Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL307757665M
Compliance #: HL307754363C

Date Concluded: September 19, 2023

Name, Address, and County of Licensee Investigated:
Cornerstone Residence Senior Care
421 6th Street Northeast
Bagley, MN 56621
Clearwater County

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

Evaluator's Name: Carol Moroney 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) neglected the resident when the resident was given another resident's medications resulting in a hospitalization.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. An error in therapeutic conduct occurred when the AP gave another resident's medications to the resident. The error was not in a pattern of errors by the AP. Although, the resident was hospitalized due to low blood, the resident returned to the facility the next day at baseline health condition. The facility retrained the AP in medication administration.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of resident medical records, hospital record, personnel files, medication incident reports and policy and procedures. The investigator observed medication administration at the facility.

The resident resided in an assisted living memory care unit. The resident's diagnoses included high blood pressure and edema (swelling). The resident's service plan indicated the resident required assistance with bathing, activities of daily living, oral hygiene, vital signs, medication management, toileting, and safety checks. The resident's progress notes indicated a history of the resident have low blood pressure and the facility staff intervention was hydration. The resident's assessment indicated occasional anxiety. The resident was cooperative most of the time but had some confusion. The resident was high risk for falls.

The residents progress notes indicated the resident was given another resident's medications which included Amlodipine (to treat high blood pressure). The AP notified the nurse of the error. After receiving the wrong medications, the resident's blood pressure became very low and emergency services were called. The resident was given juice and fluids while the facility staff awaited the arrival of emergency services. The resident admitted to the hospital over night for treatment and observation. During the event, the family changed the resident's code status to "do not resuscitate". The resident returned from the hospital the next day. The resident had no new documented related medical issues and was back at baseline.

The resident's hospital discharge record indicated the resident admitted for low blood pressure after receiving amlodipine at an assisted living facility which was not his medication. The resident was given a large amount of normal saline (intravenous fluids) in the emergency room and was given adequate oral liquids. The resident was observed overnight with no issues reported and discharged back to the facility the next day.

The facilities incident reports were reviewed, and no trends were identified. The facility completed an investigation into the medication error. The facility completed medication retraining and competency with the AP.

During an interview, the AP stated she was supposed to check the electronic Medication Administration Record (EMAR) and compare it to her number of pills the resident's medication holder contained. If the number of pills did not match the EMAR, the staff need to call the on-call nurse. The AP also stated she consistently compares the resident's name to the list of medications. The AP stated, this incident, after counting the medications as required, she put the medications into pudding, and she gave the medications to the wrong resident. The wrong resident takes their medications in pudding. The AP stated there was a lot going on with toileting other residents, giving medications, and passing meals. The AP said she was busy and made an error. The AP said she was trained on the correct way to give medications and all the proper checks. The AP said she and all other unlicensed personnel (ULP) were retrained following the event as well.

During investigative interviews, facility ULP staff collectively stated they use the EMAR to pass medications. The correct way to pass medications was to check the EMAR against the resident's medications in the medication caddie. The staff need to count the numbers of medications to

be given on the EMAR against the number available in the caddie. If the number of medications did not match the staff need to call one of the nurses for assistance. The staff said it can get busy and it is hard to keep up on everything sometimes.

During investigative interviews, nursing staff stated the same process as the ULP staff for passing medications. The nurses said all the ULP were retrained on proper procedure to pass medications. The AP was retrained by completing the medication administration education course.

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:
(a) 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: Yes.

Family/Responsible Party interviewed: No, declined.

Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility immediately rendered medical care to the resident. The facility did an investigation and determined the AP did not count the medications as required. The facility removed the AP from passing medications and retrained the AP specifically on the proper procedure.

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
	30775	A. BUILDING: _____ B. WING _____	C 08/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE RESIDENCE SNR CARE	421 6TH STREET NE BAGLEY, MN 56621

(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 August 29, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL307754363C/#HL307757665M. No correction orders are issued.	0 000		