

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL397767302M
Compliance #: HL397767002C

Date Concluded: April 1, 2025

Name, Address, and County of Licensee

Investigated:

St. Charles Assisted Living
402 West 4th street
St. Charles, MN 55972
Winona County

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

Evaluator's Name: Lena Gangestad, 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 medications were inaccurately discontinued, causing the resident to experience shortness of breath, increased pain, agitation, and hallucinations.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was not substantiated. An error occurred when a medication was medications were inadvertently discontinued without a corresponding physician order, resulting in one missed dose. The error was identified and corrected once identified, and the medication was resumed. The error was an isolated incident, and no harm occurred to the resident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident's records, internal investigation documentation, incident reports, personnel files, staff schedules, policies, and procedures.

The resident resided in an assisted living facility and had diagnoses including heart failure. The resident's service plan included assistance with medication administration.

The resident's medication administration record indicated prescriptions for haloperidol 0.5 mg, one tablet once daily for delirium, nausea, and vomiting, and every four hours as needed; and morphine solutab 5 mg, one tablet every 12 hours for dyspnea and pain, with one tablet by mouth every hour as needed for shortness of breath and pain.

A concern arose when a hospice nurse visited and discovered that all medications had been discontinued without physician orders.

During an interview, the hospice nurse stated she spoke with the facility nurse at that time, who reported receiving an order to discontinue medications but was only able to locate a discontinuation order for senna (a stool softener). The hospice nurse stated the resident's condition had been changing frequently, resulting in multiple order changes in which prior orders were discontinued and replaced with new orders, including dosage or frequency adjustments, and this included senna. However, on that day, only senna was discontinued. On the day of the incident, the resident missed a morning dose of morphine. The hospice nurse stated all medications had been destroyed, and hospice staff subsequently obtained medications from the pharmacy and delivered them to the facility. She said the resident sometimes refused medications based on overnight staff reports but typically did not refuse medications when administered by her. She described the resident as confused and requiring patience during medication administration.

During an interview, the care coordinator stated the resident's medications were changed frequently due to her condition. The care coordinator also stated the resident often refused medications and was not typically compliant with taking pills. The care coordinator reported being in the building on the day of the incident and contacted the regional nurse to confirm the medication orders were entered correctly.

During an interview, a manager stated she was not on site that day. The manager stated medication changes had occurred, and the care coordinator and hospice nurse contacted her to manually enter the medications in. She confirmed the resident missed one morning dose.

During an interview, an unlicensed caregiver stated the resident's medications were changed frequently, sometimes as scheduled and sometimes on an as-needed basis. T

The caregiver said the resident was more tolerant of medications in liquid form versus tablet form. The caregiver estimated the resident agreed to take her medications about 50% of the time.

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; or

(5) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult that results in injury or harm, which reasonably requires the care of a physician, and:

(i) the necessary care is provided in a timely fashion as dictated by the condition of the vulnerable adult;

(ii) if after receiving care, the health status of the vulnerable adult can be reasonably expected, as determined by the attending physician, to be restored to the vulnerable adult's preexisting condition;

(iii) the error is not part of a pattern of errors by the individual;

(iv) if in a facility, the error is immediately reported as required under section 626.557, and recorded internally in the facility;

(v) if in a facility, the facility identifies and takes corrective action and implements measures designed to reduce the risk of further occurrence of this error and similar errors; and

(vi) if in a facility, the actions required under items (iv) and (v) are sufficiently documented for review and evaluation by the facility and any applicable licensing, certification, and ombudsman agency.

Vulnerable Adult interviewed: No. The resident was deceased.

Family/Responsible Party interviewed: No, attempted but did not reach.

Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility: The facility and hospice worked together to resolve the error.

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: 39776	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/28/2026
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NAME OF PROVIDER OR SUPPLIER ST CHARLES RETIREMENT COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 402 WEST 4TH STREET SAINT CHARLES, MN 55972
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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 January 28, 2026, the Minnesota Department of Health initiated an investigation of complaints #HL397767302M/HL397767002C . No correction orders are issued.</p>	0 000		

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