Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL397768482M
Compliance #: HL397765304C

Date Concluded: March 20, 2025

Name, Address, and County of Licensee Investigated:
St Charles Assisted Living Facility
402 W 4th St
St Charles, MN 55972
Winona County

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

Evaluator's Name: Julie Serbus, 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 a medication order change was not implemented causing the resident's health to decline.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. There were two medications addressed in the investigation. The first was torsemide, a diuretic (medication to remove fluid buildup in the body) was administered as ordered. The second was an eye drop for which the facility did not receive the order initially however it was administered once the order was received.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family members. The investigation included review of the resident record(s), provider orders, pharmacy records,

hospice admission and orders, related facility policy and procedures. Also, the investigator made an onsite visit to observe staff and residents interacting.

The resident resided in an assisted living memory care unit. The resident's diagnoses included congestive heart failure, pulmonary fibrosis, atrial fibrillation, chronic back pain, and osteoarthritis of both knees. The resident's admission care plan included medication management. The resident also enrolled in hospice services.

Torsemide

The resident had an appointment during which his medical provider made changes to his medication regimen. However, a concern arose the facility did not implement the medication changes.

The progress notes indicated the resident had an appointment with his medical provider, who had ordered to increase torsemide to 20 milligrams (mg) twice a day. The documentation from the medical provider's office indicated the reason was for congestive heart failure. Aside from the torsemide order change, there were no other medications changes on the documentation from the appointment.

The electronic medication administration record (EMAR) and the progress notes indicated the facility administered the medications as ordered with the exception of the afternoon dose on the day the order was received after the appointment. The progress note written acknowledging receipt of the order was computer timestamped after 5 pm.

The following day the progress note indicated the facility nurse received information regarding a hospice referral for the resident.

Three days after the appointment the progress notes indicated additional parameters to titrate the resident's torsemide based on daily weight was received. However, the same day the facility informed the medical provider this was not something the facility could do.

Seven days after the medical appointment, the resident enrolled in hospice and new hospice orders indicated to reduce the frequency of weights although the dose of torsemide remained the same. In addition, hospice was to take over obtaining and monitoring resident weights. The EMAR indicated the facility administered the medication as ordered.

Eye Drops

Approximately two-and-a half weeks after the resident's appointment, the facility received a fax summary of the resident's new prescriptions which indicated the medical provider had ordered eye drops however that same prescription had not been included on the documents provided to the facility. While the pharmacy had mailed the eye drops to the facility, the eye drops had been placed in the medication bin but not implemented.

The EMAR indicated the eye drop was administered for three days and then discontinued.

The progress notes indicated the eye drops were replaced with eye compresses.

During an interview, a nurse stated the resident's family was responsible for taking the resident to his medical appointments. The nurse stated the only new order or change made at the medical appointment was an increase to the diuretic, which was implemented. The nurse stated only the evening dose of the diuretic was not administered the first night of the increase as the facility had not received the medication from the pharmacy. The nurse stated the resident's pharmacy receives prescriptions from the medical provider and mails medications to the facility. The nurse stated when medications come through the mail staff will place the packages in the nurse's office unless the facility was expecting a new order then the nurse may ask the staff to open the package since she is not there physically present every day. The nurse stated there was not mention or indication the provider had prescribed an order for eye drops until a family mentioned sometime after the resident's appointment, which prompted the nurse to search for and find the eye drops. At this point, the facility still had not received an order for the eye drops so the medical provider was contacted, an order obtained, and the eye drops were started as ordered.

During interviews with multiple family members, a family member #1 stated she took the resident to see his primary provider related to his eye redness and irritation. While at the clinic the resident was weighed, and an increase was ordered for the daily diuretic dosage. Family member #1 stated the provider also ordered an antibiotic eye drop. Family member #1 stated she felt the resident was getting worse after the medical appointment rather than getting better. Family member #1 stated the resident seemed to have more fluid and indicated the facility had not been administering the diuretic. Family member #1 stated the facility was not administering the eye ointment order for the resident as the eye was not getting better.

Family member #2, stated family decided to admit to hospice related to the decline and wanting the extra care. Family member #2 stated they met with hospice during which the hospice approach to cares was explained and the resident was enrolled into hospice.

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.

Vulnerable Adult interviewed: No
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: NA

Action taken by facility:
No action required.

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
	39776	A. BUILDING: _____ B. WING _____	C 02/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CHARLES ASSISTED LIVING	402 WEST 4TH STREET SAINT CHARLES, MN 55972

(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****** HOME CARE PROVIDER/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: #HL397765304C/#HL397768482M #HL397768544C/#HL397769442M On February 24, 2025, through February 25, 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 34 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for#HL397768544C/#HL397769442M, tag identification 1760 and 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.	
01760 SS=G	144G.71 Subd. 8 Documentation of administration of medication	01760		

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01760	Continued From page 1 Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure medications were administered as prescribed for one of one resident (R1) with records reviewed. Facility licensed staff had been unaware the medication had not been filled or administered to R1 for thirty-two days. R1 was at risk for harm with the omission of the numerous doses of the critical medication. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's face sheet indicated R1 admitted to the	01760		

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01760	Continued From page 2 facility on December 2, 2024, with diagnoses including autism, bipolar disorder with severe mania, and depression with anxiety with long term use of antipsychotics. R1's individual abuse prevention plan (IAPP) dated December 4, 2024, indicated R1 was at risk to being abused due to living in a congregate setting. R1's assessment dated, December 4, 2024, indicated R1 required assistance with taking medication and specific resident instructions related to the administration, monitoring, and documentation of medication could be seen on the medication administration record (MAR). R1's assessment indicated the resident did not have any difficulties taking her medications. This same assessment indicated the resident was at low risk related to uncomplicated medication regimen as far as specific instruction on how the medication must be ordered and filled by the pharmacy. R1's care plan dated December 18, 2024, indicated R1 required assistance for medical provider follow-ups on all health issues and appointments. The same document indicated R1 preferred medications to be effective for diagnoses and to be administered by staff members according to the medical provider's orders. Additionally, specific instructions relating to medication administration, monitoring, and documentation of medications is listed on the MAR. R1's medication administration record (MAR) dated December 2024, indicated R1 was prescribed Clozapine tablets 100 milligrams (mg) take three tablets by mouth daily and indicated	01760		

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01760	Continued From page 3 the following information: "**rems** not cycled - must reorder* *need labs and order to fill*." R1's December 2024 MAR indicated the first daily dose of the clozapine 100 mg daily was administered to the resident on December 4, 2024 through December 23, 2024 as ordered. On December 24, 2024, the MAR indicated the scheduled dose of clozapine was sent with the resident as R1 took the dose when she left the facility for the evening. However, the same document indicated from December 25, 2024 through December 31, 2024 the facility did not administer R1's clozapine as ordered by the medical provider. R1's January 2025 MAR indicated not the facility did not administer R1's clozapine for the entire month. The same document indicated had not been received by the facility from the pharmacy. R1's progress notes dated January 23, 2025, indicated a message was left for the primary care provider requesting assistance regarding additional behaviors R1 had recently been displaying. R1's progress notes dated January 24, 2025, indicated R1's provider care team contacted the facility and directed R1 to be seen in emergency department (ED) for a psychological evaluation and determine if any medications could be adjusted to help with increase in behaviors. A second progress note dated January 24, 2025, indicated R1 evaluated at the ED and discharged back to facility. Seroquel added with two additional doses as needed and recommending a	01760		

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01760	Continued From page 4 psychological consult. R1's progress notes dated January 26, 2025, indicated R1 had been restless, not been herself, refusing medication, yelling, has not eaten for a couple of days, and unsure if drinking any liquids. R1's progress notes dated January 26, 2025, indicated per a phone call received from a family member that R1 was taken to the ED and had been admitted to the hospital for a psychological evaluation, urinary tract infection, and severe dehydration. On January 28, 2025, the facility identified the failure to administer R1's clozapine to the resident. The report indicated the licensed staff had just been made aware of the error and R1 was now hospitalized. A review of the medical record did not identify documentation indicating the facility updated R1's medical provider nor took action to obtain clozapine for R1 until January 28, 2025. During an interview on February 25, 2025, at 10:34 a.m., unlicensed personnel (ULP)-E stated if a medication was not in the cart, it was to be reported to the resident care coordinator or the nurse as the extra stock of medications may be in the office. During an interview on February 25, 2025, at 1:37 p.m., resident care coordinator (RCC)-C stated unlicensed staff were documenting in the MAR "Skipped - med out of stock, Nurse notified." Even though this was the wording on the MAR it did not mean the nurse was physically contacted by staff regarding the medication was not available for administration. RCC-C stated for the lab work completed on January 14, 2025,	01760		

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01760	Continued From page 5 paperwork did not get sent along with the resident. Resident walked across the street herself to the appointment. During an interview on March 3, 2025, at 2:29 p.m., registered nurse (RN)-A stated the omission of R1's clozapine had not been brought to her attention even though on the MAR staff indicated the nurse was notified. RN-A stated when the resident admitted to the facility, R1's family member had brought in a bag with medications with clozapine included but could not tell me how many pills were handed over or date of the last lab draw. RN-A stated she was aware R1 required monthly blood draws for the medication to be filled. RN-A stated the family member would be responsible to set up the lab appointments for R1. RN-A stated she did not feel staff understood that by indicating on the MAR the nurse was notified did not automatically mean the nurse received the information. RN-A stated she was not aware R1's medication had not been reordered or received from the pharmacy until it was brought to her attention on January 27, 2025. R1 had not received her Clozapine since Christmas. RN-A stated unsure if staff have been re-educated at this point regarding this error. During an interview on March 5, 2025, at 1:56 p.m., family member (FM)-D stated the pharmacy had the lab work but did not receive a refill prescription from the medical provider to dispense the medication after the January 14, 2025, lab draw. FM-D stated R1 did not receive her clozapine until after admission to the hospital on January 27, 2025. FM-D stated the facility told her the last dose receive at the facility was January 13, 2025. FM-D stated R1 remains inpatient at the hospital since January 26, 2025. FM-D stated R1 was not back to her baseline at	01760		

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01760	Continued From page 6 this time. During an interview on March 12, 2025, at 10:43 a.m., a manager (MGR)-B stated when she signed the last dose out on December 24, 2024, that was sent with the resident for an outing MNR-B does not remember if it was the last dose. MGR-B stated if it were the last dose on the punch card, she would have mentioned it to someone. MGR -B clarified the information listed on R1's MAR when it included instructions regarding the clozapine, what "rem" means is a system providers place orders for the pharmacies. MGR -B was not aware the medication had not been administered for 32 days. MGR -B stated nursing is responsible when a resident is admitted to review meds and other clinical information. The licensee's 7.20 Medication & Treatment Orders dated January 31, 2024, indicated an order for medication or treatment must contain the name of the resident, a description of the medication, treatment or therapy to be provided and the frequency, duration, and other information needed to carry out the order. The licensed nurse will review all medication and treatment orders for progress, effectiveness and necessity on a regular basis and with resident change of condition. The license nurse will also monitor and evaluate medication and treatment/therapy orders and services for effectiveness on a regular basis. Nurse will notify primary care provider (PCP) of any discrepancies. A resident's MAR and TAR will be audited regularly by licensed nurse or designee for documentation compliance. Nurse will notify PCP of any discrepancies The licensee policy titled 7.24 Medication Error,	01760		

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01760	Continued From page 7 dated January 25, 2023, indicated for the safety of the residents at Cornerstone Management Services, the facility has a goal of zero medication errors. In the event an error occurs, staff will document, track, and resolve medication administration errors for quality improvement. Staff will be retrained if necessary. A review of information at https://www.mayoclinic.org/drugs-supplements/clozapine-oral-route/description/drg-20066859 conducted on March 20, 2025, identified the following comments regarding clozapine: Missed Dose If you miss 2 or more days of clozapine doses, talk to your doctor before you start taking it again. You might have to restart the medicine at a lower dose than you were taking before. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, 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: 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	02360		

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02360	Continued From page 8 occurred at the facility. Please refer to the public maltreatment report for details.	02360		