DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Project: HL304618802M
Compliance Project: HL304616541C

Date Concluded: March 21, 2025

Name, Address, and County of Licensee Investigated:
Mother of Mercy Senior Living
230 Church Avenue
Albany, MN 56307
Stearns County

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

Evaluator's Name: Deb Schillinger, RN BSN
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 morphine, an opioid pain medication, was administered causing the resident to fall. The resident was not assessed by an in-person nurse until the next day. The resident had a fractured hip.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident had not received morphine prior to the fall. However, after the resident's fall, the facility provided the prescribed morphine due to the resident's complaints of discomfort, notified and coordinated care with the hospice provider, who assessed the resident the day of the fall and notified the medical provider. Despite the efforts to treat the resident's pain did not resolve so the resident was transferred to the hospital where she was diagnosed with a hip fracture the following day.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement, and the family member. The investigation included review of the resident record, hospice records, facility internal investigation, facility incident reports, staff schedules, law enforcement report, and related facility policy and procedures. Also, the investigator observed resident to facility staff interactions during an onsite visit.

The resident resided in an assisted living memory care unit. The resident's diagnoses included history of a stroke, transient ischemic attacks (a temporary blockage of blood flow to the brain), syncope and collapse, and dementia. The resident's service plan included assistance with toileting. The resident's assessment indicated the resident was alert to person only, was resistant to cares, especially toileting and bathing, and ambulated with the assistance of a walker and one facility staff member. The resident was also receiving hospice care.

A concern arose the resident was overmedicated with morphine, was not assessed after a subsequent fall, and sustained a hip fracture that was not diagnosed until the following day.

A facility incident report indicated the resident had an unwitnessed fall in her room. The same document indicated vital signs were taken by a facility staff member and the facility nurse and hospice provider were notified. The resident complained of back pain after the fall.

The resident's progress notes indicated the unlicensed caregiver had checked on the resident ten minutes before the fall and the resident was sleeping in her chair. After the resident had fallen the unlicensed caregiver notified the facility nurse on-call and hospice after the fall.

Hospice documentation confirmed notification of the resident's fall and that a hospice nurse would be visiting and gave an estimated time of the nurse's arrival to be 45 minutes. The hospice nurse visit note indicated an assessment was completed where the resident initially denied pain, but did report pain with lifting her left leg and turning her torso to the left. The hospice nurse recommended the facility unlicensed caregivers give morphine every four hours through the night as needed to keep the resident comfortable. The same documentation indicated the resident's family was updated and the medical provider was contacted with no additional orders obtained.

The resident's medication administration record (EMAR) did not indicate the resident received morphine before the fall but was administered after the fall for the resident's complaints of pain.

The following day the progress notes indicated the facility reached out to the hospice provider as the resident continued to have pain despite receiving morphine for pain. The facility continued to update hospice and hospice communicated with the resident's family. Later that same day, the resident was sent to the hospital for further evaluation and a hip fracture was identified.

During an interview, the on-call nurse stated the unlicensed caregivers contacted her at the time of the fall. At the time, the family was contacted as was the hospice provider.

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

Action taken by facility:
No action required

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 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 03/11/2025

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 On March 11, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL304616541C/#HL304618802M. No correction orders are issued.	0 000		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE