Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL331674881M
Compliance #: HL331676401C

Date Concluded: September 25, 2024

Name, Address, and County of Licensee Investigated:
Serenity Place on 7th
329 7th Avenue SE
Saint Joseph, MN 56374
Stearns County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:
Katherine Barnhardt 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 AP entered a new medication order into the resident's electronic medication administration record and did not discontinue the same medication existing order which resulted in a double dose administered to the resident.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although a medication transcription error did occur; however, this was an isolated event, and the resident had no adverse effects from the error.

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

incident reports, personnel files, staff schedules, related facility policy and procedures. The investigator observed unlicensed personnel administer medications and interact with residents.

The resident resided in an assisted living facility. The resident's diagnoses included traumatic brain injury. The resident's service plan included assistance with medication administration, supervision, and behavior management. The resident was independent with most activities of daily living (ADL's), used the facility exercise room independently and ambulated with a four-wheel walker. The resident had a history of depression, however, participated in activities and played the piano.

The resident's record indicated the resident had a history of depression that developed after a traumatic brain injury. The resident was on a long-term dose of an anti-depressant to manage symptoms. Mid-summer the resident was evaluated for worsened symptoms of depression that included suicidal ideology. The provider was updated and ordered a new dose of the same anti-depressant. The new order was issued on a Friday and licensed staff were not in the building to receive the resident's new order. The resident's new order was processed by an outside on-call system.

An internal investigation indicated during a Friday clinic visit the provider submitted new orders for a dose change to the resident's anti-depressant. On Saturday the pharmacy delivered the resident's new medication dose to the facility packaged and ready for administration. Unlicensed personnel notified an on-call service of the delivered medication. The on-call service retrieved the resident's new order from an electronic system attached to the provider and entered the new orders, however, did not discontinue the existing orders in the resident's electronic administration record that directed unlicensed personnel what medications to administer and when. Unlicensed personnel administered the resident both anti-depressant doses both days of the weekend. When licensed staff returned from the weekend and reviewed the provider orders on Monday, clarification was requested from the provider and the resident's medication order was corrected the same day.

During an interview, the AP stated she was aware of the resident's medications and knew there was a short period of time in mid-summer when there was confusion about the resident's correct dose of an anti-depressant. The AP stated during the period the provider submitted new anti-depressant medication orders to the facility the AP was away on vacation. The AP stated when she was unavailable another licensed staff or the on-call service managed new orders.

During an interview, licensed staff stated the resident had visited the provider at a clinic on a Friday and the provider had adjusted the anti-depressant medication dose. Licensed staff stated on Saturday unlicensed personnel notified the on-call service a pharmacy had delivered a new anti-depressant dose for the resident. Licensed staff stated an on-call service retrieved orders for the new dose from the providers electronic system and entered the new dose into the resident's electronic medication administration record. Licensed staff stated the on-call service had not discontinued the existing dose instructions and unlicensed personnel administered both

doses to the resident on both days of the weekend. Licensed staff stated upon return to the office on Monday, licensed staff reviewed the resident's orders and requested clarification. Licensed staff discontinued the resident's existing dose instructions.

During an interview, the resident stated he had a traumatic brain injury and staff managed and administered his medications. The resident stated the staff do a good job knowing his medications and check that he takes all ordered medications. The resident stated he had no emergency room visits or hospitalizations due to medication errors and he had no concerns with the staff that managed or administered his medications.

During an interview, the resident's family stated they have no concerns with the facility and were notified of the medication incident.

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: Yes
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility conducted an internal investigation and made changes to the order processing protocol.

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
	33167	A. BUILDING: _____ B. WING _____	C 09/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY PLACE ON 7TH	329 7TH AVENUE SE SAINT JOSEPH, MN 56374

(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 September 23, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL331674881M/#HL331676401C. No correction orders are issued.	0 000	Assisted Living Provider 144G. 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.	