

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL336066707M
Compliance #: HL336061147C

Date Concluded: February 21, 2025

Name, Address, and County of Licensee

Investigated:

Lange Board and Room Assisted Living
13892 37th Street
Clear Lake, MN 55319
Sherburne County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Barbara Axness, 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 alleged perpetrator (AP), an unlicensed personnel (ULP) at the facility, neglected the resident when he failed to follow medication administration procedures and gave the resident another resident's suboxone, an opioid medication. The resident was evaluated in the hospital.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was not substantiated. Although the resident was given another resident's opioid medication, the error was an isolated incident. The resident was hospitalized for observation and returned to their baseline health condition.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted the guardian. The investigation included review of the resident record, hospital records, facility internal investigation documentation, facility incident reports, personnel files, staff schedules, and

related facility policy and procedures. Also, the investigator observed medication administration at the facility.

The resident resided in an assisted living facility. The resident's diagnoses included Schizophrenia. The resident's service plan included assistance with medication administration. The resident's assessment indicated the resident was dependent on staff for assistance with most activities of daily living, including medication administration.

Progress notes indicated the AP called the registered nurse (RN) after he realized the resident was accidentally given another resident's suboxone film medication. The AP reported he initially thought it fell in the garbage but when he noticed the resident acting different, the resident reported he felt he "swallowed a thin paper thing" with his medications. The RN directed the AP to take the resident's vitals, and all were normal except his oxygen. The RN immediately notified the primary care provider who directed the resident be seen in the emergency room for respiratory depression.

Hospital records indicated the resident was given a dose of Narcan in the emergency room and admitted for observation. The resident returned to his baseline health condition and discharged back to the facility the next day.

The AP's employee record indicated he was appropriately trained on medication administration and did not have a history of medication errors.

The facility's internal investigation indicated the AP was retrained on medication administration after the error occurred.

During an interview, the AP stated he prepared another resident's medications, which included the suboxone film, to give to her as she was outside the medication room and waiting for her medications. The AP stated after he had prepared them, the resident left so he put them back in the medication room and started working on preparing medications for the resident who was waiting for them. The AP stated he had grabbed a medication cup and put the medications for the resident in them and gave them to the resident to take. When the AP went to administer the other resident's medications, he realized the suboxone film wasn't in there and the garbage can was open, so he assumed it had fallen in there. The AP notified the RN that the medication had fallen in the garbage and continued with his shift. The AP stated about an hour or so later, he noticed the resident was acting differently and asked him if he was ok. The resident reported he felt that he swallowed paper, and the AP realized the resident had ingested the suboxone film. The AP immediately notified the RN and the resident was sent to the emergency room for evaluation.

During an interview, the RN stated as soon as the AP called her, she had him take the resident's vitals and since his oxygen was below normal levels, she reached out to the primary care

provider. Since the primary care provider was worried about possible respiratory depression, they were directed to send the resident to the emergency room.

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: Yes

Action taken by facility:

The facility reported the incident to MAARC. The facility retrained the AP on medication administration practices.

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: 33606	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/03/2025
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NAME OF PROVIDER OR SUPPLIER LANGE BOARD AND ROOM INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13892 37TH STREET CLEAR LAKE, MN 55319
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(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	<p>Initial Comments</p> <p>On February 3, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL336066707M/#HL336061147C. No correction orders are issued.</p>	0 000		

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