Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H56266082M
Compliance #: H56262142C

Date Concluded: December 2, 2025

Name, Address, and County of Licensee Investigated:
Rochester Rehabilitation and Living Center
1900 Ballington Boulevard Northwest
Rochester, MN 55901
Olmsted County

Facility Type: Nursing Home

Evaluator's Name: Kris Detsch, 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 a resident when they gave the resident steroid medication (prednisone) inaccurately. The resident received prednisone tablets at a ten times greater dosage than the physician prescribed for thirteen dosages.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. Multiple systemic facility errors contributed to the resident's inaccurate medication management. He received 50 milligrams (mg) of prednisone (steroid medication) for thirteen doses. He was supposed to receive 5 mg dosage. As a result of this medication error, he required hospitalization in the intensive care unit (ICU) due to acute (sudden) heart arrhythmias (abnormal heartbeat) and acute heart failure.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident records,

hospital records, pharmacy records, facility internal investigation, facility incident reports, and related facility policy and procedures.

The resident resided in a skilled nursing facility. The resident's diagnoses included heart failure and kidney disease. The resident had a kidney transplant and required prednisone daily to prevent his body from rejecting the transplanted kidney. The resident's care plan indicated he required assistance with dressing, grooming, toileting, mobility, and medication management. The resident had high blood pressure and heart failure. The facility staff were to monitor his vital signs (blood pressure and pulse) and notify his physician if they were abnormal.

Medical records indicated the resident lived at the facility and received services in their rehabilitation unit. The resident had wounds which required surgical intervention, so he discharged from the facility and went to the hospital. The resident returned to the facility approximately ten days later. Upon his re-admission to the facility, the pharmacy sent the facility his medications.

The resident's discharge orders included an order for prednisone 5 mg daily for renal transplant to prevent organ rejection.

Records indicated 18 days later, the pharmacy notified the facility, they erroneously sent 50 mg tablets of prednisone. (The resident was supposed to receive 5 mg tablets.)

The resident's medication administration record (MAR) accurately transcribed the correct dosage of prednisone. The MAR contained the initials of six different nurses who gave the resident prednisone from the time he readmitted to the facility, to the discovery of the prednisone error. Of those six nurses, four were agency nurses (pool nurses). Because the pharmacy only sent out fourteen 50 mg tablets, and the facility returned one tablet. The resident received thirteen tablets of the 50 mg dosage. The facility had some supply of prednisone 5 mg tablets prior to receiving the 50 mg tablets. The facility nurses failed to verify the right dose prior to medication administration when the medication card with the erroneous dose was used.

Progress notes indicated two days after the pharmacy discovered the medication error, the resident's blood pressure was 193/93 (normal blood pressure 120/80). The resident had a headache and chest pressure, so he went to the hospital for evaluation.

Hospital records indicated the resident had acute (sudden) shortness of breath, heart failure, and an abnormal heart rate due to an overdose of prednisone. The resident received care and treatment in the cardiac unit of the hospital and returned to the facility two days later.

Additionally, vital sign reports indicated the resident's blood pressure (BP) readings increased over the duration he received the inaccurate dosages of prednisone. Although there were some fluctuations in results, his BPs were significantly higher than previous recordings. There were

multiple days his systolic BP (top number) was over 170 and twice over 180. The vital sign report contained a “warning” next to the resident’s recorded BP readings. The warning indicated any systolic BP over 139 was “high.” During the time the resident received the erroneous prednisone dosages, nine out of eleven BP readings were over 139.

Medical records lacked indicated the facility nurses contacted the resident’s physician at the time they obtained unusually high blood pressure readings or adjusted his parameters in the computer system to alert nursing staff which BP reading were outside his acceptable baseline health status.

During an interview, nurse #1 said she received a call from the pharmacy who told her they sent the wrong dosage of the resident’s prednisone. Nurse #1 said she went to the medication cart and removed the card of prednisone. Nurse #1 said she compared the instructions written on the card, with the instructions written in the computer’s MAR and determined the instructions written in the MAR were correct. The instructions in the MAR contained accurate orders for staff to give the resident 5 mg of prednisone every day, but the staff gave the resident prednisone tablets from the card the pharmacy erroneously sent which contained 50 mg tablets. The nurse said she removed the medication card and brought it to the director of nursing (DON).

During an interview, nurse #2 said nurse #1 came to her and asked about the resident’s prednisone dosage. Nurse #2 said she pulled out the card of prednisone and saw it contained 50 mg tablets (written on the card). Nurse #2 said the MAR contained instructions to give 5 mg (accurate dosage). Nurse #2 said she did not take the time to compare the medication card with the instructions on the MAR before she gave the medication to the resident. Nurse #2 said there were no other cards of prednisone for the resident in the medication cart. Nurse #2 said the facility did not have any process how to check (verify) medication for accuracy when the pharmacy delivered them to the facility. Nurse #2 described the facility workload as “very busy” and said the medication carts were in disarray.

During an interview, nurse #3 said she worked for the facility less than two months when the error occurred. Nurse #3 said she noticed the discrepancy between the instructions written in the MAR and the instructions written on the card of prednisone, and reported it to another nurse who was training her at the time. Nurse #3 said that nurse told her the error was probably in the MAR. Nurse #3 said the nurse her was from an agency (pool nurse). Nurse #3 said she did not give the resident the medication and erroneously documented in the MAR. Nurse #3 said the medication carts were in disarray and organized awkwardly. Nurse #3 said the facility did not organize the medication carts by each resident’s room number, but rather by which resident received medications first in the morning. Nurse #3 said she was a new employee and did not know the residents very well. Nurse #3 said she discovered other medication errors and told mangers about them. Nurse #3 described her work experience at the facility as stressful and overwhelming. Nurse number #3 said she worked for the facility about 2 months and during this time, the facility had three different DONs.

During an interview, nurse #4 said the resident did not have parameters (baseline ranges) for his BP, but the computer system automatically "alerted" nurses when his BP was higher than normal. Nurse #4 said she was unsure how the computer system determined those parameters. When asked how nurses would know when to call the physician for an abnormal BP, nurse #4 said, "That's a good question." Nurse #4 said she was unsure how nurses would know, but as nurses they should have known what normal BP readings were and when to notify the physician even if there were no parameters in place. Nurse #4 described the workload for the nurses as "heavy", and said the facility used "a lot" of agency staff.

During an interview, a former DON said there were multiple cards of prednisone in the medication cart, but she determined the resident received thirteen dosages of the 50 mg tablets. The DON said multiple nurses gave the resident the inaccurate dosage. The DON said the nurses were not "paying attention" when they gave the medication. The DON said nurses should have noticed the difference in dosages between the instructions on the medication card and the instructions in the MAR. The DON said occasionally the nurse managers would go through the medication carts to remove discontinued medications, but this was not a regular occurrence. The DON said multiple cards of resident medications were in the medication carts because the facility did not have a place to store extra medications. The DON said nurses placed extra medication cards into the medication carts, and they administered medications from all different cards, as opposed to just one card at a time. The DON said after the error occurred, managers went through the medication carts to make sure resident medications were accurate. The DON said around this same time Minnesota Department of Health (MDH) surveyors were at the facility and determined multiple errors occurred because of the facility's mediation administration systems. The DON said there were a "whole ton" of errors, including medication cards with orders that did not match the orders in the MAR. The DON said the facility did not have a policy how to manage medication errors. The DON said "corporate" staff then came to the facility to help develop policies and procedures to address medication errors. The DON said MDH surveyors issued immediate correction orders to the facility because of medication errors.

During consultation, the pharmacist said the pharmacy sent out a fourteen-day supply of the resident's prednisone tablets (on the date he readmitted into the facility). The pharmacist said they sent the facility fourteen tablets of prednisone 50 mg, and the facility returned one tablet, so the resident received thirteen dosages.

During an interview, the resident said he took 5 mg of prednisone for "years" because of his transplanted kidney. The resident described his usual BP readings around 130/63, but said sometimes he does get higher readings. The resident said at the time of the incident, he did not "feel right" and could not breath, so he emergently went to the hospital. The resident said there were multiple medication errors from the facility, and he wanted to manage his own medications, however the facility continues to do so.

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.

Mitigating Factors considered, Minnesota Statutes, section 626.557, Subd. 9c(f):
(1) The facility followed an erroneous order, direction or care plan with awareness and failure to take action.

The facility did not direct an erroneous order, direction, or care plan.

(2) The facility was not in compliance with regulatory standards.

The facility failed to provide proper training and/or supervision of staff.

The facility provided adequate staffing levels.

(3) The facility failed to follow professional standards and/or exercise professional judgement.

The facility failed to act in good faith interest of the vulnerable adult.

The maltreatment was not a sudden or foreseen event.

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility completed medication audits.

Action taken by the Minnesota Department of Health:
MDH previously investigated the issue during a standard abbreviated survey under 42 CFR 483, Subpart B, Requirement for Long Term Care Facilities, and substantiated facility 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

The purpose of this investigation was to determine any individual responsibility for alleged maltreatment under Minn. Stat. 626.557, the Maltreatment of Vulnerable Adults Act.

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

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Olmsted County Attorney
Rochester City Attorney
Rochester Police Department
Minnesota Board of Pharmacy
Minnesota Board of Nursing

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29822	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rochester Rehabilitation And Living Center	**1900 BALLINGTON BOULEVARD NW , ROCHESTER, Minnesota, 55901**

(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) COMPLETION DATE
20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: The Minnesota Department of Health investigated an allegation of maltreatment, complaint H56266082M and H56266063M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. The following correction order is issued for H56266082M, tag identification 21850.	20000		

Office of Primary Care and Health Systems Management

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

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29822	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/06/2025

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20000	Continued from page 1 The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul .htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "reviewed" in the box available for text. Then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	20000		
21850	Patients & Residents of HC Fac.Bill of Rights CFR(s): MN St. Statute 144.651 Subd. 14 Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, as the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. This LICENSURE REQUIREMENT is NOT MET as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment. 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.	21850		