Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL348752582M
Compliance #: HL348754547C

Date Concluded: May 28, 2025

Name, Address, and County of Licensee Investigated:
Talamore Senior Living
215 37th Ave. N
St. Cloud, MN 56303
Stearns County

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

Evaluator's Name:
Jana Wegener, RN, Special Investigator

Finding: Substantiated, individual 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 alleged perpetrator (AP) neglected the resident when the AP administered another resident's medication to the resident in error. The resident was transferred to the emergency department (ED) and was hospitalized due to complications from the error.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The AP was responsible for the maltreatment. The AP failed to ensure safe medication administration practices were followed when she took medications prepared by another staff and gave them to the wrong resident with the same first name. The AP did not verify which medications were prepared by the other staff and did not ensure she was administering the medications to the correct resident. The resident was transferred to the emergency department (ED) and hospitalized for 8 days with complications associated with the medication error.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family. The investigation included review of the resident record(s), hospital records, facility internal investigation, facility incident reports, personnel files, staff schedules, related facility policy and procedures. Also, the investigator observed medication administration practices, residents, and staff at the facility.

The resident resided in an assisted living facility with diagnoses including coronary artery disease, hypertension, and gastroesophageal reflux disease (GERD).

The resident's assessment and service plan indicated he was cognitively impaired related to dementia and received medication management and administration services.

A facility incident report and progress note the day of the incident indicated the on-call nurse was notified the resident was given another resident's medications in error at about 10:40 p.m. including Metoprolol extended release (ER) 50 milligrams (mg) (a blood pressure medication), Remeron 30mg (an antidepressant that can cause drowsiness), and Seroquel 100 mg (an antipsychotic medication that can cause sleepiness, confusion, and difficulty swallowing). The report indicated staff were instructed to call 911 at 11:07 p.m. The resident was sent to the ED and hospitalized.

A facility investigation report indicated the AP received report at shift change that indicated staff had trouble administering medications to a resident with the same first name as the resident. The staff asked the AP if she could try to administer the medication, removed the prepared medications from a paper pouch, placed them in a med cup, and gave them to the AP to administer. Shortly after, the AP received a message to be cautious because the resident she was supposed to give the medications to had a dog. At that point the AP realized she had administered the medications to the wrong resident. The facility investigation indicated the AP immediately notified the on-call nurse and leadership nursing of the error. The facility investigation indicated the AP acknowledged via text message she should have been more diligent and completed the rights of safe medication administration prior to giving the medication.

The resident's ED and hospital record indicated the resident presented to the ED for evaluation following a medication error. The record indicated the resident received his routine medications around 6:00 p.m., then was given another residents medication in error. The resident developed a wet sounding cough, required suctioning, was unable to tolerate oral intake, or protect his airway and was admitted to the hospital. A progress note indicated although the medications given to the resident in error did not directly affect the resident's ability to breathe, they had sedative properties which likely altered the resident's mentation enough to worsen his ability to manage his secretions contributing to the resident's inability to protect his airway. The resident developed worsening confusion with respiratory distress and hypoxia requiring 15 liters of oxygen and was transferred to the intensive care unit (ICU) for close

monitoring. The resident required intravenous antibiotics for concerns of aspiration pneumonitis with possible aspiration pneumonia and was diagnosed with acute encephalopathy with delirium secondary to the medication error. The resident developed sepsis from the aspiration, was hospitalized for 8 days, and discharged back to the facility on hospice.

The AP's personnel files indicated the AP was educated, trained, and competent to administer medications to residents at the time the incident occurred. The AP's training and competency included the rights of safe medication administration to ensure the right medication for the right resident.

When interviewed facility leadership stated the AP was going to do evening cares for the resident when she was asked by staff to help administer medications to another resident with the same name. Leadership stated the names got mixed up in the AP's mind, and the AP gave the medications to the wrong resident. Leadership indicated when staff mentioned something about the other resident's dog it clicked for the AP that she had given the medications to the wrong person because the resident did not have a dog.

When interviewed the other staff involved stated she had reported difficulty giving medications to a resident (same first name) who had sicced his dog on the staff person. The staff asked the AP to try to give them because they were important medications and stated the first and last name of the resident who needed the medications, then gave the pills to the AP to administer.

When interviewed the AP stated the PM (evening) staff reported they had issues giving medications to a resident with the same first name. Although the AP denied hearing the first and last name of the resident who needed the medications, the AP stated she did not know what medications she was giving and had not verified the medications with the MAR prior to administering them. The AP indicated it was not acceptable to give medications someone else had prepared that were not verified to ensure the rights of safe medication administration were followed. The AP stated she should have checked the resident's MAR prior to giving the medications.

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.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The resident was transferred to the ED for evaluation and hospitalized. The facility investigated the incident, provided coaching and re-education to the staff involved in the incident, and safe medication administration training to all staff.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment.

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

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
Stearns County Attorney
St. Cloud City Attorney
St. Cloud Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34875	A. BUILDING: _____ B. WING _____	C 05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TALAMORE SENIOR LIVING	215 37TH AVENUE NORTH SAINT CLOUD, MN 56303

(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 ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL348752582M/#HL348754547C On May 15, 2025, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 140 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL348752582M/#HL348754547C, tag identification 2360.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

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02360	Continued From page 1 sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: Based on interviews and document review, the licensee failed to ensure one of one residents (R1) reviewed was free from maltreatment Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, a individual facility staff person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		