Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL303609426M
Compliance #: HL303607165C

Date Concluded: June 21, 2024

Name, Address, and County of Licensee Investigated:
Cornerstone Residence of Fosston
115 1st Street East
Fosston, MN 56542
Polk County

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

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 facility neglected the resident when staff failed to administer the resident's medications according to physician orders and in accordance with the resident's service agreement. The resident was given another resident's medications, which included a medication to manage blood sugar levels. The next day, the resident was found unresponsive and taken to the emergency room where she was treated for low blood sugar.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the resident was given incorrect medications, the error was an isolated incident. The resident's physician was immediately notified of the error and staff monitored the resident's condition. When a change in condition was observed, the resident was sent to the hospital for further evaluation. The resident was treated in the hospital for low blood sugar and returned to their baseline health condition. The unlicensed personnel (ULP) responsible for the medication error

received appropriate training and did not have a history of medication errors. The facility reported the incident and took action to reduce the risk of recurrence.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of resident records, hospital records, facility internal investigation documentation, facility incident reports, personnel files, staff schedules, and related facility policies and procedures. Also, the investigator observed care and services in the facility and the medication storage system.

The resident resided in an assisted living facility. The resident's diagnoses included dementia and hypertension (high blood pressure). The resident's service plan included assistance with dressing, toileting, transfers, and medication administration. The resident's assessment indicated the resident did not have any past issues with low blood sugar and did not take any medications for blood sugar management.

Facility documentation indicated an overnight shift ULP gave the incorrect medications to the resident. Day shift ULP noticed the resident's medications were still in her medication box and the resident whose medications the ULP was supposed to administer were not in the medication box. The ULP immediately notified the registered nurse (RN). The resident's vital signs, including blood sugar, were checked and within normal limits. The resident's primary care provider was updated and advised staff the error shouldn't be a problem. The facility's internal investigation determined the resident was likely given another resident's medications which included Amaryl and Metformin (medications to control high blood sugar in people with type two diabetes). The resident's blood sugar did not drop until the next day. Staff were directed to monitor the resident and when night shift staff checked on the resident, she was not responsive. The on-call RN was contacted and 911 was called.

Hospital records indicated the resident's blood sugar was 14 when checked by emergency medical service personnel. The resident was unresponsive when she arrived at the emergency room, spent two days in the hospital, and discharged back to the facility.

During an interview, the facility RN stated she was not sure how the error happened because the ULP who made the error had been a long-term employee who did not have a history of medication errors.

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.
(c) For purposes of this section, a vulnerable adult is not neglected for the sole reason that:
(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, due to cognitive impairment
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility immediately notified the physician after the error was identified. Facility staff monitored the resident. Emergency medical services were immediately notified after the resident was found unresponsive. The facility reported the incident and retrained facility staff.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30360	A. BUILDING: _____ B. WING _____	C 04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE RESIDENCE FOSSTON	115 1ST STREET EAST FOSSTON, MN 56542

(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 April 19, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL303609426M/HL303607165C. No correction orders are issued.	0 000		