Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL329389243M
Compliance #: HL329387882C

Date Concluded: April 18, 2025

Name, Address, and County of Licensee Investigated:
A Janesville Senior Living/Oakwood Senior Living
543 OAKWOOD DRIVE
JANESVILLE, MN 56048
Waseca 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 prescribed monthly injection was not administered within the required time.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was not substantiated. While it was true the medication injection was not administered on the correct day and the resident experienced anxiety and a change in mental health, the resident did receive the medication later but a week late. The medical records indicated this was an isolated error and the resident did not require immediate medical attention nor hospitalization.

However, during the course of the investigation, it was found the resident's electronic medical administration record (EMAR) indicated the injection was given on the correct day additional documentation in progress notes indicated it was administered seven days after the scheduled

date. The facility failed to follow-up on the medication error and a compliance correction order was issued.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a medical provider and guardian. The investigation included review of the resident record(s), EMARs, pharmacy records, provider notes, and facility policy and procedures. Also, the investigator observed staff interaction with the resident.

The resident resided in an assisted living facility. The resident's diagnoses included schizoaffective disorder and other mental health conditions. The resident's service plan included nursing to administer a monthly injection and medication administration. The resident's assessment indicated the resident was unable to administer his own medications and prescribed medications were stored in a locked medication cart. Prescribed medications and directions for administration were listed on the EMAR.

A concern arose one month when the resident did not receive his scheduled medication injection as ordered causing a change in mental health which could have been avoided if medication injection would have been administered as ordered.

The resident's EMARs indicated the resident had orders to receive an injection every 28 days. The order was listed in the EMAR with the trained medication aid to inform the nurse on the day the injection was to be administered. The EMAR was reviewed with the resident receiving his injections on the 28th day except for the month in question when a recently hired nurse initialed electronically, she had administered the injection on the 28th day [every four weeks].

The medical record indicated the resident was aware of his medication order schedule and documented the times on a personal calendar when each injection was due and whether he received it or not. On this occasion, the resident did not receive his injection as scheduled and was not until the 35th day when he received the injection.

Email communication with the facility indicated even though the nurse had initialed off on the 28th day she had administered the medication, it was not actually administered until day 35 according to a progress note.

During an interview, an unlicensed caregiver stated unlicensed staff are not permitted to give the injection and that the nurse must administer it. The caregiver stated the order was listed on the EMAR and when the order comes up every 28 days unlicensed staff inform the nurse the injection is due on that date. Caregiver stated a licensed nurse would give the injection and then sign off on the EMAR once administered.

During an interview, the resident stated the provider ordered the injections for every 28 days and does have a personal calendar to keep track of the date due. The resident stated on the

month in question he asked the nurse for his injection on day 28. The resident stated the nurse stated it was to early and the injection was not due yet and so the injection was not administered until the next week and had the nurse initial his calendar. The resident stated he been on the medication for several years and can tell one or two days before the injection he needs it. The resident stated receiving the injection seven days late caused him a set back to his mental health which was very troubling and took him several days to get back to baseline. He stated he described his symptoms to his therapist.

During an interview, a nurse [a different nurse involved in the incident] stated she was aware the resident kept a personal calendar with dates of injection and a licensed nurse had to give the injection. The nurse stated changes to the EMAR can only be done by nursing and it was unclear the previous nurse, who had not been here long, did not administer the medication on day 28. The nurse stated she was unable to find a completed medication error form to explain what had taken place, however she did find information in electronic notes the injection was given on the day 35.

During an interview, a therapist stated the resident had a scheduled appointment a day before he received the late injection with resident not thinking a clear and having some hallucinations. The therapist advised resident to use coping skills and as needed oral medication. The resident was able to return to baseline within days after the injection was given.

The attempts to interview the specific nurse involved in the medication error were unsuccessful. The nurse was no longer employed at the facility.

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.
(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

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: NA

Action taken by facility: The medication was given albeit a week late. The error remained isolated.

Action taken by the Minnesota Department of Health: Correction order issued to the facility related to documentation of administration of medication.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32938	A. BUILDING: _____ B. WING _____	C 03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A JANESVILLE SENIOR LIVING LLC	543 OAKWOOD DRIVE JANESVILLE, MN 56048

(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****** HOME CARE PROVIDER/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: #HL329387882C/#HL329389243M On March 25, 2025, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were 22 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL329387882C/#HL329389243M, tag identification 1760.	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.	
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication	01760		

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01760	Continued From page 1 Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a medication injection was administered as prescribed for one of one resident (R1) with records reviewed. Additionally, the facility failed to fill out a medication error form and conduct an internal investigation. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R1's diagnoses included schizoaffective disorder and other mental health conditions. R1's service agreement, dated February 13, 2024, indicated R1 received medication	01760		

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01760	Continued From page 2 administration and nursing services to administer a monthly injection. R1's February 2025 electronic medication administration record (EMAR) indicated an order for Invega Sustenna (psychotropic medication used for schizoaffective disorder) 156 milligrams (mg) extended release (ER) injection. Inject 1 milliliter (156 mg) intramuscularly every 28 days with staff to inform registered nurse that injection needs to be delivered. The injection may be given 1 - 2 days early if needed, if the 28th day falls on a weekend or holiday. The EMAR indicated the resident did receive his injection on February 4, 2025, as registered nurse signed off. R1's facility progress note dated, February 12, 2025, at 4:27 p.m., indicated R1 received his Invega injection on February 11, 2025, at 2:30 p.m. in his right thigh. Prior to this progress note there was no previous documentation to indicate the injection was not given on February 4, 2025, as the nurse had indicated on the EMAR. During an interview on March 25, 2025, at 12:27 p.m., R1 stated he was to receive his Invega injection on February 4, 2025, as his last injection was given to him on January 7, 2025. R1 stated he documents on a personal calendar when his injection is due (every 28 days) and had recently started to have nursing initial on that calendar after they have administered the injection. The resident stated his medical provider set up the injection to be given every 28 days and he stated as the time gets closer to the injection, he is aware he needs the medication related to mental health. On March 25, 2025, at 2:35 p.m., the registered nurse consultant (RN)-A stated medication errors	01760		

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01760	Continued From page 3 are reported to the nurse with the unlicensed staff to start the paperwork and the nurse to complete the paperwork and close out the investigation. RN-A stated when she gave R1 his injection in March R1 mentioned he documents on calendar and injection was given late in February. During an interview on March 25, 2025, at 2:03 p.m., unlicensed personnel (ULP)-B stated in the EMAR the injection is set up to show up every 28 days. When the reminder pops up the ULP on the medication cart is to notify the nurse to administer the injection. ULP-B stated R1's order has been consistent for every 28 days at 9:00 a.m. ULP-B stated the facility recently hired a new registered nurse for a short period and during that time that nurse moved the date on the MAR and gave the injection on February 11, 2025, instead of February 4, 2025, which was the 28th day. ULP contacted the primary provider of the error and completed a near miss form for the missed injection. ULP-B stated she turned in the completed form to the facility executive director and unsure what became of the near miss of the medication form which was handed over. During an interview on March 27, 2025, at 12:08 p.m., a therapist stated she does not prescribe the residents medications but does see him twice a week. The therapist stated the resident expressed concerns with his mental health as he had not received his injection as ordered for the month of February 2025. The therapist stated when R1 does not receive his medication as ordered he becomes very anxious. The time the injection had been late the provider had a visit with R1 where he was not able to focus, would stare off, and was not thinking clearly. The therapist stated after the missed injection (injection administered on 35th day) had visited	01760		

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01760	Continued From page 4 with R1 and could tell R1 was still not back to baseline as it took him a few days after injection. An email received from the licensee on March 27, 2025, at 2:57 p.m. from RN-A indicated review of the EMAR in the facility system indicated the medication was administered on February 11, 2025, at 2:00 p.m. This was seven days late and, on the EMAR, there is a section which the nurse could have indicated reason the medication was administered late but did not select utilize this area appropriately to explain. Review of the facility's medication errors from November 1, 2024, through March 25, 2025, did not identify a medication error was documented or internally investigated to prevent further errors. The licensee's Documentation of Medication, Treatment and Therapy Management Services, dated November 7, 2024, indicated RNs, LPNs, and ULPs will appropriately document all medications provided to residents. Staff will document each task immediately after that task has been performed. Entries in the resident record will never be redacted. If there is an error in electronic documentation, staff will follow the HER's process for striking out an erroneous entry. The licensee's Medication Errors policy dated November 7, 2024, indicated whenever a medication error occurs the person discovering the error or the person responsible for the error will contact nursing supervisor immediately and explain the situation with details. The nurse will investigate and determine the potential harm and significance of the medication error. The RN will determine if the physician/prescriber needs to be notified. The RN or the RN's designee will call	01760		

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01760	Continued From page 5 the elder's representative, physician and/or ER if necessary. The same document indicated the nurse must immediately investigate the incident and determine if it is reportable to the common entry point. The same document indicated the internal investigation regarding a medication error will be led by the RN, consistent with VA investigation procedures and is responsible for implementing any follow up correction actions. TIME PERIOD TO CORRECT- Seven (7) days.	01760		