at 1:20 p.m. (after the resident had missed 4 doses of the medication and was brought to the ED with increased pain). Although the facility faxed refill requests there was no indication the pharmacy received or responded to the request nor did the facility follow up with the pharmacy to ensure the resident had the medication available.

A provider rounding form and after visit summary (AVS) dated September 10, (the day before the resident's medication ran out) indicated the resident was seen by her provider at the facility on rounds. There was no indication the facility communicated the resident needed a refill of Tramadol. No medication orders were placed.

The resident's medication administration record (MAR) indicated she was prescribed scheduled Tramadol (4 times daily) 100 milligrams (mg) at 8:00 a.m., and 50 mg at 12:00 p.m., 5:00 p.m., and 10:00 p.m. The MAR indicated the resident missed 4 scheduled doses of Tramadol over 2 days. On September 11, at 10:00 p.m. unlicensed personnel (ULP) was unable to give the Tramadol as ordered, and documented "waiting for the medication from pharmacy." On September 12, at 8:00 a.m. and 12:00 p.m. another ULP documented the resident's Tramadol was unable to be given because it was "out of stock" and indicated the nurse was notified. At 5:00 p.m. another ULP documented the Tramadol unable to be given, and indicated the resident was given a dose of as needed (PRN) Tylenol at 5:07 p.m. The ULP documented the Tylenol was not effective at 6:49 p.m.

A provider rounding form and AVS dated September 12, indicated the facility failed to communicate to the resident's provider that the resident needed a Tramadol refill and had not received scheduled doses of her Tramadol as ordered due to being out of the medication.

The resident's progress notes indicated on September 6, at 2:51 p.m. a Tramadol refill request was sent to the pharmacy. 3 days later a progress note indicated the facility had not received the resident's Tramadol and another fax was sent to the pharmacy. 2 days later a progress note (the day the resident ran out of Tramadol) indicated the facility still had not received the resident's Tramadol, another fax was sent to the pharmacy, and a nurse called the pharmacy and left a voicemail asking when they could expect the Tramadol. The note indicated the nurse later received communication from the pharmacy that the resident was out of refills and the provider was contacted. There was no indication the facility communicated with the pharmacy prior to the resident running out of Tramadol when the medication refill requested was not received. On September 12, at 6:39 p.m. a progress note indicated the on-call nurse received a call from the resident's family member about the resident's Tramadol. The family was informed they were waiting for the provider to authorize a refill of the medication and the nurse would notify the family when the medication arrived. At 8:35 p.m. the on-call nurse received a call the family member was taking the resident to the ED because the resident stated she was going to die without the Tramadol. The progress notes lacked any documentation of the resident being monitored for increased pain, adverse effects, or possible withdrawal symptoms when the resident's Tramadol was not available to be administered. The progress notes failed to indicate the resident's provider was notified of the medication error – omission or need for a refill of Tramadol.

The resident's ED/hospital medical record indicated on September 12, the resident reported her chronic low back pain was worsened because she was not getting her tramadol at the facility. The record indicated a dose of Tramadol was given in the ED with the resident reporting feeling significant improvement of her symptoms and denied pain after receiving a dose of Tramadol in the ED. The record indicated the resident had chronic pain syndrome, was chronically on tramadol, and the ED provider had concern for withdrawals on admission with worsening pain from the resident not receiving Tramadol as ordered at the facility.

An incident report of the resident's Tramadol medication error resulting in omission of 4 doses of the resident's Tramadol over 2 days and facility investigation of the incident was requested, none was provided.

During email communication and interviews facility nursing leadership verified the facility had not communicated the resident needed a Tramadol refill to the resident's provider prior to the resident running out of the medication, or when the providers were at the facility to see the resident on rounds. Nursing leadership verified the provider was not notified of the medication error omission after the resident ran out of Tramadol. Nursing leadership indicated staff reported the resident had increased pain, but the record lacked documentation this occurred

and what action was taken for the resident. Nursing leadership indicated the resident was assessed and monitored by nursing staff with no signs of adverse effects or withdrawal symptoms after the omission of scheduled Tramadol occurred. However, the resident record had no documentation assessment or monitoring occurred.

When interviewed one ULP staff stated the resident reported she didn't feel good, could not eat, was assisted to go to bed early, expressed having severe back pain, felt very cold, and stated she "felt like she was going to die" because she had not received Tramadol. The ULP stated the resident's family member felt the resident could not wait any longer for the Tramadol and brought the resident to the ED.

When interviewed the resident's family member stated the resident called and stated she had not been receiving her Tramadol and was in so much pain. The family member stated when she arrived at the facility the resident had a look of distress on her face, was crying, weak, shaky, trembling, and appeared to be in extreme pain. The family member indicated she called the pharmacy who stated the facility had not requested a Tramadol refill until the day the resident ran out of the medication, and indicated the medication may not be delivered to the facility until 10:00 p.m. The family member indicated the resident was in so much pain she could not wait any longer, and the resident was brought to the ED.

When interviewed the resident stated she was suffering in pain when she ran out of Tramadol. The resident stated she was shaky and her back hurt her so bad she just curled over in pain. The resident stated one staff provided Tylenol for pain which did not help. The resident stated when she expressed concern about not having her Tramadol to the facility, they offered to have the resident move from her apartment into the nursing home. The resident appeared visibly upset about being asked to move and stated she was not going to move because the facility did not order her medication.

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: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility implemented a change in the controlled medication reordering system to include faxing the provider for a refill request.

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
Stens County Attorney
Albany City Attorney
Albany Police Department

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30461	A. BUILDING: ___ B. WING ___	C 10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	**230 CHURCH AVENUE ALBANY, MN 56307**

(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 PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL304615924M/ #HL304618585C On October 17, 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 58 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL304615924M/ #HL304618585C, tag identification 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.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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02360	Continued From page 1 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 interview and document review, the facility failed to ensure one of one of one residents reviewed, (R1) was free from maltreatment. R1 was neglected. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details. No plan of correction is required for this tag.	02360		